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Understanding the Health Inequalities of LGBT
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**“Normalized Absence, Pathologised Presence”
Understanding the Health Inequalities of
LGBT People in Greece**

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School of Applied Social Sciences

February 2017

**Thesis submitted to Durham University for the degree of
Doctor of Philosophy**

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ACKNOWLEDGMENTS

I am grateful to many people who contributed to this thesis. Most importantly of all, I wish to express my sincere gratitude to all participants who gave their time, stories and insights; and without whom this research would not exist.

I also offer my sincere gratitude to my supervisor Dr.Vasilios Ioakimidis for the faith he showed in me which was a strong encouragement to start this research journey in the first place. As a supervisor, your trust, respect and self-confidence provided me the freedom to grow as a researcher. I also thank you for your comments, feedback, and guidance throughout this process. My thanks also go to my co-supervisors Dr.Mark Cresswell and Dr. Kimberly Jamie who extended this support during the first and the latter stages of this Phd.

The Greek Foundation for State Scholarships (I.K.Y) for funding this study as well as the people who work in the section of overseas scholarships for their help with dealing with all administration and bureaucratic matters.

I would also like to acknowledge the contribution of Christos Sagredos, Irene Petropoulou and Venia Kyriaki regarding the editing of my thesis.

I also want to express my deep appreciation and heartfelt thank you to Alexandra Vassiliou and Nancy Papathanasiou for being such wonderful and inspiring affirmative psychotherapists. Alexandra was a source of great emotional support and a teacher of what affirmative practice is. And Nancy brought hope, understanding and humor throughout some of my darkest moments. I am not the only one that you have helped prevent slip through the cracks, so I thank both of you for being there for me but also for the support you provide to others and to the LGBT community in particular.

To my father, Kostas Giannos, for his unconditional love and support over the years. And to my uncle, Ilias Giannos, who always believed that I could become a good writer and encouraged me to always analyze societal structures critically. I also owe a special mention to my sister Natassa Giannou and cousin Lena Kelvasilidou for always being there for me.

My colleagues and friends Barbara Carbon and Patrick Knaap for their support and fun we shared during the first year of my studies in Durham.

To my special friends, Maria Bousga, Venia, Kyriaki, Alkis Souliotis, Georgina Galanopoulou, Anna Andreou, and Niki Papagiannaki. Thank you all for believing in me, for listening, and offering support and advice through these years. I am also thankful to my colleagues Aleka Kyriakou, Lizeta Tsiftsi, Leonidas Liakos and Maria Kaltsi for their friendship, support and effort to maintain a collegial atmosphere at work despite the divisive and cruel hierarchical order in public services.

To a special treasure of my heart, my god-daughter Olga Mikroni. I appreciate the trust and the love you have always shown to me. You have always filled my heart with pride and inspiration as I was watching you making the best of every situation, even those you haven't necessarily chosen. I wish these experiences will broaden your horizon and add to a unique and bright future I am sure you will have!

Finally, to Efi Deli. This thesis was crafted with the force of my desire to not allow homophobia to hurt us. It is through our relationship I have learned that anything deserving to be eternal and liberated depends on our ability to transform ourselves and the world around us. I am grateful that you came into my life. It has been an incredible ride!

ABSTRACT

Homophobia and transphobia are two main modes of oppression affecting LGBT people. These interlinked forms of oppression make LGBT people feel disempowered, discriminated, and marginalized. Although there is a comprehensive body of literature exploring the impact of oppression on this part of the population, sexual orientation and gender identity are not yet highly recognised as factors of health inequalities. Respectively, health care services have been structured within a homophobic and transphobic society resulting unavoidably in important barriers and poor quality of health care for LGBT people. Internationally, there is a growing number of health studies that outline the ways homophobia and transphobia construct health inequalities for LGBT people. Being the first of its kind in Greece, this study aims at contributing to this body of knowledge by providing an opportunity to LGBT people in Greece to describe for themselves their realities in the public domain. To this end, an ethnographic approach was employed in drawing upon observations and interviews with LGBT groups and LGBT individuals, as well as with doctors, which facilitated a rich understanding of the ways that homophobia and transphobia violate LGBT health rights.

The findings of this study revealed that the health inequalities of LGBT people in Greece can be founded upon Phoenix's couplet "normalized absence, pathologised presence" (Phoenix, 1987). Invisibility in its many dimensions is undeniably interrelated with LGBT participants' experience of (low quality) health care (services) and is a recurring issue noted in every pattern of homophobia and transphobia I discuss throughout this thesis. Within a culture of silence and invisibility, the very system of ideas that historically pathologise LGBT people, is after all fostered. These findings are of value to those who want to promote the accessibility and the quality of health care services that LGBT people deserve. My suggestion is that in order to achieve these two goals, we should on the one hand overcome the invisibility of LGBT people, and comprehend the real notion of being discriminated, on the basis of sexual orientation and gender identity on the other. Unless we efficiently address such critical goals, 'sexual orientation' and 'gender identity' as bases of discrimination will remain abstract terms in official documents regarding health rights.

CHAPTER 1 INTRODUCTION

1.1 The rationale and the research questions of the study

In 2013, the Greek LGBT youth group “Good as You(th)” took action against the medical textbook ‘Forensics: from theory to practice’ (Psaroulis, 2008), which had been previously distributed to Medical School students at the Aristotle University of Thessaloniki. In this book, the author describes homosexuality as a sexual disorder, “a serious medical-social problem” presented as a subsection of pederasty. In addition, the author refers to gay men using the obsolete and derogatory 19th century term “uranians”. Therefore, the cause of male homosexuality appears to be the result of distant father-son relationships and over-protective mothering. Likewise, the author suggests that lesbianism is the result of the distance between mothers and daughters (Psaroulis, 2008).

The university, under the pressure from the LGBT activist group, decided to re-print a new edition of the book which omitted the section referring to homosexuality. Interestingly, however, the textbook is still distributed to students albeit with a characteristically blank page in it, as a stubborn reminder of the homophobic incident and since then no other action has been taken on the part of the university. Yet, very recently, the offensive content of the infamous blank page and its homophobic ideas re-emerged as part of the argumentation in favor of the banning of the 4th Pride Parade in the streets of Thessaloniki submitted to the Mayor of the City by Theology students.

This action, initiated by the University’s Theology students of Thessaloniki, can be surely seen as an explicit expression of hostility, demonstrating that invisibility is an important instrument of power. Yet, the explicit nature of their intention of banning the Pride makes resistance possible. The effort to suppress the Pride Parade was also fuelled by the University’s assumption that discrimination ends by simply erasing a page instead of dealing with the deeply rooted homophobia in Greek campuses. Ignoring everything that is relevant to LGBT people has always been the most common, yet powerful and effective form of oppression against LGBT people. Such oppressions are not confined in academia but, as this study

will demonstrate, invisibility in its many dimensions pervades every aspect of life of the LGBT community. In the field of health care in particular, LGBT patients experience the destructive power of 'invisibility' as a recurring issue associated with every known pattern of homophobia and transphobia.

The motivation of this study is based on a commitment to contribute to the emancipatory efforts of the LGBT community in Greece, which struggles for the creation of alternative politics and institutions based on diversity and inclusion. Therefore, this study is what Hansen et al. (2013) refer to as politically engaged ethnography. My hope is that the study will serve as a resource and a forum for public debate on the social determinants of LGBT health inequalities. Such debates may fundamentally advance the potential for the LGBT community to realise its demands for the creation of new modes in healthcare delivery and organization that will be respectful to LGBT people and respond proactively to their specific health care needs.

The aim of the study is to map, contextualize and understand the nature and impact of health inequalities experienced by LGBT people in Greece, by focusing on the role of homophobia and transphobia. Furthermore, there is a particular focus on 'how' these inequalities are structured and interrelated with other forms of oppression. The specific research questions of the study can be summed up as follows:

1. How is homophobia/transphobia experienced by LGBT people in health care settings in Greece?
2. How do homophobia/transphobia and the fear of homophobia/transphobia have an impact on the quality of health and health care experienced by LGBT people?
3. How do doctors perceive the impact of homophobia/transphobia on LGBT people's health and health care?

Additionally, several considerations and theoretical underpinnings framed this study and had important implications for both the objectives of the study and its design, which will be discussed in detail in the Methodology chapter. Epistemologically, this study is underpinned by intersectionality. As an inherently

critical approach, intersectionality stresses that social studies must have an explicit anti-oppressive purpose and therefore must be contributing to liberation movements (Lykke, 2010). Nevertheless, I do acknowledge that the degree to which I accomplished a critical analysis remains an open question given that what counts as critical in critical studies cannot be predetermined or answered straightforwardly (Potts and Brown, 2005).

Intersectionality also acknowledges multiple systems of oppression, which is rather important given that LGBT people compose a highly diverse community (Fish, 2008). Although the acronym LGBT is used as an umbrella term, and the health needs of this community are often grouped together, each of these letters represents a distinct population with its own health concerns (Institute of Medicine, 2011). Furthermore, among lesbians, gay men, bisexual men and women and transgender people, there are subgroups based on race, ethnicity, socioeconomic status, geographic location, age and other factors. Despite the diverse backgrounds and experiences among the LGBT group, hurtful, discriminatory and violent experiences due to homophobia and transphobia are what form LGBT people as a community (Institute of Medicine, 2011). This means that LGBT people suffer from the same socio-economic inequalities as all other heterosexual people as they can be found in all classes and income groups. Pre-existing inequalities related to class, gender, and ethnicity are therefore exacerbated by the effects of heterosexism, cissexism as well as the consequent invisibility and structural and societal discrimination (Dodds et al., 2005).

I have also used the strengths of the ethnographic approach which enabled a systematic and in-depth description of people's experiences associated with health issues and the experience of homophobia and transphobia. Ethnography has been described as a method that can make visible that which by definition is hidden from view (Hansen et al., 2013). This is particularly important given that homophobia and transphobia are still undertheorized, and the invisibility of LGBT people prevails in health and social care even in countries that have taken important steps for the elimination of LGBT inequalities (MacDonnell and Daley, 2015, Fish, 2006, Wilton, 2000). Moreover, as I will demonstrate in section 1.5, sexual orientation and gender identity are not adequately taken into consideration

as axes of health inequalities in health research and consequently in health services.

To my knowledge, this is the first study on health inequalities of LGBT people in Greece, which played an important role in my decision to provide an extended outline of the health care issues of the participants. At times, this was at the expense of a more in-depth exploration of particular issues, and more importantly, a restriction on my ability to operationalize intersectionality equivalently for all the issues discussed in this study.

The adoption of European Directives marked an important step towards the elimination of discrimination on the basis of sexual orientation and gender identity in Greece. For example, the Criminal Code, which already listed racist and homophobic motivation as an aggravating circumstance, was amended to include gender identity in 2013. In September of the following year, a new anti-racism law (Law 4285/2014) was adopted by the Greek Parliament aiming at strengthening the existing anti-racism criminal legislation. In December 2015, the legislation on Cohabitation Agreement was amended to include same-sex couples. Until then, Greece was one of the last countries in Europe where same-sex couples did not have a framework for a formal recognition, leading to Greece's conviction by the European Court of Human Rights (*Vallianatos vs Greece* on 7/11/2013).

From a comparative perspective, one could assume that with this legislative progression, Greece can be counted among the Western European countries where LGBT people have historically had more visibility and societal equality. Without an in-depth cultural understanding though, such assumptions remain questionable as culture cannot be legislated or controlled by changes in law. The Greek society has traditionally been influenced by the Orthodox Church which still retains a central role in the regulation of moral and social issues. The explicit homophobic stance of the Orthodox Church tends to interlock with the important institutions of Greek society such as family, the state, the military, the police force and the education system.

Furthermore, in an era where Greece was forced to adopt extreme austerity measures that brought Greek citizens to unprecedented deprivation, nationalism was fuelled by a generalised common feeling of injustice and impunity. Within

this climate, the slogans *Hellas Hellenon Christianon* (“Greece of Christian Greeks”) and *Patris, Threskeia, Oikogeneia* (“Fatherland, Family, Religion”) rooted in the dark period of the authoritarian regime of the junta during 1967-1974, were once again revived. Although not always explicitly included in current right wing politics, the slogans still encapsulate the renaissance of conservatism in Greece where the Orthodox Church and the patriarchal family are perceived as joint forces which care to rescue the Greek nation and its “moral order”. In the context of the rise of the Neo-nazi party Chrysi Avgi (Golden Dawn), racist, homophobic, transphobic violence and hatred discourse have substantially increased (ECRI, 2015). Despite the lack of an end-to-end system for the appropriate reporting of racist, homophobic and transphobic violence in Greece, the data recorded by the Racist Violence Recording Network¹ (RVRN) indicate an explosion of racist and/or homophobic/transphobic violence in Greece in recent years. Just for the year 2015, the RVRN reported 273 incidents of racist violence with more than 300 victims. LGBT persons were targeted in 185 of these incidents. In 75 incidents immigrants or refugees were targeted due to their national or ethnic origin, religion or color. In the remaining 11 incidents human rights defenders, a member of the Muslim community, Roma children and symbolic spaces or spaces used by collectivities were targeted (RVRN, 2015).

It is precisely this context of LGBT people’s lives in Greece that makes health and health care issues of LGBT people in need of special attention and documentation. However, homophobia and transphobia have not been reinvented by the rise of right-wing extremism and conservative rhetoric. As I will demonstrate in this thesis, LGBT people are traumatised and invisibilised even within health care contexts that are socially assumed to be incompatible with violence, politically neutral and oriented to the humanitarian treatment of all. The results of this study testify the need to place the health care sector in a higher priority when it comes to policy intervention for the protection of LGBT people against discrimination and poor quality health care treatment. The data analysis

¹ The Racist Violence Recording Network (RVRN) is an initiative of the National Commission for Human Rights (NCHR) and of the United Nations High Commissioner for Refugees’ Office in Greece (UNHCR). It is an umbrella network and its members are Non-Governmental Organisations (20 today) as well as other entities offering legal, medical social or any other support services that come into contact with victims of racist attacks. Since its establishment in October 2011, the joint forces of the RVRN, record cases of violence with a racist motive.

of this thesis also provides space for dialogue which will hopefully expand our understanding of homophobia and transphobia which are often discussed in decontextualised, abstract and/or narrow ways. This theoretical expansion is necessary for a broad-based paradigm shift towards more inclusive health care provision and policies.

Much of the relevant literature reviewed is incorporated into the findings chapters rather presented in a separate chapter. I found this method to be the most adequate way to combine the existing literature with my analysis and to allow the reader to easily access the links between data and theory. An exception to this pattern has been made to the first couple of subsections where I introduce the Greek health care system as the context where this study took place and then I frame my study within the international discourse and data on the LGBT health inequalities.

1.2 The health system and the right to equal treatment in Greece

Health is consolidated as a social right in the Greek Constitution. Founded in 1983, the National Health System (NHS) of Greece was based on the principle that all people deserve equal and free access, and the state was to be fully responsible for the provision of services to the population (Economou, 2010). However, the 2016 report of World Health Organisation (WHO) indicates that significant elements of the Greek NHS were only partially implemented or not implemented at all, causing particular problems in weak and fragmented primary care (e.g. urban health centers were never established), a lack of referral mechanisms and information and planning systems, and accumulation of substantial debt.

Moreover, the Greek NHS never accomplished recognition as a publicly provided service and the private sector expanded rapidly mainly through the establishment of diagnostic centers (Economou, 2010). In fact, Greece is consistently rated among the EU member states as having the highest levels of private expenditure (official and unofficial) on health care. As a result of the financial crisis and the inability of people to afford health care, out-of-pocket expenditure decreased to

26% in 2013. Nevertheless, it is still almost twice as high as the average for the EU member states (WHO, 2016, Economou, 2010).

Under-the-table payments, corruption and the black economy also pose a persistent structural problem in the Greek NHS, disproportionately burdening lower socioeconomic groups (Economou, 2010). With many doctors being (illegally) handed the well-known *fakellaki* (little envelope stuffed with cash) by patients, an interest in maintaining these practices was established. This also means that doctors are able to influence the entry of patients to hospitals, bypassing the queue, and such preferential treatment is rewarded with additional payments. Moreover, it is likely that many NHS and insurance funded doctors receive informal payments from private centers to channel patients for diagnostic or laboratory tests (Mossialos et al., 2005, Ballas and Tsoukas, 2004, Liaropoulos, 1998).

In terms of the right to equal treatment, in December 2016, the Greek government introduced anti-discrimination Law 4443/2016 to replace Law 3304/2005, which was the basic legal framework for the protection against discrimination during the previous 11 years. This law provides a framework for the protection against discrimination on the grounds of race, ethnic origin, religion, political or other beliefs, sex, disability, age or sexual orientation and extends to both the public and private spheres. It covers employment, social protection, education, health care and access to public goods and services, including housing. However, Law 4443/2016 adds gender identity/gender characteristics to the list of protected characteristics, defines the Greek Ombudsman (Συνήγορος του Πολίτη) as the primary national complaint mechanism supported by additional human and financial resources. The new legal framework aims at tackling the widespread and deep-rooted problem of police ill-treatment in Greece by establishing a national mechanism for investigating incidents of arbitrariness in security forces and in detention facilities.

Despite these promising legal developments, there is no anti-racism or anti-discrimination National Action Plan per se in Greece and failures in implementing earlier anti-discrimination laws persist. For example, Law 3304/2005 entrusted

three specialised bodies for the promotion of the principle of equal treatment: the Greek Ombudsman (Συνήγορος του Πολίτη), the Labour Inspectorate Body (Σώμα Επιθεώρησης Εργασίας) and the Equal Treatment Commission (Επιτροπή Ίσης Μεταχείρισης). Nevertheless, after 11 years the Greek Ombudsman seems to be the only fully operative equality body in Greece and constitutes the main body which provides information about legal protection against discrimination (Theodoridis, 2015). The Commission, in particular, shows a few signs of effectiveness. There is no information on the work of either the Committee for Equal Treatment or the Labour Inspectorate as complaints have not been recorded (Theodoridis, 2015). Similarly, there are no available statistics on the number of discrimination related cases having been brought to justice (ECRI, 2015). This is a severe gap given that situation analysis is a prerequisite for concrete action to fight inequalities and discrimination.

The result, in relation to gender identity and sexual orientation, is that Greece does not have an effective policy for the protection of LGBT persons or a strategy to promote tolerance vis-à-vis this group (ECRI, 2015). In addition, there is no national programme to raise awareness public and combat negative stereotypes and prejudices (ECRI, 2015). This is an institutional shortcoming that refers not only to LGBT people but to all other minorities (Theodoridis, 2015).

However, important changes for LGBT people have recently come into force. In 2014 a new anti-racism law (Law 4285/2014) was adopted by the Greek Parliament aiming at strengthening the existing anti-racism criminal legislation (ECRI, 2015). Sexual orientation and gender identity were included as grounds of aggravating circumstances in the old Article of the Criminal Code, and in Law 4285/2014, which added the new Article 81A on hatred motivated offences to the Criminal Code (ECRI, 2015). In 2015, Law 4356/2015 entitled same-sex couples to civil partnership although right to adoption was omitted. In addition, intersex people were recognised in legislation for the very first time. Besides, a few months earlier, the Health Public Law 39A, which allowed police to detain individuals they thought were HIV positive and enforced HIV screening, was officially repealed (ILGA, 2016).

1.3 Exploring LGBT health inequalities at a time of austerity in Greece

Despite the shared experiences among the LGBT communities internationally that primarily emphasize homophobia, LGBT people in Greece are currently faced with the extraordinary conditions created by the evolving economic crisis engulfing the country since 2007. The austerity measures that followed have deepened the crisis and disproportionately affected the most vulnerable groups of the population.

The loan conditions imposed by Greece's creditors brought massive cuts in public expenditure, mainly targeting public sector salaries, pensions, as well as budgets in health, education and welfare sectors. They also led to the privatization of public services and the liberalization of markets (e.g. private health sector) (Ifanti et al., 2013, Ioakimidis and Teloni, 2013, Kondilis et al., 2013). At the same time the unemployment rate is steadily increasing, reaching 24.4% of the population in January 2016 (more than 1 million unemployed people). Overall, the socioeconomic life in Greece, during the austerity years, is characterized by high rates of unemployment, job insecurity, decreased household income, poverty, and increase of mental disorders including high rates of suicides and substance abuse (Kondilis et al., 2013, Ifanti et al., 2013). Austerity brought an increased gap between the lower and the higher social class, disadvantaging the lower class and vulnerable social groups by significantly decreasing their purchasing power.

The effects of the economic crisis on the health care sector in Greece have been reported as disastrous (Kentikelenis et al., 2011, Kondilis et al., 2013). The Greek Government had by 2012 reduced public expenditure in health by more than 30% (Kondilis et al., 2013, Ifanti et al., 2013). These reductions resulted in closure of public hospitals and medical units (public hospitals were reduced from 216 to 83), understaffing of public hospitals, deficits in important medical supplies, a reduction in the number of hospital beds (from 35,000 to 33,000), drug shortage and, 75% payroll cuts from health personnel (Ifanti et al., 2013, Kondilis et al., 2013, Kalafati, 2012). In conjunction with the reported increase in the number of people using and asking for public health services, the quality of health services

has been reduced due to inability of the health system to maintain standards of care (Kaitelidou and Kouli, 2012, Kalafati, 2012).

Access to health services is extremely restricted as a result of the privatisation of health services that were free before the crisis and increased copayments for drugs and diagnostic tests (Ifanti et al., 2013, Kondilis et al., 2013). Against this background, a number of NGOs and grass-roots health care clinics staffed by volunteers provide standard medical services to the general population in a similar way they do during humanitarian crises in developing countries (Leigh, 2011, Ioakimidis and Teloni, 2013). In fact, it has been argued by Kentikelenis et al. (2011) that approximately 30% of Greek people seek medical attention from NGOs. Overall, because of Greece's bailout agreement, several health policies shifted costs to patients, leading to reductions in health care access (Economou et al., 2014, Kentikelenis et al., 2014). As Kentikelenis et al. (2014) report, compared with 2007, a significantly increased number of people reported unmet medical need in 2011. Inability to afford care or to reach services because of distance or scarcity of transportation was reported as the most important barrier in health care.

Health promotion and prevention policies have also been inhibited. The HIV/AIDS control budget has been severely decreased, policies for the control of epidemics (e.g. distribution of needles and condoms among drug users) were inhibited while some of the already limited number of drug rehabilitation/substitution programs and outreach-work programs have been suspended (Kondilis et al., 2013, Kentikelenis et al., 2011, Malliori et al., 2011). These events led to an outbreak of new cases of HIV infections among injecting drug users (from 15 in 2009 to 484 in 2012), and incidences of tuberculosis among this population has more than doubled since 2012 (Kentikelenis et al., 2014).

Austerity had also had a negative impact on the field of human rights too. For example, under the 31A Public Health Act between the periods 2011-2013, HIV testing for drug users, sex workers and immigrants was enforced under police supervision. On 29 April 2012, 27 women who were alleged to be sex-workers were arrested with criminal charges based on HIV status, their pictures and personal data (including confidential health information) were exposed in the

media upon statutory orders. In 2014, one day before World AIDS day, Katerina, one of the women who were imprisoned, prosecuted and shamed publicly, committed suicide. Moreover, within this human rights crisis, transgender citizens became particularly vulnerable and in summer 2013, the Greek Transgender Support Association reported purges and arrests of transgender citizens on a daily basis. Under the pretext that police should establish whether a particular person was a sex worker, trans women who were presumed as being sex workers by appearance were arrested, left to wait in police departments for more than 3-4 hours to be identified while they were humiliated, threatened and offended by the police officers (Greek Transgender Support Association, 2013, Galanou, 2013). The Greek Minister of Citizen's Protection, Mr. Dendias, justified the systematic police harassment of transgender women as an action to "improve the image" of city areas (TGEU, 2013). Not surprisingly, the lawsuit filed by a group of seven trans women against the police was deemed unfounded by the public prosecutor and the case was archived (Greek Transgender Support Association, 2015).

Another important indicator of the devastating effects of the economic crisis to Greeks is the increased rates of suicides, suicide attempts and mental health problems (Ifanti et al., 2013, Kondilis et al., 2013, Kentikelenis et al., 2011, Madianos et al., 2011). For example, in the first half of 2011, suicides had increased by 40% compared to the same period in 2010, particularly affecting men younger than 65, who were afflicted harder by unemployment (Ifanti et al., 2013, Kondilis et al., 2013). Despite these alarming numbers, mental health services have been seriously affected due to austerity measures. State funding for mental health decreased by 20% between 2010 and 2011, and by a further 55% between 2011 and 2012 (Kentikelenis et al., 2014). As a result, the mental health sector in Greece started to be re-directed towards a hospital-oriented direction. The economic crisis exacerbated the accumulating structural problems of the Psychiatric Reformation in Greece which has been in progress since 1984 and was led to a dead end (Hyphantis, 2013). Public and non-profit community mental health services scaled back operations, shut down, or functioned understaffed. In addition, plans for development of child psychiatric services have been abandoned (Kentikelenis et al., 2014, Hyphantis, 2013). Mental health

services in general hospitals are overwhelmed having to deal with enormous workload and waiting lists. Concerns about violation of human rights have also been raised, since the understaffed and overcrowded by patients psychiatric departments of general hospitals returned to the most repressive practices of total institutions including locked doors, restraints, seclusion, the unilateral use of drugs, the insufficient or even complete lack, of follow up and continuity of care (Megaloeconomou, 2012).

1.4 The LGBT movement in Greece

LGBT activism in Greece sprang after the fall of the military junta, which held power from 1967 to 1974 and following a violent coup wanted to keep Greek society away from communist ideas, western ideas and culture so as to enforce its nationalist and Christian values. However, even within a context of absolute censorship imposed by the junta, Greek gay students studying abroad and political dissidents living in self-exile provided information to gay people in Greece about the growing level of homosexual activism around the globe and the international discourse on issues of gender, sexuality and kinship (Kantsa, 2014, Dendrinou, 2008). Shortly after the fall of junta, some of the men who had joined the gay movement in France and Italy returned to Greece and formed AKOE (Greek Homosexual Liberation Movement) which was the first collective body of action to campaign for the equal rights of gay people as citizens of Greece (Maies, 2015, Dendrinou, 2008, Riedel, 2005).

During the first year of its life AKOE included only gay men and a few transvestites as its members. Greek lesbians did not formally join the organisation until 1978 since they were primarily focused on a feminist agenda and participated in women's organisations (Dendrinou, 2008, Myers, 2003). However, the Greek lesbians' participation in the feminist movement was also inscribed by the marginalisation of their issues, leading lesbians to a continuous struggle to find their place both within the gay and the feminist movements (Dendrinou, 2008). Similarly, although transvestites were involved in gay activism, their participation was contested by gay men who saw the participation of transvestites as a threat. As Dendrinou (2008) states:

“For many gays in Greece, this visibility of the transvestites was seen as further promoting and strengthening an unwanted association of homosexuality with effeminacy and deviance in the minds of some heterosexuals [...] a factor which led to the denial of a masculine status for the homosexual men and thus to their subsequent marginalisation” (Dendrinis, 2008, pp.196)

In the spring of 1978, AKOE began publishing *Amfi*, the first LGBT publication in Greece. *Amfi* succeeded in opening a public discourse on sexuality and gender issues by making available translated texts and interviews of important theoreticians such as Foucault (Maies, 2015, Dendrinis, 2008, Riedel, 2005). *Amfi* quickly became a crucial source of strong support particularly for the most oppressed and isolated segment of the LGBT community, namely those who lived in rural Greece. At that time, many gay people were experiencing their sexuality believed they were abnormal and the only ones in the world. *Amfi* played a key role in providing a support network and ending this isolation, particularly because there was a noticeable absence of support networks for gay people outside the boundaries of Athens (Dendrinis, 2008). As Maies (2015) argues, *Amfi* was not only a hallmark for the development of the LGBT movement but for the empowerment of gay people. The published letters of readers, their stories and the responses they attracted from the editorial team constituted the most important part of the magazine.

By the mid-1980s, lack of funding, the inability to attract and recruit new members, and most importantly the AIDS epidemic, had severely damaged the morale of LGBT activists in Athens. Riedel (2005) also argues that the political climate brought by the new government of PASOK in 1981 and its leader Andreas Papandreou who promised social change, redistribution of wealth and power in favour of the “non-privileged”, took the momentum away from the social movements of the Left, including AKOE. After the disintegration of AKOE in 1989, EOK emerged as the principal LGBT group in Greece and became the first to become a member of the International Lesbian and Gay Association (ILGA) in 1989 (Riedel, 2005).

In the 1990s and the first years of the twenty-first century, LGBT activism in Greece witnessed the emergence of a number of new grass-roots groups both in

Athens and in other cities of Greece. (Dendrinou, 2008, Riedel, 2005). However, the groups were quite limited in size and worked independently from one another while initiatives for an all-encompassing LGBT organisation into an “umbrella” association with a common agenda and plan failed as a result of personal differences between key LGBT activists (Dendrinou, 2008, Riedel, 2005). Despite these failures, OLKE, founded in 2004, tried to achieve a more collective organizational format to limit the concentration of political power in the hands of few leaders and avoid rivalries that impeded the development of the community (Riedel, 2005). One of the first steps taken by OLKE was to pursue the right to civil marriage regardless of gender, sexual orientation or preference, a priority topic on the agenda of Greek LGBT activists at the beginning of the new millennium (Kantsa, 2014, Dendrinou, 2008). SATTE, (Solidarity Union for Greek Transvestites/Transsexuals), founded in 2003, and since 2010 its successor SYD (Greek Transgender Support Association), responded to the growing need for a separate group that would deal specifically with transgender issues.

Outside Athens LGBT activism started in Thessaloniki, Greece’s second largest city, with two very active groups: In 1998 O.P.O.T.H [Homosexuals Initiative of Thessaloniki] and in 1995 Sympraxis (Cooperation against Homophobia). Sympraxis became one of the most active LGBT groups in Greece which is active to date. One of the most important activities is the co-organisation of the annual “Thessaloniki International LGBTQ Films Festival”, in which many other national and international groups take part (Chatzitriton, 2014).

Since 2005 annual Pride parades and festivities have been held in the center of Athens. In Thessaloniki, the first Pride parade was held in 2012 and in Crete in 2015.

1.5 Exploring the international debate on LGBT health inequalities

Health is primarily seen as a socially constructed condition, although often described in medical terminology. This is because when we speak about health we usually refer to the management of an illness and the ways that medicine intervenes in the biological and genetic causes of diseases (Dimoliatis, 2006).

However, the gradual incorporation of social constructionist approaches in medicine, public health and epidemiology has enabled the appreciation of health as a condition dependent on social, political, economic and historical processes (Wilkinson and Pickett, 2010, Schulz and Mullings, 2006). Currently, health is defined as “a state of complete physical, mental, emotional, and social well-being and not merely as the absence of disease or infirmity” (WHO²), and it is acknowledged as decisively determined by the socio-economic conditions of societies. Therefore, health is often perceived as the most important measurement of people’s thriving because it accurately reflects if a population is benefiting from the set of social arrangements (Marmot, 2005). Similarly, Sen (1992) has argued that health and health inequalities should be central to any debates and evaluations on social justice and central components of what poverty means.

The right to health is often elaborated and analyzed through the formation of determinants. Although there is no definite list, social status is perceived as the most important determinant of health followed by others such as: poverty, unemployment, stress, household living conditions, conditions in communities and workplaces, the health care system, social exclusion, early life living conditions, and the policies affecting any of the mentioned determinants (Graham, 2006, Graham and Kelly, 2004, Wilkinson and Marmot, 2003). All social determinants have both direct and indirect health impact, contribute to health inequalities, are interconnected and may operate at different levels (Farrel et al., 2008, Graham, 2006).

As a prominent determinant of health, the social position of people reflects that health is determined by the social advantages and disadvantages that are distributed among the social groups at different levels in a social hierarchy. Therefore, social groups with less power and fewer privileges are at higher risk for poor health (Graham, 2006). The concept of health inequalities refers to the unfair or unjust nature of health differences between social groups that are generated by social conditions which are systematically reproduced. All people

² Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The Definition has not been amended since 1948.

occupy multiple social positions because of the variety of interlocking structures of inequality (Graham and Kelly, 2004). So far, health inequalities are measured almost exclusively in terms of people's socio-economic status which is in turn measured via income, education, occupation and place of residence (Wilkinson and Pickett, 2010, Graham, 2006, Galobardes et al., 2007).

There is a substantial amount of research data which evidences that sexual orientation and gender have a direct (e.g. limited civil rights), and an indirect (e.g. risks of victimization, discrimination) impact on the social position of people, which in turn is the major determinant of health (Wilkinson and Pickett, 2010, CSDH, 2008, Graham, 2006, Marmot, 2005). There is also a growing awareness of homophobia and transphobia as major environmental and social stressors that unequally burden the health of LGBT people by increasing their disease vulnerability, predicting health-related risk factors and obscuring their access to the health care system (Wilton, 2000, O'Hanlan et al., 1997).

Homophobia and transphobia create a hostile and stressful social environment for LGBT people who have to endure stigma, prejudice and discrimination in their everyday lives (Herek et al., 2007, Meyer, 2003). This is an immediate and persistent health inequality which is often elaborated through the concept of minority stress, which explains the multiple ways in which social stress can have a strong impact on the lives of people belonging to stigmatized social categories related to socioeconomic status, race/ethnicity, gender, or sexuality (Meyer, 2003). According to this theoretical concept, stressful processes including the experience of prejudice, rejection or the expectation of rejection, the concealment of identity, internalized homophobia, transphobia and the efforts to advance coping strategies, pose an increased risk for advancing mental health problems to LGBT people (Dentato, 2012, Meads et al., 2012, Institute of Medicine, 2011, King et al., 2008, Herek et al., 2007, Meyer, 2003). Other in-group differences within the LGBT population are worthy of attention too. For example, LGBT youth are found to be more likely than heterosexual youth to attempt or commit suicide and they also have higher rates of depression, drug use and homelessness than the general population of young people (Fergusson et al., 1999, Remafedi et al., 1998). This in part relates to the fact that, unlike other cultural minorities, LGBT

youth cannot necessarily rely on the support and protection of their family (Ritter and Terndrup, 2002, Appleby and Anastas, 1998). Similarly, Grant et al. (2011) found that 41% of transgender and gender-nonconforming respondents in the U.S report having attempted suicide at some point in their lives, compared to 2% of the general population. Lesbian and bisexual women are also found to be more vulnerable to “stress-sensitive” disorders that can be attributed to the effects of homophobia and lack of social support (King et al., 2008, McNair, 2003). Minority stress is also associated with higher rates of risk-taking behaviour including substance abuse, greater risk for sexually transmitted infections and HIV and rates of self-harm are much higher in LGBT studies (Meyer, 2003). In addition, lesbians and bisexual women may use preventive health services less frequently than heterosexual women (Institute of Medicine, 2011, McNair, 2003).

The health care services have respectively been structured within a heterosexist and transphobic society resulting unavoidably in important barriers and poor quality of health care for LGBT people (Institute of Medicine, 2011, Meyer, 2003). In particular, homophobic and transphobic behavior among health care practitioners including the use of inappropriate language have been extensively documented and LGBT patients report negative experiences when making use of health services (Heyes et al., 2015, Ellis et al., 2014, Butler, 2010, Hinchliff et al., 2005, Brotman et al., 2003). In addition, LGBT people often experience the spaces of health care as unwelcoming or even threatening when heteronormativity and cisnormativity are not questioned by signs (e.g. inclusive intake forms in hospitals, affirmative practice) that could reflect positivity towards queer identities (Heyes et al., 2015, Goldberg et al., 2011). Overall, the institutionalized erasure and invisibility of LGBT people and the marginalisation of the holistic concerns of LGBT people have been widely reported in health care, and can thus be described as a systematic discrimination against LGBT people (Williams et al., 2013, Institute of Medicine, 2011, McNair and Hegarty, 2010, Bauer et al., 2009, Fish, 2006, Namaste, 2000, Wilton, 2000).

Despite the increasing weight of evidence indicating that LGBT people experience substantial health inequalities, sexual orientation and gender identity are generally not appreciated as equally important as other sociodemographic characteristics such as sex and race/ethnicity in health research (Williams et al.,

2013, Institute of Medicine, 2011). As a result, LGBT people are often ignored in health research or included in HIV-related studies (Institute of Medicine, 2011, Price, 2011). Similarly, Wilkinson and Pickett (2010) and Graham (2006) point out that the inequalities of axes such as sexual orientation, as well as gender, ethnicity and disability are often shadowed in health research. Moreover, information on sexual orientation is not routinely collected as a sociodemographic characteristic in censuses, social, epidemiological, large-scale health studies, which may also account for the inability to estimate the actual size of LGBT populations, the failure to capture the diversity of the LGBT communities and variety of definitions and categorizations of sexual minorities (Price, 2011). Equally, gender items in studies do not recognize identities that cannot fit into the binary male/female sex categories. Meads et al. (2012) and Fieland et al. (2007) argue that the invisibility of LGBT people and the consequent limited health data are institutional barriers which have led to a lack of investigation into sexual orientation as a social determinant of health and obscure the prioritization of LGBT health in official policy reports and objectives.

Another problematic area in health research is the uncritical focus on health differences among populations which erases the ways that social structures effect on the differences found. This, in turn, strengthens negative stereotypes for social groups and sexual minorities in particular. For example, Wilton (2000) argues that there is often a tendency to focus primarily on the potentially harmful health consequences of a lesbian or gay “lifestyle” (e.g. reported obesity in lesbians), while health outcomes are never measured in terms of the heterosexual “lifestyle” (e.g. high rates of domestic violence in heterosexual relationships). Due to heterosexism which leaves heterosexuality as the unquestionable norm of human behavior, some health risks which are associated with heterosexual “lifestyle” and hence seen as undeniable truths or as exclusively gender issues (Wilton, 2000). The health risks associated with contraception, for example, are almost exclusively discussed as a gender issue and are rarely related to heterosexual sex. At the same time, the risks of pregnancy and childbirth are unproblematically linked to heterosexuality although many lesbians are biological mothers too (Wilton, 2000).

Gender and sexual orientation are not inherently hazardous for health. Nevertheless, increased health risk factors are attributed to specific social groups through social structures such as sexism, racism, homophobia, transphobia, heterosexism etc. (Institute of Medicine, 2011, Dodds et al., 2005, O'Hanlan et al., 1997). Health research is a tool that can reveal the effects of such social structures on health, and advance the potential of LGBT people to transcend invisibility and marginalisation. To this end, Dodds et al. (2005) argue that research must concentrate on a more structural understanding of homophobia, transphobia and heterosexism. In particular, they argue that studies should concentrate on the processes that reproduce homophobia, transphobia and heterosexism as well as how these might exacerbate other structural or social factors (such as class or ethnicity).

1.6 Chapter Breakdown

This thesis comprises six chapters. This first chapter provides an overview of the thesis by firstly presenting the rationale for the study, the research questions and a brief summary of theoretical underpinnings, my research approach and some considerations that informed the study design. Then, I provide some details of the Greek health care system in light of the on-going recession. Later, in this chapter, I discuss a part of my literature review which frames my study within the international discourse on LGBT health inequalities. This study has not followed the conventional PhD structure with regards to presentation. In fact, the reader may easily notice that there is not a single part in the manuscript entitled "literature review". This is because, given the different areas each section of this study explores, the review of literature has been incorporated in different parts of the manuscript. The benefit of such an approach is that it helps the text flow and allows the reader to engage with the specific aspects of literature relevant to each section.

In chapter 2, the research methodology is presented, starting with a brief introduction to intersectionality, which is the theory that informed all the levels of the research process. Subsequently, I present the reasons for choosing an

ethnographic approach to conduct my research followed by a detailed presentation of my data collection methods, my reflections of the fieldwork process, the procedure of my data analysis, and the ethical considerations. In this chapter I also reflect on the place from which I speak throughout this study, which is also relevant to the insider/outsider question (Koobak and Thapar-Bjorkert, 2014).

In chapters 3, 4 and 5 I present, analyze and discuss the findings of my study. In Chapter 3 I focus on the factors that appeared to construct the unwritten, yet firmly steadfast “don’t ask, don’t tell” policy within the health care services as well as the factors that affect the participants’ decision to either disclose or hide their sexuality or gender identity to a health provider. Chapter 4 discusses the ways that the pathologisation of LGBT bodies and sexual practices shapes participants’ access to care and the role of the LGBT community as a factor that moderates some of the barriers in health care for LGBT people. In the end, in Chapter 5 I focus on the ways that invisibility and the pathologisation of LGBT participants appeared to be reproduced in the mental health care services.

The final chapter contains my concluding remarks, the study limitations, my suggestions for further research in the field of LGBT health as well as policies and practices that can improve the accessibility and quality of health care of LGBT people.

CHAPTER 2 RESEARCH METHODOLOGY

Introduction

This chapter discusses the methodological and epistemological choices underpinning the current study. It is organized into five sections. Initially, I present the theoretical background of the study, and in particular intersectionality which informed the study from its initial steps to the data analysis and writing of the thesis. Following this, I discuss the use of ethnography as the appropriate research design for the purposes of this study. In section 2.3 the methods used to collect primary data are outlined along with the sampling procedure. I also provide more detailed descriptions of the fieldwork process (group interviews, individual interviews) as well as the place from which I speak throughout this study. In section 2.4 I discuss the purposes and the procedure of my data analysis and I close this chapter with the ethical considerations encountered during the research process.

2.1 Intersectionality as the theoretical context of the study

All levels of the research process have been influenced by intersectionality which was chosen as the appropriate epistemological foundation to guide my decisions and interpretations of the data. This makes objectivity or “objective truth” impossible. Besides, it is within the epistemological standpoint of this thesis that there is no ‘objective’ method to guide us to an absolute understanding of the world. Drawing on the interpretivist position, reality is complex, uncontrollable and context specific. Interpretivism is more interested in discovering and understanding how people construct, perceive and experience the world on an internal subjective basis. In this sense, social reality cannot be fully understood without subjective interpretations of reality (Rubin and Babbie, 2001, Hughes and Sharrock, 1997).

The ideas of intersectionality were first introduced by black feminists during the 1970s and challenged the dominant views of middle-class white feminists who dealt with sexism as a universal model of women's subordination while they remained silent on racial issues (Lykke, 2010, Taylor et al., 2010). Though not explicitly articulated, the quest for an intersectional analysis of oppression was progressively developed within the feminist movement as part of its shared struggle with other social movements (Lykke, 2010). Therefore, intersectionality was at least partly developed out of the ongoing discourse of social movements on the prioritizations of power issues and their consequent political agendas. The fact that intersectionality is rooted in social movements makes it an important critical theory and methodological paradigm in approaching social justice issues and various systems of oppression.

The conceptualization of intersectionality was first presented by Kimberle Crenshaw in the late 1980s and since then, various tensions and approaches have been developed. Despite the many variations in approaches, intersectionality has been described as a critical theoretical and methodological process which aims to broaden one-dimensional identity politics by capturing and analyzing the ways that power differentials around gender, race, class, sexuality, dis/ability, age and so on, interweave with each other and in doing so produce different kinds of societal inequalities and unjust social relations (Lykke, 2010). Intersectionality focuses on the simultaneous interactions between different aspects of identity by not prioritising any particular system of oppression (Hankivsky et al., 2009). One of the main purposes of intersectionality is to enable the revelation of the dynamic interaction between social categorizations and outline the relationship between different systems of oppression.

My study is underpinned by theories which acknowledge that all people occupy multiple social positions and therefore are subject to a variety of interlocking structures of inequality (Graham and Kelly, 2004, Lorde, 1984). Moreover, LGBT people, though often considered as a coherent social group or community, are highly diverse and are subject to many forms of discrimination beyond homophobia, transphobia and heterosexism (Institute of Medicine, 2011, Wilton, 2000). The latter acknowledgement is not intended to minimize the oppressive function of these structures. On the contrary, I agree with Lorde (1984) that every

system of oppression corrupts or distorts people's sources of power that can be found in all facets of people's identities including the privileges that may arise from those. In order to be able to deeply understand the various systems of oppressions, people should not be perceived as having singular identities but instead as being comprised by a synthesis of various identities that cannot function independently from each other (Maalouf, 2000).

Hankivsky et al. (2009) have argued that there is a common goal between those seeking to understand the social determinants of health and intersectionality that is the inclusion of populations which are often excluded from health research thus rendering their health needs unable to be acknowledged and met. However, it has been argued that sexual orientation is unreasonably missing from the scope of the determinants of health (Logie, 2012, Wilton, 2000), and health inequalities are mainly measured in terms of the socio-economic position of people while other axes of discrimination are ignored in health research (Wilkinson and Pickett, 2010, Hankivsky et al., 2009, Graham, 2006). At the same time, the intersection between class and sexuality remains under-theorized and it appears that there is a persistent separation between sexuality and class issues (Taylor, 2010). Similarly, Fabeni and Miller (2007) and Shakespeare (2000) argue for the unspoken and often ignored intersection between sexuality and dis/ability issues which is partly a result of the historic de-politicization of both sexuality and disability. Shakespeare (2000) argues that there is a common dilemma troubling both the LGBT movement and the disability movement in gaining access to the mainstream of sexuality and persisting in challenging the ways that sex and sexuality are constructed in societies. Additionally, Yekani et al. (2010) contend that both movements have a common struggle against the domination of medical and psychiatric power over the body.

Conducting studies that strengthen these lines between social movements is important. In fact, it is within the purposes of structural intersectionality to enhance political alliances and coalitions by enhancing the ability of social movements to be empowered. This can be achieved through the entanglement between power differentials rather than by ignorantly allowing these differences to cause conflict and tension (Lykke, 2010, Crenshaw, 1991).

Against this background, I follow Crenshaw's (1991) conceptualisation of identity categories as being coalitions or, as she suggests, "coalitions waiting to be formed" (Crenshaw, 1991, pp.1299). Identity categories then, imperfect and ever changing though they may be, they still encapsulate people's agency and resistance strategies to "occupy and defend a politics of location rather than to vacate and destroy it" (Crenshaw, 1991, pp.1297). This is particularly important, because although intersectionality problematises fixed categories (similar to post structuralism and anti-essentialism), its premise is to challenge the practices of inequality from which identities stem. Therefore, identities remain a useful basis for political organisation and a site of resistance for members of subordinated groups (Carastathis, 2013, Crenshaw, 1991). However, fixed categories often reduce the multiple dimensions of social life and therefore the multiple experiences of subordination (McCall, 2005). The scope of intersectionality is then to expand the subject of analysis so as to mirror the complexity of social life and reveal the interlocking oppressions.

This presupposes a critical stance towards categories. McCall described three approaches that are defined in terms of their stance towards categories and how they are used in order to explore the complexity of intersectionality in social life; the anti-categorical, the intra-categorical and the inter-categorical. These approaches fall on a continuum, with anti-categorical and inter-categorical located at the extremes of the spectrum (McCall, 2005). The anti-categorical approach gives emphasis to the socially constructed nature of analytical categories and therefore its methodology is focused on deconstructing analytical categories (e.g. gender) by challenging their validity (McCall, 2005). The inter-categorical approach adopts existing analytical categories and focuses on the complexity of relationships among multiple social groups within and across analytical categories. The management of this complexity is done by reducing analysis to one or two inter-group relations at a time (McCall, 2005). The approach chosen for my analysis, the intra-categorical approach, focuses on particular social groups at neglected points of intersection and challenges single social groups by unraveling influences of gender, race, class and other analytical categories (Monro and Richardson, 2010, McCall, 2005). With this approach in-group differences and larger social structures influencing their lives can be explicated.

The complexity in this approach is managed by focusing on a single group represented by individuals (Monro and Richardson, 2010)

In my study I employ “LGBT” and the social groups that the acronym represents (“L” lesbians, “G” Gay, “B” Bisexual, “T” Transgender) as the subject of my analysis. However, terminology such as “LGBT” can become suspect for symbolising and enacting exclusion of other identities since the LGBT acronym refers to a broad coalition of groups that are diverse with respect to gender, sexual orientation, race/ethnicity, socioeconomic status or ideology (e.g. pansexuals who resist the gender binary). Moreover, as Monro and Richardson (2010) state: “there have been longstanding historical tensions between all of the groups included within the acronym “LGBT”; tensions which have continued in the sense that there is still some misogyny amongst gay men, and disbelief that bisexuality exists, and attempts amongst lesbians and gay men to disassociate from people who are changing their gender identity (Monro and Richardson, 2010, pp.101). The framing of trans persons is also problematic given that not all trans persons are heterosexual and the trans community is highly diverse in its own right (Monro and Richardson, 2010). Yet, “LGBT” is a collective political term, and widely used, echoing the historical resistance of people who are oppressed due to society’s cultural norm of the exclusively heterosexual individual who conforms to traditional gender roles and expectations (Institute of Medicine, 2011, Price, 2011) Therefore, it is this critical element of LGBT’s lives that serves to forge a sense of community and an ongoing need for political action although the alliances that the acronym “LGBT” reflect are uneasy (Monro and Richardson, 2010).

There might be some inconsistency in the terminology I use in the sense that I generally employ the term “LGBT”, but when I discuss what participants said, I use the language and terms they used to refer to their identities. I also dilute the LGBT acronym when I want to discuss differentiated experiences between people occupying the identities that the acronym represents or particularly when I explore “within-group” complexity that intra-categorical analysis addresses.

2.2 Qualitative research studies and ethnography

Qualitative methodology is in line with critical theory and intersectionality which see reality as contextually relevant, complex and political rather than value neutral (Shaw and Gould, 2001). Moreover, qualitative methods have been argued to be highly compatible with the purposes of intersectionality as they are able to elicit detailed information and rich data about individuals, their social circumstances, allowing an intersectional analysis which will grasp the interlocking function of oppressive structures (Taylor, 2010, Valentine, 2007, McCall, 2005).

The qualitative orientation of this study also strengthens its emancipatory purposes by allowing the voices of participants to be foregrounded which is particularly important when researching vulnerable minorities (Shaw and Gould, 2001). Besides, LGBT people in Greece have rarely had the opportunity to define their realities for themselves and therefore it is within the purposes of this study to create a path for the Greek LGBT community to be heard in the public domain.

Additionally, the study adopts an ethnographic approach. Despite the diversity in ethnographic approaches, they are characterised by a shared commitment to first-hand experience and exploration of the cultural constructions in which we live, attaining an emic perspective or what might be described as the “insider’s point of view” (Hoey, 2014). This presupposes long-term engagement in the field setting in which the researcher “must both become a participant in the life of the setting and maintain the stance of an observer, someone who can describe the experience with a measure of what we might call detachment” (Hoey, 2014). Although ethnography and participant observation are often discussed in an indistinguishable manner they do not necessarily share the epistemological position of the emic perspective. Therefore, ethnography should be defined by its purpose and epistemological position rather than as a method (Forsey, 2010b, Mason, 2002b). As Mason stresses:

Ethnographers have led the field in the use of observational methods, but they use other methods too, and some researchers who would not class their approach as ethnographic nevertheless make extensive use

of observation. It is important to realise, therefore, that ethnography is not defined by observational methods (Mason, 2002, pp.55)

As is typical in other ethnographies, I also immersed myself in the everyday conditions and contexts of the participants and formed connections with them. The plan was to spend non-structured time with LGBT people, participate in their social activities and events and interact with them in casual conversations within their natural settings. These observations were incorporated in my interviewing, questioning and on-going interpretations in the manner of a “cyclical iterative process” (Wolcott, 1995) to enhance the quality and accuracy of the collected data. Because of my engagement with the field and the participants, many of the conducted interviews were part of an evolving conversation rather than following the question/answer model. As (Forsey, 2010a) argues, ethnographic interviews are conducted with an ethnographic imaginary, aimed at revealing the cultural context of individual lives. In this way, interviews with LGBT participants took the form of engaged listening, a term coined by Forsey (2010b) to depict more appropriately how ethnographers actually report “what is there” in the field. According to Forsey (2010b) and Cohen and Rapport (1995), casual conversation and formal interviews should be perceived as part of what is ‘observed’ in the field.

The purpose here was to employ a study design which would enable the revelation of detailed – often referred to as “thick” – descriptions of the ways participants experienced homophobia and transphobia when dealing with health and health care related issues. This necessitated an interpretive approach to my ethnography which gave priority to the reporting of participants’ own meanings, understandings and interpretations of what constitutes homophobia and transphobia in the context of accessing health care. Participants’ subjective experiences of social constructions such as homophobia and transphobia are less attainable through observational methods. Furthermore, observing LGBT people directly in accessing health care would be inappropriate on ethical grounds. Therefore, the interviews of this study form a core contribution to addressing the particular research questions of my thesis.

In presenting the ethnographic data I also include relevant quotations from recorded interviews. The purpose here was to allow LGBT participants voice their stories in their own words and present them as accurately as possible. As Maanen (1988) has emphasised “Extensive, closely edited quotations characterise realist tales, conveying to readers that the views put forward are not those of the field worker but are rather authentic and representative remarks transcribed straight from the horse’s mouth” (Van Maanen, 1988, pp.49). Although I acknowledge that transcription can be partial, and judgements made throughout the process of interviewing may impose inappropriately the researcher’s views onto the data (Mason, 2002b), I argue that reconstructing a dialogue or an argument of a participant through my field notes would entail greater risk of inventing rather than presenting data (Fine, 1993).

2.3 Sampling and Data Collection

The ethnographic material for this thesis was generated through:

- 4 group interviews with members of LGBT organizations
- 30 semi-structured interviews with LGBT individuals
- 10 semi-structured interviews with doctors
- 2 semi-structured interviews with key informants

As in many studies on LGBT populations, it has been impossible to frame the sample into an exhaustive list of population members and subsequently even if a nonprobability sampling method is employed, the sample cannot be statistically valid in terms of its representativeness (Price, 2011). This is partly due to the fact that there is no absolute way to define who falls under the LGBT acronym. For example, not all men who have sex with men or women alike would choose to identify themselves as LGBT (Price, 2011, Fish, 2006, Cochran, 2001, Institute of Medicine, 2011). LGBT populations have often been termed as “hard-to-reach” since the population is relatively small to the general population, identification as an LGBT person involves stigma and some LGBT networks are not open to outsiders (Heckathorn, 2007, Price, 2011, Fish, 2006, Meyer, 2003, Lee, 2008).

Qualitative studies like this one typically use purposive sampling when aiming at an in-depth investigation in a particular context. In this sampling strategy the credibility and accountability of the study is not based on the sample size, as the goal is depth as opposed to breadth. Therefore, the sample is sufficient when the researcher judges that s/he has reached the required depth or situation. Furthermore, in purposive sampling the sample is composed of participants who can provide the rich information necessary for the purpose of the study and meet identified criteria of interest. Purposive sampling has been extensively used in studies on LGBT issues as this method has been recognized as effective in accessing hidden populations (Heckathorn, 2007, Fish, 2006).

Based on this rationale, purposive sampling was employed in order to reach persons who self-identify as LGBT, which was possible by sampling from within LGBT community venues. This is one of the most frequently used methods for recruiting participants in LGBT studies (Meyer and Wilson, 2009, Fish, 2006).

However, this sampling method encompasses several challenges. First of all, it excludes people, who, even if they do not identify themselves as LGBT, may experience homophobia in health care settings or their health may be influenced by the fear of homophobia (e.g. children of LGBT parents). Furthermore, as Fish (2006) notes, self-reported identification tends to include those who are most confident, visible and highly affiliated with the LGBT communities and therefore possibly less vulnerable among the sexual minorities. Secondly, the diversity of LGBT community might be underrepresented and there might be an over-representation of groups as participants tend to recruit others who are like them (Fish, 2006). In order to overcome these limitations, Meyer and Wilson (2009) and Fish (2008) suggest the usage of multiple sampling methods.

At the beginning of this study, my insider status within the LGBT community was very helpful as I was already immersed within some of the important venues where LGBT people can be reached including lesbian and gay bars-cafes, and web-based LGBT forums. I also had established contacts with LGBT organisations through my participation in LGBT events and meetings. Progressively, my familiarity with the LGBT community evolved and I was able to advance the diversity of the sample by using new venues I did not know prior to

my fieldwork. My evolving familiarity with the LGBT community was also helpful in preventing oversampling of those who were highly affiliated with the LGBT community or those who had high levels of activity within LGBT organisations (Meyer and Wilson, 2009). To this end, I also employed the snowball technique and asked initial contacts from within the LGBT community to nominate potential participants from among their social networks. In turn, they too were asked to suggest further participants from their own social networks and so on (Bailey, 2007, Heckathorn, 2007).

Another method I used in order to enhance the diversity of the sample was to invite personal contacts from rural areas of Greece. This is because the latter typically have limited connection to LGBT organisations, are less visible and their views are hardly known even within the LGBT community. I had met some LGBT people during a period of living and working in rural areas during the last 15 years. Although some refused to be formally interviewed, they agreed to speak about themselves openly in informal conversations. Through these informal discussions I was able to understand their ways of dealing with everyday challenges often inscribed by the forces of homophobia and transphobia. However, some of my personal contacts accepted the invitation to participate in an interview and they helped me to contact with others.

The study was also advertised via the internet and social media. Social media and LGBT sites have become a primary way of linking LGBT people (McCormack et al., 2003). This sampling strategy proved to be a useful method to recruit participants across several age ranges but especially younger people and those who lived in rural areas.

For the group interviews I invited LGBT organisations from both Athens and other regional and rural areas of Greece to participate as a group. Although there is no centralized list of LGBT organizations in Greece, I compiled a potential set of organizations by using the internet and the information provided by the LGBT organizations I already knew. The list was restricted to the LGBT organisations of the mainland, as I could not possibly afford the expenses of travelling to the islands of the country. This strategy was effective in my effort to reach LGBT organisations which were active in the regional/rural areas of Greece. It was also

beneficial because I wanted to detect LGBT organisations and groups which are particularly interested in health issues or disabilities. From this process it was not possible to detect such groups apart from organizations particularly interested in HIV/AIDS which maintain an anti-homophobic political agenda as they have many LGBT members. Nevertheless, through my participation in some LGBT events I reached some individuals who lived with chronic illnesses but due to constraints of time and in some cases their health care priorities rendered these interviews difficult to carry out.

The LGBT organisations who accepted my invitation for group participation also determined the places I visited during my field trips. Although these field trips usually ranged from only 3 to 5 days, I enriched my data by participating in LGBT events, spending non-structured time with LGBT individuals, and conducting individual interviews.

My fieldwork in the regional and rural areas of Greece also required careful decisions in terms of whether I would disclose the real names of LGBT organisations and that of the cities/town where my fieldwork was held. Many of the LGBT activists as well as the groups who participated in group interviewing did not have a problem to use their actual names. However, many of the participants who lived in regional/rural areas did not feel comfortable to be identified either by their name, the city of their residence or their stories. Some LGBT activists, who knew that I was moving from group to group in and outside their cities, had their own worries about my access to information that could be used by activists against each other if I were to reproduce anything they said in different settings.. To be consistent in protecting all of my participants, I do not mention the names of the groups that participated and I use pseudonyms for the regional/rural cities I visited as well for the names of the participants. My data also include interviews with doctors and two key informants that expanded my understanding of the context where the health inequalities are constructed for LGBT people in Greece. Although I did not intend to formally interview social scientists, there was a case that I chose to interview a social anthropologist who was working in an NGO for the support of immigrants and refugees. My contact had important information for the health care needs of LGBT persons with refugee status and this information was in line with my purpose to further explore

the interlocking oppressions (e.g. refugee status- sexuality-gender). However, ethical considerations such as the access of interpreters to sensitive information about particularly vulnerable people such as LGBT individuals with refugee status made me prioritize their safety over my wish to advance the diversity of my data.

Doctors were recruited during the last stage of data collection. To reach them, I first approached the Medical Association of Athens with a twofold purpose. First, I wanted the support of the Association to advertise my study to their members by distributing my informative research letter in their mailing lists. Secondly, I wanted the views of the official body of doctors on the themes raised by my interviewees and the LGBT activists. I was also hoping that through this process I would have the chance to immediately contribute to the LGBT community by bringing their issues to the attention of the representatives of the Medical Association who have the power to bring about changes to the field of health care. Unfortunately, none of these happened. The Medical Association refused to use their mailing lists to promote my study. They instead suggested that I could leave the informative letters in the corridors and offices of the Association, but no doctor was recruited by this method. I was also directed to make a formal request to the Board of the Association asking the Association's participation to my study by interviewing a representative. After a few months the Board approved my request and I was asked to meet the president of the Board. In our meeting which lasted less than 5' minutes, I was asked to quickly describe my research topic and be careful not to harm the reputation of the Association. The president told me that I would be called soon to book an appointment with a representative. In the following months nobody ever called me and when I called several times I was told to just wait.

I finally reached two doctors through my professional network and two others were recruited when I happened to visit these doctors as a patient. Those doctors accepted the invitation warmly, although they did not know me in advance, but they thought that their working experience with HIV-seropositive patients was relevant to my study purposes and therefore they were pretty willing to participate. One of them was possibly motivated by an additional factor: during our interview she self-identified as bisexual and during our discussion she also reflected on her experiences as a bisexual person, doctor, patient, and on how she views LGBT activism. The rest of the doctors were recruited by having my

initial contacts identify others. All doctors were private practice doctors but with an experience of working in public hospitals.

As other qualitative researchers have argued, the use of triangulation of methods, with both individual and group interviews with LGBT individuals, activists and doctors, worked well in crosschecking the context and advanced the validity and credibility of the study in terms of its findings (Mcilveen, 2008).

In the sections that follow, the characteristics of the participants and my reflections on the data collection methods used will be discussed along with issues relevant to the insider/outsider questions and my positioning as a researcher within my research.

2.3.1 The participants

The study focused on LGBT people who lived either in Athens or in other regional or rural areas of Greece. The sample characteristics are listed in Tables 1 & 2 and present participants' self-reported identities in terms of sexual orientation and gender. It must be acknowledged that in some cases these reported identities differ from how individuals presented themselves to others in their everyday life as well as that these reported characteristics also fail to capture the fluidity of sexuality and gender identification which is revealed through some participants' stories. For example, a participant who identified as a trans man may also have lived his life as a cis gender lesbian.

Forty three sample members who participated in individual or group interviews identified their race/ethnicity as Greek, and three as mixed race/ethnicity of Greek and another including Albania, Italy or Germany. Individual race/ethnic identification is not specified in tables 1 & 2 so that the anonymity of participants is protected.

At the time of the interviews 21 of the participants lived in Athens and 25 in a regional/rural area. However, as 15 participants were university students, the place of residence of some was temporary. Ten participants were unemployed

and the employment status of two is characterized as semi-unemployed as they worked in business without being officially registered. As a result they had no entitlement to work rights (e.g. sick leave), health insurance or pension scheme.

Twenty participants had a University degree (three had an additional postgraduate degree), three had completed vocational education, seven had completed high-school and one participant had dropped out without completing high-school. The mean age of participants was 29 years.

Table 1: Characteristics of LGBT participants (individual interviews)

Name	Gender	Sexual orientation	Age	Education	Employment status	Place of residence
Jason	Trans man	Queer	18	University student		Athens
Theano	Trans	Not specified	55	University degree	Unemployed	Athens
Lena	Trans woman	Queer	22	University student		Athens
Angelo	Trans	Not specified	18	High school	Unemployed	Athens
Melina	Trans woman	Heterosexual	29	High school	Unemployed	Athens
Fanie	Trans woman	Lesbian	34	University student	Freelancer	Athens
Nick	Man	Bisexual	19	High school	Unemployed	Regional/rural
Helen	Woman	Bisexual	23	University student		Regional/rural
Irene	Woman	Bisexual	34	University degree	Unemployed	Regional/rural
Xenia	Woman	Lesbian	48	University degree	Public servant	Athens
Tania	Woman	Lesbian	50	University degree	Public servant	Regional/rural
Antigone	Woman	Lesbian	53	University degree	Public servant	Athens
Valerie	Woman	Lesbian	32	University degree	Private employee	Regional/rural
Stefany	Woman	Lesbian	34	University degree	Unemployed	Athens
Nelie	Woman	Lesbian	23	University student	Private employee	Regional/rural
Sofia	Woman	Lesbian	32	High school	Self-employed	Athens
Natassa	Woman	Lesbian	26	University degree	Private employee	Regional/rural
Evie	Woman	Lesbian	44	High school	Private employee	Athens
Mary	Woman	Lesbian	41	Post-	Freelancer	Athens

				Graduate degree		
Elias	Man	Gay	47	Vocational school	Public servant	Regional/rural
Alex	Man	Gay	51	University degree	Public servant	Athens
Michael	Man	Gay	35	Post-Graduate degree	Private employee	Athens
John	Man	Gay	49	Junior High school	Unemployed	Regional/rural
Orestis	Man	Gay	30	University degree	Private employee	Athens
Manos	Man	Gay	25	University degree	Unemployed	Athens
George	Man	Gay	24	Vocational school	Unemployed	Athens
Lambros	Man	Gay	35	University degree	Semi-unemployed	Regional/rural
Vaggelis	Man	Gay	50	Post-Graduate degree	Private employee	Athens
Argyris	Man	Gay	33	University degree	Private employee	Regional/rural
Vassilis	Man	Gay	38	University degree	Private employee	Athens

Table 2: Characteristics of LGBT participants (group interviews)

Name	Gender	Sexual orientation	Age	Education	Employment status	Place of residence
Andreas	Trans Man	Pansexual	23	Vocational school	Unemployed	Regional/rural
Apostolos	Man	Gay	28	University degree	Semi-unemployed	Regional/rural
Chloe	Woman	Lesbian	22	University student		Regional/Rural
Georgina	Woman	Pansexual	22	University student		Regional/rural
Panos	Man	Gay	19	University student		Regional/rural
Aris	Man	Gay	20	University student		Regional/rural
Lizeta	Woman	Lesbian	37	University degree	Self-employed	Athens
Paul	Man	Gay	37	University degree	Public servant	Athens
Daphne	Woman	Lesbian	35	High school	Private employee	Regional/rural
Stavros	Man	Gay	22	University student		Regional/rural
Katerina	Woman	Bisexual	19	University student		Regional/rural
Elina	Woman	Bisexual	19	University student		Regional/rural

Popie	Woman	Bisexual	22	University student		Regional/rural
Alexia	Woman	Queer	24	University student		Regional/rural
Niki	Woman	Queer	20	University student		Regional/rural
Tasia	Woman	Lesbian	20	High school	Private employee	Regional/rural

The characteristics of doctors are set out in Table 3. All doctors with the exception of a bisexual woman, were heterosexual men. Seven out of ten doctors lived and practised in Athens while the remaining three mainly in regional/rural areas. The average age of doctors was 45.5 years. Three were psychiatrists, three pathologists, two GPs, one endocrinologist and one gynecologist.

Table 3: Characteristics of doctors

Name	Gender	Sexual orientation	Age	Specialty	Employment status	Place of residence
Panagiotis	Man	Heterosexual	47	Psychiatrist	Private practice	Athens
Leonidas	Man	Heterosexual	56	Psychiatrist	Private practice	Athens
Stelios	Man	Heterosexual	44	Psychiatrist	Private practice	Athens
Kostas	Man	Heterosexual	45	GP	Private practice	Regional/rural
Kosmas	Man	Heterosexual	38	GP	Private practice	Regional/rural
Dimitris	Man	Heterosexual	46	Pathologist	Private practice	Athens
Ariadne	Female	Bisexual	42	Pathologist	Private practice	Athens
Lucas	Male	Heterosexual	56	Pathologist	Private practice	Athens
Andreas	Man	Heterosexual	52	Gynecologist	Private practice	Regional/rural
Thanos	Man	Heterosexual	45	Endocrinologist	Private practice	Athens

2.3.2 Fieldwork and research sites

My fieldwork started in a regional city of Greece, early in June 2014, when I decided to re-introduce myself as a researcher to the only LGBT group of the city,

in which I was already immersed as a lesbian member. Because I was a regular visitor to the city I was already familiar with the field and with some of the participants. This fitted well with my original plan to include in my study the voices and the insights of those who live outside the capital of Greece.

My familiarity with some of the participants allowed me to quickly start asking direct questions and request interviews without worrying too much whether I was intrusive, particularly since I was asking questions on health issues which are sensitive topics to discuss with a complete stranger. I also sensed that these participants could more readily express their feelings and emotions about their health care experiences.

My primary purpose during this stage of my fieldwork was to formulate an initial set of questions that would be helpful during my in-depth interviews that were to follow as well as to identify some initial themes. On several occasions during this first stage, I spent whole evenings in the company of participants and many of these discussions were remarkably 'confessional'. They were often held in private places but occasionally we would later go for a drink or food to a public space where our topics of discussion would shift to the day's events or issues that were not LGBT related, sometimes in order to conceal our LGBT status while in these places. However, by observing these shifts I got to experience aspects of life that are lived daily by LGBTs and to witness events play out in line with what was previously described or confessed (i.e. how LGBTs negotiate issues of in/visibility). Overall, engaging with participants gave me insight into their beliefs, fears, hopes, expectations and life struggles through close observation while participating in their meetings, events and while socializing together and discussing in informal and casual ways.

During the first three months, I also had the chance to encounter other LGBT people, in the various recreational spaces around the city who preferred to remain distant from the LGBT group, their LGBT status being known only individually by some initial participants or other personal contacts and to whom I was introduced during the course of my fieldwork. The fact I was able to gain access to participants who were neither active nor known to the LGBT activists of the group was very important for my understanding of the diverse sub-cultures and the

varied realities of LGBT people. Again, spending non-structured time with these people to get to know each other was a crucial part of my fieldwork which, as a process, was also helpful when I began the in-depth interviews with them.

After three months, I went to Athens and I stayed there until the end of my field work, which overall lasted 10 months. Although I was already immersed into some venues where LGBT individuals are visible and active in Athens, it was during my fieldwork where my immersion lasted more than quick visits. In fact, some of the LGBT activists that I initially thought I knew enough to anticipate trust and participation, had not paid any attention to me prior to my re-entrance into their natural settings as a researcher.

The frequent sites for my fieldwork were the bars and the cafes in the area of Gazi which is the centre of the gay scene in Athens. It was the area where most of the participants went for their recreational outings in the city. The cafes around the Exarcheia square were also a frequent site for my fieldwork. Although not an exclusively gay scene, the Exarcheia region is a well-known quarter for Greek anarchists, leftists and a safe area for ethnic/racial and sexual minorities. It was a very popular area among participants and sometimes preferred for discussions, not only for safety reasons but also because the area was not as noisy as Gazi.

During the course of my fieldwork I also tried never to miss an opportunity to participate in important events of LGBT groups. Informal conversations with LGBT people during LGBT events and meetings gave me more personal insight into the various groups and their internal discursive processes. In addition, access to a segment of the trans community would have been impossible if I had not participated in one of their group's open meetings. At these meetings members' familiarity with me created trust and increased interest in my study.

I also paid particular attention to how LGBT activists acted when a member was hospitalized or when members shared their health concerns during casual conversations. Over the course of my field work, I was sometimes inclined to use my social work skills to assist participants in their personal crises, to inform them about welfare resources and - on two occasions involving LGBT youth - even encouraged them to contact the LGBT community. Overall, the LGBT persons I met during my fieldwork rarely discussed in detail personal health issues in the

context of a large group and much of the data which were focused on their health care issues were obtained in the context of individual meetings or planned interviews. However, engaging with participants in their everyday realities was important to identify certain themes that emerged during the research and to cross-check the context and the validity of my findings (triangulation) (Mcilveen, 2008).

2.3.3 Reflections on group interviews

The purpose of the group interviews with LGBT activists was to elicit important themes relevant to the health and health care of LGBT people as defined by the processes of LGBT organisations and the collective meanings of health inequalities experienced by LGBT people in Greece. This initial data collection technique permitted a more focused policy analysis and the collection of vital information on important health issues identified by the LGBT organisations. In addition, LGBT activists and organisations became familiar with my research purposes and, particularly those located in regional cities, attained an active role in the whole research process (e.g. by promoting the study to other members).

Three of the four group interviews with LGBT activists were held in regional cities of Greece³. Each group consisted of, on average, 5 participants and the discussion lasted approximately 3 hours. The one held in Athens consisted of 2 participants and the discussion lasted approximately 1.5 hours. In this one, because of the small number of participants, the format resembled parallel individual interviews.

In all group interviews participants knew each other as they shared membership in the same LGBT group. The fact that I interviewed pre-existing groups enhanced the interaction between the participants as the familiarity among them enabled an open discussion and minimized the fear of embarrassment. In addition, probing was more frequent leading to richer data (Kitzinger, 1994). Moreover, the LGBT groups that participated in this study can be viewed as

³ The names of the regional cities are not shared in order to protect confidentiality and anonymity of the participants.

natural groups in natural social contexts in which understandings and ideas are formed (Jenness, 2013, Coreil, 1995). This proved to be particularly important given that many of the participants argued that health issues are rarely discussed within their groups.

My job as a facilitator of the group interviews was primarily to ensure that everyone has access to all study information, and provide the appropriate time and space for everyone to ask questions. When I felt satisfied that the members were informed enough to give their consent, I asked them to sign the consent form and I started the audio-recording. However, in one of the group interviews, three participants joined much later than the formal beginning of our discussion. This was reasonable given that the format of the group interview resembled that of a community meeting, as described by Coreil (1995), and I had already made known that participation is open to all members. The flow of our discussion continued after a quick pause to make room for the newcomers, to introduce to each other and to ensure that they knew that the discussion is recorded.

I usually started the group interview by asking the participants to present themselves and talk a little bit about the reasons and their story on how they became members of the group. Then, I directed the discussion on the ways they perceived the meaning of health inequalities experienced by LGBT people and I was prompted them to provide examples from their personal lives. Participants were encouraged to talk to one another, ask questions and comment on each other's experiences and points of view.

2.3.4 Reflections on semi-structured interviews

During my fieldwork I had a continuous and nagging feeling that homophobia, transphobia and their accompanied fears were what defined the place where the individual interviews would be conducted. This was despite my usual strategy to ask my participants to choose the place that they would feel more convenient and safe to meet me and be interviewed. In all cases where my interviewees lived with their families, it was never proposed that the interview could be held at their homes. By contrast, LGBT individuals who lived alone or with a same-sex partner

would usually suggest their home environment for the interview. As Dendrinou (2008) argued, this may to some extent indicate the silence and the preventing attitudes of families in Greece towards homosexuality (and transgenderism, I would add). From the interviews that were held in the home environment of the participants, there were at least four occasions I understood the participants' concern to lower their voice or close their windows so as not to be heard by their neighbors.

LGBT friendly cafés were also a frequent space where LGBT activists chose to be interviewed. These spaces were also frequently used for their recreational activities. For those who were not involved in LGBT activism, LGBT friendly cafés were not necessarily spaces that ensured safety to them or which they were accustomed to visiting. Yet, choosing the space they personally used for their recreational activities was not an option since they were afraid to be exposed to a public space in which they were known. Therefore, finding a public place which could simultaneously ensure anonymity and privacy was a frequent obstacle and a continuous concern I shared with some of my informants.

The purpose of individual interviews with LGBT participants was to elicit their accounts of their health care experiences and reflect on the ways that homophobia and transphobia impact their health care and health-care needs. The purpose of individual interviews with doctors was to reflect on their practice with LGBT patients. I also asked them to reflect upon some issues that LGBT participants and groups had brought forward. All of these interviews were held in doctors' private offices and their duration ranged from 1.5 to 3 hours. In all interviews I typically used prompts to allow participants to discuss their experiences in more depth, clarify and elaborate their views and descriptions (Marshall and Rossman, 2011).

Individual interviewing allowed the space for participants to describe in their own words their realities and therefore reveal the deep meaning of their own experiences (Marshall and Rossman, 2011). Through individual interviews was provided a great informational yield as well as more detailed descriptions of health issues, which often entailed sensitive and personal information of the

participants. Much of this information could not be possibly discussed or observed during informal discussions or socials. To allow my informants to talk freely about their personal experiences and feel comfortable discussing sensitive information, I opted for a semi-structured set of questions. As D'Exaerde (2001) notes, this seems to be the best method of interviewing as semi-structured interviews are close to everyday conversation.

2.3.5 Narrating the place of “I” within my research and the insider/outsider question

Feminist epistemologies have a long history of disrupting and breaking away from the depersonalized genre of traditional scientific inquiry and reporting (Lykke, 2010, Naples, 1996). The idea is that the whole research process and the knowledge it produces are inevitably shaped by the multiple positionings and mobilities of the researcher in terms of gender, class, ethnic, sexual and other social identities (Davis, 2014). Within this framework of thinking, I will reflect on personal stories which explain the place from which I speak throughout this study as well as how I am affectively connected to the LGBT participants of my study.

The first story is held within the metaphorical place and psychic structure of “the closet”. It was ten years ago when I was still struggling with internalized homophobia and my fears of being socially rejected and demeaned for being a lesbian. Although I did not want to accept for myself the cruel destiny of the closet, I was not ready to abandon the fantasy that I could still have the option to be part of the heterosexist privilege.

At the time, I was occasionally participating in a web forum of lesbians mostly as an observer. One day, the web-based discussion was about the pathologisation of same-sex attraction and the conspiracy of silence among powerful elites who maintain a societal position that could bring important impacts to the ways that homosexuality is socially perceived. I vividly remember the words of a lesbian: “Where are all these lesbian psychologists? They must take a stand! They must speak out!”.

Although this woman seemed to forget that social workers are also seen as experts and definers of what pathology is or not, I remember myself bursting into tears as I instantly felt that I was completely powerless to stand up for my own sexuality and my lesbian relationship, let alone stand up for a whole community of lesbians as she was angrily demanding. However, at this vulnerable moment I felt that this woman uncovered my powerlessness and I remember myself making a promise to her although I never responded to her message. The promise was to stand up and fight in the way I imagined her fighting and struggling with homophobia. Thereafter, this imaginary warrior and her voice became part of my spiritual strength. Her voice also became an affair to remember, part of my social work and lesbian consciousness, and when I decided to become a researcher, part of my inspiration and my ethical imperative to conduct research that could reveal the oppression lived by LGBT people and advance the emancipatory potentials of the LGBT community. In fact, seeking social justice and satisfying one's own identity quest have been identified as primary motivations of the researchers who are engaged in researching their own social identity groups (Labaree, 2002).

The year I began this research I was working as a social worker in a Welfare Department in Levadia, which is a rural area in Greece. It is the place where I still live and work. Although I had to live away from my partner, something that was financially and emotionally exhausting, I still had the privilege of maintaining employment in the field of social work, namely a job in the public sector which provided me with a sense of financial and professional security. This was at a time when most of my colleagues were beneficiaries of EU programs that provided a 4 month job contract per year that offered less than 480 euros per month, and they were usually in a considerably vulnerable position within their working environments (e.g. treated as students or 'dogs bodies') as a result of their restricted employment rights.

My second privilege was that I was granted a scholarship for doctoral studies by the State Scholarship Foundation (IKY) which provided me with the chance to continue my studies, leave the countryside, share a house with my partner, limit our expenses and open up my professional future without having to quit my job.

This was due to a law which obliged public departments not to deny any educational leave of employees who are supported by IKY provided that their educational course was not completely irrelevant to their profession.

However, my application for educational leave triggered a huge turmoil in my job. In a context of understaffed departments and insufficient recruitment, there was already a growing culture of negativity towards transfers or any kind of employees' leave. Not surprisingly, only a few colleagues congratulated me thus allowing me no room to be cheerful. Instead, I was instantly messaged that the personnel department and my manager would attempt to challenge my right to educational leave. What I did not imagine though was that my application and the topic of my study would lead to a storm of nasty homophobic comments and a rather negative atmosphere. Until then, my lesbian identity was predominantly dealt with silence, embarrassment or pretended blindness usually expressed with statements like "we are all equal", or, at worst, homophobic jokes. However, I soon experienced my sexuality being suddenly in the foreground as an issue for gossip and curiosity among colleagues and managers. The fact that I was about to focus on LGBT people became entangled in the rationale of my department to ban my educational leave.

The authority which was to assess and decide upon my claim for educational leave was the Official Board. The latter was comprised by managers at the highest levels of hierarchy. However, I knew that the power dynamics were much more complicated than an assumed rigid hierarchy. As many of my colleagues had access to these people but, most importantly, the power to influence its decisions, I could find out the intentions of the Official Board and act accordingly. What could also enforce the positive decision by the Board was my ensuring a supportive climate upon my claim among my colleagues and not to allow anyone distort the meaning of collegiality against me. This could easily happen since I would not be replaced and my duties would be shared between colleagues who were already overburdened.

Informal discussions which were held in my workplace on an almost daily basis for one and a half months were the framework in which I struggled to defend for myself and my rights. In these discussions I was accused of inappropriately

conflating my personal “issues” and “difference” with professionalism and my social work duties. I also experienced my social work practice being analyzed and my motives being frequently questioned. I was especially asked to explain the reasons I did not choose any other social group instead of LGBT persons in that the latter were not generally viewed as a minority that social workers have a reason to work with. Additionally, I had become the topic of discussion or gossip among my colleagues or managers; I was often asked to keep silent about my identity or told that I was unnecessarily speaking out on LGBT issues. One well-intentioned administrator, who happened to have access on my research proposal, commented that it was good to repeat the LGBT acronym because in this way maybe nobody would notice for whom I was talking about. Participating in and responding to all these informal discussions was undoubtedly an implacable, constant and exhausting battle although it was inevitable for my effort to build solidarity and become aware of how homophobia could be acted out.

Gradually I became very militant and learnt to employ particular strategies to defend for labor and LGBT rights. On the day of the assembly of the Official Board I was asked for a hearing, although this was not part of the typical procedure. When I was asked to explain my research proposal and started to use words such as homosexuality and gender transition, I immediately saw Board members’ eyes fall and I sensed the embarrassment that dominated the space. The only question I was asked when I finished my speech was by the president who asked me “Do you really offer services to.... these...” He never managed to finish his sentence by articulating the word gay or homosexual or any other identity category my research was about. And it was at this moment as I was watching him in silence, expressing his own homophobia that I felt my victory.

This story became the most intensely emotional part of this research process for me not only because it was a personal battle but also because it nurtured within me a sense of participating in the collective struggles of the LGBT community. As I transcended from the personal to the collective, I was growing a solid sense of “insiderness” regarding my position in relation to the LGBT community and my informants. Yet, as Naples (1996) has stressed, I had ignored the interactive processes through which “insiderness” and “outsiderness” are constructed and

therefore problematized the assumed fixed or static insider/outsider distinction. The key events that revealed the fluidity of my standpoint as an insider was when some participants, usually LGBT activists in Athens, expressed their mistrust about how I would use the research data since they had no idea about what kind of findings I would finally produce. On one occasion this was explicitly expressed during an interview with two LGBT activists in Athens when I appeared to be interested in an issue that was perceived as an internal matter to the LGBT groups. Interestingly, the issue was brought up by the LGBT activists themselves who seemed to speak freely in front of me while we were walking to the café where we planned to go for the interview. However, when I brought this issue myself during the interview, one of the participants appeared to be reluctant to provide answers.

DG: ok, now I want to discuss another issue.... you were speaking about this in the beginning and I was listening, it is not very relevant to what we have discussed so far, but I am also interested in LGBT activism... I want to discuss what happened in Facebook and the leaflet of...

Paul: you mean you want to speak about transphobia?

Lizeta: Don't Paul! Wait...

DG: about the leaflet of QueerTrans group which expressed a criticism about Athens Pride and had fuelled an intense conversation about this issue... What do you think is the meaning of this for the LGBT community?

Lizeta: Did we change a subject?

DG: Yes

Lizeta: This is a completely different subject

Paul: We covered everything else Lizeta dear

Lizeta: I asked because I don't understand how our answers on this will help you with your PhD

Paul: Don't you like to be interviewed Lizeta?

Lizeta: Yes, no... but...

The above example from my fieldwork illustrates how quickly my status occasionally shifted from that of a trustful member of the LGBT community to that of a researcher and vice versa. This particular experience was a challenging moment for me. I got instantly angry with Lizeta not because I was about to be denied access to information that I valued as important for my study, but because this denial made me feel I was unfairly denied membership in the community that I considered that I belonged to and identified most closely with. Although I do not

consider my anger as totally irrational, I came to realize through this experience that insiderness is a phenomenon that reflects the complex nature of relationships between the researcher and the informant, and therefore remains a process of negotiated achievement (Labaree, 2002). In this sense, my insiderness could not rely solely on the fact of my lesbianism or my experiences of homophobia. Instead, it should be nurtured through meaningful processes in the same way that communities do not build up solely on the basis of outside threats, but more importantly, on the basis of what people develop as they engage with each other (Blasius, 1994).

Nevertheless, my insider status in Athens was ambiguous also due to my feelings in terms of locality. When I entered the field of Athens I felt strangely alienated. I was an outsider there and I did not really fit in comfortably. In the last 15 years of my life I have lived in regional and rural cities of Greece and although Athens is the city I was born and raised, I feel certainly confused in terms of where exactly is my hometown. As I had only occasional visits to the LGBT scene my connection with the LGBT community was not stable either. . As a result, I had a sense of belonging and “unbelonging” at the same time, and at least partially, I was seen as a newcomer by the LGBT activists in Athens.

In addition, it was the first time I was working on behalf of the LGBT community as a researcher and I felt that I had to negotiate this legitimacy with the LGBT activists who were the gatekeepers of the meanings of “harm” and “benefits” –the LGBT politics. I was not confident enough to do so particularly because my insiderness was pushing me to be considerably responsive to a collective worry of protecting the boundaries of our stigmatized community and defend its reputation from potentially damaging outsiders. This has also been noted by Crowley (2007) who argued that individual members of stigmatized communities usually react strongly and in a variety of protective ways to a researcher’s request for access to and information. As I inhabited both identities, I was inclined to constant self- surveillance which at times was emotionally exhausting and restricted my access particularly in the case of the trans community which I considered the most vulnerable among LGBTs.

In complete contrast, during my field trips in the rural and regional cities I used to feel more at home even in cities I had never visited before. LGBT activists embraced my study and my presence in their hometowns earnestly. To most of them, the fact that I was living as an out lesbian in a rural area was a shared experience which was viewed as my credential for being a trustful member of the LGBT community. This was often reflected verbally as I was often introduced as a “comrade” or a “researcher of our community”. At the same time, however, some events revealed the fragile sense of community and consequently the way I experienced my insiderness.

For example, when I met Lambros, a 35-year-old gay activist, we were in an anti-racist festival in which Lambros was participating by keeping a kiosk of his LGBT group while many other kiosks, mainly held by leftist groups surrounded the space of the festival. Although many people would greet Lambros during the night, his kiosk remained with only a few people while other kiosks were more crowded. However, while Lambros and I were discussing the possibilities of the development of the LGBT movement in his city he said: “do you see all these people? Most of them are bisexuals”. This statement interestingly echoed the complex relationship that exists between bisexual orientation and bisexual identity as it is extensively documented that overall bisexual people are essentially less likely to identify themselves as bisexuals yet they comprise a majority group within the sexual minorities usually subsumed in the term LGBT (See and Hunt, 2011, Weinberg et al., 1994). However, this event also revealed my outsidership in terms of my access to ethnographic encounters in which I was a comrade and a stranger at the same time. This example from my fieldwork also illustrates that the LGBT community is so diverse that even LGBT researchers find it impossible to maintain an insider status in all of its segments. As Deutsch (1981) has noted on the complexities of the insider and outsider dichotomy, researchers are multiple insiders and outsiders and the boundaries between those two are situational and defined by many factors including the perceptions of those being researched.

2.4 Data Analysis

Following the theory of intersectionality, the purpose of data analysis was to explore and highlight the ways that multiple identities and systems of oppression interconnect (Fish, 2008). However, intersections were not always expressed explicitly by the participants. According to Hankivsky et al. (2009) and Bowleg (2008) it is within the purposes of intersectional analysis and interpretation of data to articulate explicitly how the pathways through social inequality are related to the various aspects of social identities. Furthermore, a structural intersectional analysis bridges the participants' experiences within the specific contextual realities in which they occur (Bowleg, 2008, Crenshaw, 1991).

Another goal of my data analysis was to highlight the theoretical implications of the ethnographic data so as to advance the potential of theoretical extension and the systematic understanding of how social structures, such as homophobia and transphobia, are reproduced in health care (Snow et al., 2003). This was one of my greatest concerns given that homophobia and transphobia remain undertheorized concepts (Fish, 2006, Wilton, 2000), and this is –to my knowledge– the first study to describe the ways that homophobia and transphobia are replicated in the reproduction of health inequalities of LGBT people in Greece. Therefore, following the model on analytic ethnographies suggested by Snow et al. (2003), I tried to allow my field observations and data to speak as loudly as theories, so that they would mutually complement each other. However, this strategy limited, at least to a point, the detailed accounts of local social contexts that reveal the richness of social life usually found in ethnographic texts (Snow et al., 2003).

During the data collection process all interviews including group interviews were recorded and transcribed while extensive field notes and memos were kept during the data collection process. Memos functioned to enable me to remember and outline my personal reflections as well to identify my assumptions in reference to the meaning of data (Mason, 2002b).

I undertook all the transcription myself and a second careful hearing of the tapes was undertaken to check the accuracy of transcription. Sharing the same language with participants meant that there were no linguistic difficulties in ensuring effective communication and transcribing the data. However, translating

participants' narratives into English was at times a challenging task. This is because translating words and concepts that were culturally bound to the Greek language into English risked altering or restricting their meaning (Nes et al., 2010). Although translation was involved only during the writing process of the final thesis where I introduced quotations from participants' interviews, transferring their meaning into English was not easy as my fluency in English is not equivalent to that of my Greek. This is particularly important as the validity of qualitative research is also measured to the extent that "the distance between the meanings as experienced by the participants and the meanings as interpreted in the findings is as close as possible" (Nes et al., 2010, pp.314). In order to limit the possibility of misinterpretations, all quotes throughout the thesis were translated with the support of my supervisor, who also speaks Greek fluently, and two other editors (one being a professional translator) with whom I discussed possible wordings.

A detailed and systematic coding was employed to build up common themes and categories often linked to my memos and reflections of the research process as well as to other literature. Through this process differences in the data were also identified and therefore sub-codes were created so as to maintain their distinguishing characteristics. Thereafter, codes and sub-codes were sorted into themes and I collated all the relevant coded data extracts within the identified themes (Braun and Clarke, 2006). The identified themes were defined, named and analysed in relation to the relevant research questions. This was one of the core purposes of data analysis. Emerging themes, patterns and links between the sub-themes were essential for the holistic understanding of explanations provided by the rich qualitative data (Braun and Clarke, 2006). Typical of other qualitative studies, my study elicited large amounts of data, therefore the N-vivo software program was used to store and organize the data as well as to assist the coding process and enable comparisons within the data (Mason, 2002b).

2.5 Ethical Considerations

Ethical considerations were carefully considered at all stages of this study by following the ethical guidelines provided by the Ethics Committee of Durham University who also granted approval for this study (Appendix 1). Ethical approval was not required from the Panhellenic Medical Association which maintains a supervisory and regulatory role in the regional Medical Associations in order to interview private practice doctors (Appendix 2). Doctors participated of their own free will and discretion.

LGBT people have been harmed for centuries due to the pathologisation of homosexuality. Focusing on LGBT health issues may unintentionally lead to their medicalization and the institutionalization of negative attitudes (Institute of Medicine, 2011). This was a major ethical consideration thoughtfully examined at all stages of this study. I tried to limit the potential of negative consequences for the participants by attaining a contextual orientation in my study and an in-depth understanding of LGBT participants' meanings (Dodds et al., 2005). Some of the important contextual factors that influence the health issues of LGBT people include the history of LGBT people in Greece, the effects of stigma, laws and policies, demographic factors and barriers to care (Institute of Medicine, 2011). Although theoretical expansion was indeed one of the purposes of my data analysis, I was also aware of the potential pitfalls of manipulating, and therefore marginalizing the stories and the 'truths' of participants so as to construct or validate a "grand narrative"- that is to dilute participants' stories into what Smith (1999) names as the "imperial eyes of the researcher".

Another major ethical consideration was that the research process itself entailed a risk of becoming a stressful experience since people often feel that they must be exposed and be subjected to a scrutinizing process (Lee, 2008). I considered LGBT participants to be particularly vulnerable to experiencing the research process as a stressful one given that many of their stories were relevant to their trauma(s) stemming from homophobia, transphobia and the accompanying stigma. To minimize the potential harm for the participants, the study was informed by the minority stress perspective which is considered to be important for studies that recruit people experiencing stigma (Institute of Medicine, 2011). Moreover, I focused on Herman (1992) ideas on trauma. I was constantly very careful about creating a safe space for participants to share their stories. I

allowed participants to have as much control as possible of the place and the time of the interview as well as the degree of disclosure they wished to maintain. I also provided the time to build a trusting relationship with my participants before inviting them to an interview, so I usually spent some time with them on an “everyday conversational” basis. When this was not possible, I tried to incorporate this time during the first stage of the interview without going too quickly with questioning or probing for detailed descriptions of personal experiences. In addition, I always made clear to my participants that they were free to communicate with me again after the interview if they wanted to discuss, re-craft their stories, ask questions, get information or withdraw their stories from my study.

Issues of confidentiality and anonymity were also thoughtfully examined at all stages of this study. All participants were reassured that I would provide anonymity for themselves and others who were included in their stories. In the text of this thesis, there were times when I had to omit detailed description of stories or contexts so as to protect the identity of all participants.

All participants were provided with letter with the research purpose, contact information, a consent form and I usually communicated verbally a set of basic interview questions that would be asked during the interview (Appendices 3, 4 and 5). Having an idea of some of the issues discussed during the interview appeared to empower the participants and made them feel more secure during the process. All participants were expected to be able to give their own informed consent, therefore individuals under 18 years old were excluded from the study.

Conclusions

This study adopted an ethnographic approach of social inquiry committed to interpretivism, qualitative methodologies, and intersectionality. All of these commitments have been presented in this chapter in which I have discussed in detail the research design and fieldwork process. In the following three chapters I discuss the research findings. The latter are presented with a view to showing

how homophobia and transphobia construct health inequalities for LGBT people in Greece.

CHAPTER 3 THE CONSTRUCTION OF LGBT INVISIBILITY IN HEALTH CARE

Introduction

Invisibility is primarily produced by normalizing and normative straight-jacketing social processes which grant recognition to social groups within very selected parameters (Puwar, 2004). Most societies are structured around two binary genders, male and female and only one “normal” sexual orientation, namely the heterosexual one (Mahon, 2009). LGBT people fall out of this norm, therefore their experiences are rendered invisible and the way they are seen by others is distorted by stereotypes and ideas of inferiority. This is because normalization transforms difference into deviance (Puwar, 2004). Therefore, normalization is a source of structural oppression as people’s differences are de-humanized; people themselves are marked as outcasts and marginalized when they cannot meet the dominant norms.

Historically, LGBT people are subject to overt and blatant forms of oppression such as homophobic and transphobic violence and hate crimes, institutional discrimination and denied access to key social institutions such as marriage or even enforced psychiatric treatment. At the same time the integrity and the very existence of LGBT people is threatened by means that do not necessitate their physical abuse. Crucially, society denies the existence of LGBT by rendering them invisible, denying their collective identities and forcing people to suppress their identities. Therefore, LGBT people are forced to deny important aspects of themselves. Invisibility represents the most subtle, yet the most persistent and difficult to change form of social oppression against LGBT people. This is perhaps more evident in countries like Greece which are still attached to Orthodox religious customs and have not accomplished the progress in terms of LGBT rights and visibility that is found in other Western European countries (see also pp.11).

In this chapter I pay attention to the invisibility of LGBT people and how this is reproduced in the health care settings. Invisibility is a multidimensional and

complex phenomenon constructed by a number of interrelated factors, some of which are beyond the scope of my analysis. In this chapter my focus remains within the health care context and in particular on the disclosure choices of LGBT participants and as well as the doctors' attitudes towards questions relevant to the sexual orientation and gender identity of their patients. Nevertheless, as the social position of LGBT people is highly marked by the dynamics of invisibility, it is impossible to frame these dynamics into one chapter's discussion. Therefore, issues of invisibility will re-emerge throughout this thesis.

In the first five sections of this chapter I discuss five factors that appeared to construct the unwritten, yet firmly placed "don't ask, don't tell" policy within the health care services. In section six I discuss the invisibility and the erasure of bisexual and non-binary identities in health care settings. In the seventh section, I explore the safety strategies of LGBT people when they decide to disclose their sexuality or gender identity to a health provider. Through an intersectional analysis I shed some light into how race, age and the division of urban/rural intersect to the issue of confidentiality in health care settings. In the eighth section I discuss how LGBT participants appeared to negotiate their invisibility in order to ensure visitation rights in hospitals.

3.1 The heterosexual assumption as a form of discrimination in health care

The heterosexual assumption was one of the most common ways where the invisibility of LGBT participants appeared to be perpetuated in health care settings. This was not a surprise given that the heterosexual assumption is a governing principle in most of the everyday social interactions of LGBT people. Overwhelmingly, all participants said that they were never asked to disclose information about their sexual orientation while most of them said they were routinely presumed heterosexuals. This was often communicated to the LGBT participants primarily by health professionals' questions such as: "are you married?", "are you planning to get married?" or referring to a husband/ boyfriend when talking to a lesbian/bisexual woman or a wife/girlfriend when talking to a gay/bisexual man. This finding is consistent with those of other studies which

have shown that doctors frequently assume that all their LGBT patients are heterosexuals and/or cisgender (Barbara et al., 2001, Eliason and Schope, 2001). Such assumptions contribute to the informational and institutional invisibility of LGBT people in health care systems, which, in turn results in systemic barriers to care (Colpitts and Gahagan, 2016, Bauer et al., 2009).

Nevertheless, both LGBT participants and doctors did not identify invisibility as a root cause of health inequalities especially when invisibility entailed a voluntary concealment of sexual orientation or trans identity by the LGBT individuals. Moreover, since the assumption of heterosexuality ensured that LGBT individuals would be at least treated “in the same way” as their heterosexual counterparts, it was believed there is no possible room for negativity or discrimination at least towards homosexuality. In a sense, where difference is shadowed there is no obvious reason to evidence discrimination since its very notion presupposes difference to be at least at the front ground. However, when I was invited to observe an event where lesbians shared their stories of cancer, the heterosexual assumption was explicitly defined as a form of discrimination by Ioanna who angrily described her experiences of being repeatedly assumed heterosexual when her sexual health and the possibility of pregnancy were scrutinized and monitored by doctors every time she was about to have chemotherapies. When she implied that she does not challenge the heterosexual assumption of her doctors, a lesbian activist interrupted her and urged Ioanna to always come out to her doctors. She reflected on her health care experiences on diabetes and argued that she always comes out as a lesbian in the same way she introduces herself with her name. Ioanna obviously annoyed responded that cancer is different and “we must always choose our battles”.

For some LGBT participants the assumption of heterosexuality was becoming a part of their proactive strategy to protect themselves from possible homophobic attitudes and embarrassment. Embarrassment and discomfort were often seen as the inescapable emotional cost for the LGBT participants when they were presumed heterosexuals. For example, Mary, a 41-year-old lesbian reflected on her feelings whenever she is presumed to be heterosexual by a doctor:

It makes me feel uncomfortable, because by assuming this, I must either continue this lie or I am positioned to say “you know this is not the case, it is the other way”... so... you know... but if they asked me straightforwardly I would just come out and that would be the end of the story, so now I must put this person out of his feigned fallacy... especially when this is pretty obvious to me and the other pretends that he is not seeing it, well then it is even more difficult to shake down all his..... bizarre situations happen and I don't see why they should.

Pretending not to see the LGBT status of a person, as suggested by Mary's description, was also commonly replicated in many other of the participants' stories. Signaling sexual orientation such as touching or hugging a partner in front of a health professional or performing a stereotypical “gay” behavior was sometimes preferred by some participants rather than making a “big statement” about their sexual orientation. This also appeared to function as a strategy to minimize stress-related coming-out process. In other cases, signaling sexual orientation was part of a person's effort to appraise the possible risk of a homophobic overt hostility and decide to come out at a later time when safety could be ensured. Nevertheless, many LGBT participants argued that pretending not to see these signals was always the response and part of the unwritten policy of “don't ask don't tell” within health care settings. For many LGBT participants this attitude was clearly an effort of health professionals or other people in hospitals to cover their uneasiness and discomfort felt due to homophobia. For example, Paul, a 37-year-old gay activist characterized this attitude as a “fake politeness” and believed that this attitude was assumed by health professionals as a positive discrimination towards LGBT people. I asked Paul to explain more explicitly the ways he experiences this positive discrimination, and he said:

A positive discrimination is when, for example, you deal with an issue or when you want to speak about a problem you have and you see that the person you speak to does not act normally or in the way that he/she would act, either s/he will show a fake politeness or s/he will try.... s/he will not discuss anything, for example the fact that nobody will discuss my relationship status is presumed a positive discrimination, and this is politeness, right? But if I was in his place and saw a couple , if I saw a girl lying in bed and a young man coming all the time, and that given, these two were a couple, at some point I would ask them “hi guys! How long do you know each other? How did you meet?”, you know, through a casual conversation

Other examples indicate that the assumption of heterosexuality can be so rigid within health care settings that, even after an explicit coming out, it remains unchanged. Nelie, a 23-year-old lesbian, had delayed periods and decided to come out to a gynecologist so as to ensure that, by providing as much information as possible, she would have a proper diagnosis. Part of her safety strategy was to choose a female gynecologist as she believed that women are less homophobic than men. Nelie argued that despite her coming out as a lesbian and without being asked to provide a detailed sexual history the doctor expressed her certainty that Nelie was pregnant.

Of course gynecologists must know about my sexuality, but even when I told this to a woman her face was soured and she didn't want to accept this, and she even told me to have a pregnancy test, she could not accept it! Maybe she tested me for pregnancy just to take the piss out of me, and she was saying "you are not pregnant? Yeah, right!"

Nelie took the pregnancy test under her doctor's pressure and insistence on her initial diagnostic possibility of pregnancy. I asked Nelie if her doctor said anything after the negative test result. She replied that in the next visit the subject was not brought up again. "What could I say to her?" she said. Nelie's doctor proposed a series of other medical tests but Nelie decided to just go and see another doctor. Interestingly, Nelie's coming out was not sufficient to confirm the "existence" of lesbians and was also clearly insufficient to challenge her doctor's assumption of heterosexuality. This is particularly important since the heterosexual assumption is sometimes handled as an outcome of naivety or ignorance that can be easily eradicated when the closeted LGBT individuals decide to come out. Instead, the heterosexual assumption is a deep rooted principle of our everyday social interaction and as a mechanism of heterosexism encapsulates the heterosexist assumptions about the inferiority of LGBTs including the associated stigma and prejudices about homosexuality (Fish, 2006, Escoffier, 1998).

Doctors' views on the heterosexual assumption further confirm this understanding. On the basis of what is statistically most probable, almost all doctors said that it is justifiable to assume that a patient is heterosexual. Although three of the doctors acknowledged that they are responsible to ensure a safe environment for LGBT patients to come out, assuming LGBT patients'

heterosexuality prior to their coming out was not appraised as problematic. In addition, avoiding the convention to automatically assume heterosexuality appeared a difficult task even when it was accompanied with a well-meaning effort to provide appropriate health care to LGBT patients. For example, during our discussion with Kostas, a 45-year-old GP, he expressed his belief that it is within doctors' responsibility to make sure that LGBT patients feel safe enough to come out and be able to provide information about their sexual history. He said he had limited experience in working with LGBT patients as only a few eventually feel confident enough to come out. I asked him if he thought it would be possible for him to create a supportive environment where a woman could speak openly about her lesbian sexual orientation. He replied:

There will always be a chance to ask something in order to refer to this issue, for example you can even start backwards, I would ask for example "what about you? Won't you... won't you... how can you stand this? Won't you get married?"

In some other cases doctors explicitly stated that it would be problematic to ask an open question. For example, Ariadne, a 42-year-old pathologist who also identified as bisexual was one of the three doctors who acknowledged that the assumption of heterosexuality is not appropriate for LGBT patients. However, she also acknowledged that implying that a patient could have an LGBT identity could be offensive for heterosexual patients. She particularly said:

No doubt all doctors, while they are taking a medical history from a patient, should ask him/her without any hesitation if s/he is heterosexual or homosexual, we are far from this, because if a woman comes here, right? Who is not a doctor and I ask her "are you gay or not?" there is a strong chance to tell me to fuck off, right? So, if you see it in a professional way.... It is... a doctor may know or imagine thousand things, but sometimes when you know that society is not ready it is hard for a doctor to ask some things

Ariadne's argument is indicative of the powerful societal norms that influence medicine despite the presumed pure and absolute scientific status objectivity and rationalism over the norms of society. Although Ariadne referred to an imaginary case scenario, the fear of societal punishment when dominant norms are

challenged already determined a compromise of what Ariadne defined as good medical practice. Furthermore, the idea that heterosexuals are a statistical majority in a society unready to accept homosexuality appeared to restrict space for LGBT appropriate medical questions. This is also another dimension of the heterosexual privilege, linked to the ongoing favoring of the presumed heterosexual majority. This persists even when it entails the invisibility and the stigmatisation of a presumed minority, the LGBT people. This is why the invisibility of LGBT people, when maintained, is the direct outcome of a perpetual state of discrimination. As Rondahl et al. (2006) state, invisibility is a form of indirect discrimination which is sustained by the prominence of heterosexism and heteronormativity and leads to social exclusion of LGBT people.

The persistence of the invisibility of LGBT people in health care and health research are increasingly recognized and reported as the most important factors contributing to LGBT health inequalities (Williams et al., 2013, Institute of Medicine, 2011, Potter et al., 2008). Due to the lack of routine monitoring of sexual orientation and gender identity by providers in health care settings but also by researchers in population-based and epidemiological health studies, there are significant gaps in data and knowledge about the health needs, outcomes and the quality of services received by LGBT people. This lack of knowledge also perpetuates heterosexist assumptions and the inappropriate response of the medical profession to their LGBT patients. As Potter et al. (2008) argue, the failure of clinicians to recognize their LGBT patients is the result of the “don’t ask ,don’t tell” unwritten policy in health care settings which is, at least in part, related to doctors’ inability to appropriately question gender identity and sexual orientation and their lack of knowledge, or concern, about creating safe environments in which patients can feel comfortable volunteering this information. Indeed, all doctors stated that they never received any kind of training on the health issues of LGBT people during or after their studies in medical schools. One doctor even mentioned that homosexuality was only once referred in the course of psychiatry but as medical students had overall little interest in psychiatry nobody really paid any attention.

Not surprisingly, when I asked doctors if they found it important to monitor the sexual orientation of their patients, some said that they would require some sort

of training before they begin asking this question. Kosmas' response is representative:

It [the question on sexual orientation] is important but doctors don't ask this question, I personally don't ask because I am not trained to ask this, they should have trained me, I never heard, for example, a course about these issues. For example you could be invited in a course to general practitioners, very soon you are going to have your PhD on this issue, it is a very important issue, you could provide a lecture to doctors for example, because very soon you are going to be an expertise on this, right? All these are related to training, everything is about training (Kosmas, 38 years old, GP)

In this section, the experiences of LGBT participants were discussed in relation to the ways they experienced the heterosexual assumption when they received health care services. Though rarely acknowledged as an aspect of discrimination against LGBT patients, the heterosexual assumption appeared to intensify feelings of discomfort and the coming-out stress of LGBT participants when in health care settings. At the same time, an open question on sexual orientation that would abolish the heterosexual assumption was assumed by doctors to be offensive and irrational given that the majority of their patients were assumed to be heterosexuals. Even those who acknowledge that the heterosexist assumption may lead to inappropriate questioning argued that they lack appropriate training to start asking in a more appropriate way. Furthermore, in a context where heterosexuality was routinely assumed implicit and non-verbal, it was not a surprise that a question on the sexual orientation of the patients was also assumed as unnecessary. This prevailing idea will be discussed in the following section.

3.2 Assuming information on sexual orientation as being irrelevant to health care

In my initial communications with LGBT people, a common assumption that I had to dispel was that of my study focusing on HIV and STDs. In one case this assumption appeared to aggravate the fear that research can be actually a weapon turned against the gay community when it unintentionally strengthens

negative stereotypes. In particular, during the first minutes of a group interview with an LGBT organization, Stavros, a 22-year-old gay activist appeared to believe that what I define as “inequalities” is basically my belief that the gay community is disproportionately affected by HIV and therefore my research was already biased by focusing only to the LGBT community. Stavros particularly said:

S: When I first read your letter, I thought: “why only LGBT persons?” I believe a lot of progress has been already made, we have confidentiality, and there are check points which screen for HIV exposure

[Me. So you think my study is about HIV]

S: yes, HIV is a very big stigma and I think it is the most deadly STD, I think, I am not sure... but the HIV also concerns the straights, gays, bi, trans or whoever

Clearly, the fear of the HIV stigma, the fear of being classified as a person at higher risk of getting HIV just because you identify as gay, along with the perception that sexual orientation is irrelevant information for a proper medical diagnosis, appeared to determine the ways that many gay men saw the issue of disclosure to health professionals. In a climate that the fear of stigmatisation appeared to prevail, it was not a surprise when Manos, a 25yearold gay activist, told me that it would be politically incorrect for a doctor to monitor the sexual orientation of their patients. Yet, in all other aspects of his life, Manos appeared to be guided by an emotional and political imperative to be “out”. He stressed that he would never consider disclosing his sexual identity to a doctor and allowing him/her to think that his homosexuality was somehow related to his health status.

Likewise, Apostolos, a 28-year-old gay man, argued that since there is no medical reason for a doctor to know the sexual orientation of a patient this could only strengthen stigmatizing linkages between health problems and homosexuality. He referred to the exclusion of gay men from blood donor programs which he thought as a blatant discriminatory practice although he had a Thalassemia trait which barred him from being a donor anyway. He continued his reasoning by memorizing a story when in the army. The story was about a soldier who was hospitalized as he suffered from ileum and his health problem became the indicator of his involvement in anal intercourse which enacted a series of

homophobic jokes and comments from other soldiers in the camp. Apostolos reflected on his painful position to be the observer of a terrible unfolding of homophobic assumptions while he was closeted in order to “socially survive”, as he said, and while he was trying to dismantle soldiers’ prejudices.

There was a guy whose bowel was twisted and he couldn’t go to the bathroom for days, he had a bloating bowel, anyway, they took him to the hospital and a soldier started to say “someone fucked him, that’s why his bowel was twisted”, and they started to make a full diagnosis for him, “they ripped his ass”, and things like that, “they fucked him and his bowel was twisted”, and I told them “come on guys, are you serious? Do you really believe this?”

The soldier in Apostolos’ story was not explicitly assumed or named as gay neither was he assumed to be involved in a pleasant anal intercourse. He was assumed to have been sexually assaulted, as within a heterosexist environment anal sex can be only an assault to men’s sexuality, masculinity and hazardous to their health (Scarce, 1999). The story is revealing of how current representations of anal sex are in actual fact “old” as they are facets of the well-established heterosexism which still pervades in western societies, including Greece. Although many heterosexual people and lesbians may find pleasure in anal sex, it is historically connected with gay identity, therefore, the pathologisation of anal sex feeds the pathologisation of gay identity and vice versa (Scarce, 1999). Homosexuality and its linked sexual practices have a long history of being pathologised, as sciences and particularly medicine have always sought to find a cause, a gene, a classification as mental or sexual disease and inevitably a cure of homosexuality (Fish, 2006, Wilton, 2000). Not surprisingly, the relevance of health care to homosexuality was dealt with suspicion by many participants as the LGBT status is excluded from the heterosexual privilege; an exclusion which partially means to be under a continuous effort to disentangle mis-relations of your sexuality and health problems (Fish, 2006, Wilton, 2000). In this sense, the unwillingness and suspicion towards the idea of disclosing sexual orientation information to doctors was also a resisting strategy to misconceptions and the medicalization of gay identity (Mason, 2002a).

Nevertheless, non-disclosure to health professionals often entailed the cost of

being misinformed on health issues that would necessitate an implicit or explicit reference to sexual orientation. Interestingly, some participants would reflect on stories of being misinformed about health issues after the realization that their previous searching of important medical reasoning for coming out to health care providers was inherently underpinned by a heterosexist imperative to come out only for a good reason. For example, as Apostolos developed his arguments on the relevance of sexual identity to health care, he asked himself: “I am just saying, is it necessary to come out after all?”, Apostolos made a small pause and he then replied his own question: “of course this is also a trap, because many times people ask you if it is necessary to tell others that you are gay”. By reflecting on his everyday experience of heterosexism, Apostolos was able to identify the cost of his invisibility when closeted to health professionals. He remembered that when he was hospitalized for a hemorrhoidectomy, he wanted to know when he could have anal sex after the surgery but he didn’t dare to ask his doctor. Again, the interplay of heterosexism and homophobia appeared to construct a shared silence among Apostolos, his doctors and his gay friends around issues of anal sex, sexual identity and health. Apostolos explained:

Before I had this surgery I asked some others who had the same surgery like me “what did doctors tell you about when you can have sex?” Nobody dared to ask.... I didn’t ask either [...] of course the doctor could mention this without waiting for me to ask, but the doctor probably is afraid to say something because someone could take this as an assault, namely.... because the taboo is involved

Similarly, when I asked Stefany, a 34-year-old lesbian activist in a lesbian group, if there are lesbians or bisexual women who ask for group’s support on their health issues, she referred to an e-mail that she characterized as a “weird claim”. The e-mail was sent by a non-member lesbian who asked for a lesbian-friendly gastroenterologist. Stefany initially considered this claim weird as she could not think of any medical reason to come out as a lesbian to a gastroenterologist but she immediately identified that questioning the reason to come out may be an inherently oppressive question:

It was a weird claim because I don’t see the reason to speak to a gastroenterologist about your sexuality, but this “there is no reason” is

a bit strange [she laughs], and the truth is that I recently met a psychologist who told me that when hiding we internalize to our unconscious that we are doing something wrong

Michael, a 35-year-old gay activist, who like Stefany often had to respond to a mailing list of people who lived with HIV, argued that gay men often ask for information about both “HIV-friendly” and “gay-friendly” doctors of various specialties, including dentists who have been repeatedly reported to have denied services to people who live with HIV. However, he interestingly furthered his argument saying that the claim of “gay-friendly” attitude is not limited to doctors but also for other professionals such as lawyers and accountants. Michael characterized the claim for a “gay-friendly” accountant as being funny since he could not comprehend the need to come out as a gay man to an accountant. However, he affirmed this claim on the basis that everyone has a different situation to deal with and reasons that necessitate disclosure of sexual orientation may vary.

Undoubtedly, the claims for “gay-friendly” professionals reflected the contextual reality of LGBT people of unsafety as the societal positivity towards LGBT identities is not taken for granted. Societal negativity and the consequent unsafe environment that is created for LGBT people erode the very meaning of visibility as an inherent aspect of human dignity since it reinforces the idea that the LGBT visibility must always be reasoned. This idea is usually underpinned with the normative function of heterosexism which allows heterosexuality to unproblematically encompass homosexual experience (Fish, 2006). As a consequence, coming out within health care settings must always be justified especially when it is assumed that health professionals do not care for the sexual orientation of heterosexuals either. However, heterosexuality is not so equally erased in health care settings as homosexuality is. As Fish (2006) argues, heterosexuals do not need to come out as their privilege rests exactly on their ability to be implicit to their lives.

To summarise, the idea that the information on sexual orientation is irrelevant to appropriate health care services prevailed among doctors and LGBT participants and predicted low levels of disclosure to health care providers. This finding is

consistent with a study on the experiences of lesbians in health care which found that lack of relevance was one of the most common reasons for non-disclosure in health care (Hitchcock and Wilson, 1992). The idea appeared to be underpinned by the ignorance that heterosexuality of patients is already assumed or asked in implicit ways and the heterosexist idea that homosexuality must be revealed only for important medical reasons. Other factors that appeared to enforce the idea that sexual orientation is irrelevant to health care were related with the historic pathologisation of homosexuality. In particular, LGBT participants appeared to resist any association of their sexuality to health as part of their strategy to avoid stigma, HIV-stigma and enactments of homophobia. The cost of this strategy was the loss of important information on health issues that were related to sexuality. The thread of LGBT invisibility in health care systems further unfolds with a discussion below on the idea that the needs of LGBT patients are identical with those of heterosexual patients.

3.3 Same treatment in unsafe environments

All doctors recognized that LGBT patients are entitled to the same standards of care as heterosexuals. Yet, this was assumed to be ensured when treatment was undifferentiated, an idea that seemed to be underpinned by the assumption that the health care needs of LGBT people are identical with those of heterosexuals. However, as Fish (2006) and Wilton (2000) argue, treating everyone as if they were the same leads to poor standards of care since treatment is tailored to assumed sameness of people rather than responding to people's diversity and their specific health care needs and context realities.

For the majority of the doctors the biological sameness of all humans was an unquestionable fact and as such medical treatment could be applied unproblematically to all people. According to doctors the only necessary human categories to their practice were those related to anatomy and these were assumed to be neatly distinguished by the definite rules of biology and medical sciences. Other than the difference between men and women, which were dealt as two single categories no other difference of humans, and especially those

related to sexual orientation, necessitated a different medical approach. Sexual orientation was treated primarily as a social identity and doctors appeared to be reassured that social identities of people do not interrupt in any way the appropriate treatment of diseases. Therefore, they appeared pretty much confident that at least in the case of LGB people they are able to ensure high quality standards of health care. In fact, one doctor argued that when homosexuality is appraised as a health problem it would probably ensure better or more sensitive treatment for a gay man although this sensitivity would mean pitying the patient as the result of inferiority ideas about homosexuality.

The pathology does not change, it is the same in all cases, I will give you a simple example, suppose I am diabetic and there is a homosexual man who is also diabetic, should my treatment be different? No, my job is to strike out diabetes, I don't care if he is this way or the other way... and maybe I will be more kind with the homosexual, namely I might treat him better, because he has an additional problem, because truth be told this is a problem, isn't it? (Lucas, 56 years old, pathologist)

Like the above quoted doctor, three other doctors expressed explicitly their inferiority beliefs about homosexuality. However, all doctors supported that their beliefs about the sexual orientation or any other trait of personality or identity of a patient never compromise their practice. By reflecting on the Hippocratic Oath the doctors argued that it was part of their ethical commitment not to discriminate or deny services to any patients according to their traits of personality, sexual orientation, gender, ability, class, race, religion or any other social or political identity. The Hippocratic Oath was also assumed to guarantee that doctors' personal beliefs or possible disapprovals of patients' identities would not intervene in the services they provide or, when involved, it would be only for the benefit of a patient and not to exclude the patient from a needed treatment. Although all doctors agreed that the visibility of LGBT patients in health care settings usually triggers homophobic and transphobic comments, jokes, laughter and mocking, these were believed to be only communicated among (heterosexual/cisgender) health professionals and never in front of a (LGBT) patient. Indeed, using LGBT identities as a source of comedy or gossip appeared to be endemic in health care settings. None of the LGBT participants or doctors

said that these jokes were ever challenged or addressed somehow. As a result, jokes about LGBT identities were always “successful” as everybody laughed. Moreover, doctors appeared not to believe that by making a “gay joke” they participate in mainstream culture’s derogation of LGBT people and under the prevalence of heterosexual and cissexual assumption nobody believed that someone would be personally offended.

One day a trans woman came in the Emergency Room, she came for a precordial episode and of course we laughed A LOT! But OK, we laughed discreetly (Kosmas, 38 years old, GP)

Similarly, one psychiatrist argued that derogative language towards homosexuality or gender reassignment is a form of gossip or cynicism that had no hurtful or offensive effect to anyone.

We still say when we see someone «Ah! he is a homosexual», yes we say it but this doesn’t mean that we want to marginalize him or to reject him, it is discussed as a gossip, like when we say “he went out with her”, “he made this or that”... namely I don’t think this is to reject someone (Lambros, 56 years old, psychiatrist)

Doctors assumed that homophobic and transphobic language can be somehow communicated “discreetly” or in a way that has no offensive effect to people. Nevertheless, many participants’ experiences evidenced that in contexts where the heterosexual and cissexual assumptions prevail and remain unchallenged, it is impossible to fully control the pain that is spread to LGBT people and those who are related. For example, LGBT participants who were studying in medical schools described many examples of exposure to homophobic language by their professors or other health professionals. Fay’s story which is quoted below is one of the most representative examples:

When I go to classes held in hospital clinics I see many professors who are homophobic. One day, for example, two gay men came in and the professor named them fagots, not in front of the patients, but this hurt me bad, I got very mad with this professor and of course when we evaluated the course I evaluated him with zero

The heterosexual and cissexual assumptions undoubtedly open the ground for the exposure of LGBT participants to insults about their sexuality and gender, which were often expressed in a very blatant way. When these assumptions were absent, homophobic or transphobic ideas were expressed in more subtle ways and often entailed the well-meaning intention of doctors to show their acceptance to their patients after coming out as LGBT. One of the most characteristic examples is Irene's story of her doctor's reaction during their first meeting when she came out as bisexual and his response during their second meeting where he wanted to communicate his acceptance of Irene's sexuality. Irene said that her doctor's immediate response was to get serious; he embarrassingly stopped looking at her eyes and said that he had "no problem" with her sexuality. During her next visit, Irene described that she saw her doctor being less uncomfortable and deliberate to express his acceptance for Irene's sexuality. Unfortunately, her description is indicative of how easily homophobic ideas can be communicated when they remain unexamined regardless the speakers' intentions:

In our next meeting he started this conversation and he started differently, namely he said "I want to discuss something with you" and he said "yesterday, I met a gay couple and I discussed with them, I was with my wife, and I was impressed of how smart these guys were". I got shocked! I told him that sexuality has nothing to do with IQ, and he continued "and balanced, and conscientious", I told him that gays are not the caricatures that television shows, "yes, you are right, in fact this is why I wanted to discuss it with you" he said, but I started to cut the conversation and I became strict because I was there to get informed by him not to inform him... at least during my examination he was very formal because otherwise I would yell at him

Not surprisingly, many LGBT participants did not feel safe within health care settings and in order to avoid derogative language many argued that they would prefer their doctors to maintain professional neutrality and not express their personal beliefs about homosexuality or any other political or religious belief when they provide services. In some cases, the expectation to professional neutrality was underpinned on the idea that medicine is a value-free science and therefore doctors' behavior should express exclusively their beliefs in scientific evidence rather than any other political or religious beliefs.

I get shocked every time I see religious icons in doctors' offices and I don't trust these doctors to examine me because they cancel their profession, they cancel the scholarship of medicine when they say they believe in Orthodox Church and I can't stand this. I am very dogmatic on this opinion, I am like a Taliban on this issue. I believe that if you are a scientist you cannot follow a religious belief, this is absolute, I see it very dogmatic and I am black or white on this issue. Namely I am always shocked when I see it, namely I declare this as a witness that in the majority of medical clinics, even in the private clinics you see saints on the walls (Manos, 25 years old)

Turning against one's identity was perceived as an unacceptable behavior by the majority of LGBT participants as they have been personally affected by societal rejection of their sexuality or gender. This was evident particularly for the LGBT activists who were trying to be politically correct not only in terms of how they referred to one's sexuality/gender but to other axes of individuals' identities as well. Nevertheless, the boundaries imposed by political correctness were often loose and in some cases participants felt they had good reasons to express themselves negatively about the Christian Orthodox religious identity. This came as no surprise given the explicit homophobic stance of the Orthodox Church. For example, many Metropolitans from throughout Greece have used their pulpits to speak harshly against same sex unions including Metropolitan Ambrosios of Kalavryta who, calling them "scum" of society and "not humans", even encouraged followers to physically abuse gays and spit on them(Charalampakis, 2015).

The religiosity of doctors often expressed with religious icons hung on the walls or placed on the desks of their clinics was not only perceived as incompatible with scientism but for many it was a clear signal of hostility towards homosexuality, which often resulted to feelings of unsafety, discomfort, and fear to disclose information on sexual orientation or gender identity even when this would entail the loss of important health information. In the below quotation, Alex described how his initial decision to come out as gay man was changed after receiving implicit signals of negativity towards homosexuality in a doctor's office including religious icons, nationalist and racist comments by the doctor :

My PSA test was bad so I needed to go to an urologist, I was suggested to visit a high profile university doctor who was also the

Manager of “S” hospital, so I went to this doctor... I wanted to come out.... I wanted to come out not for any other reason but to explain to him that since I am having passive sex then I have a rubbing cock in my prostate so I would like to know if this has any effect in a way, if it is dangerous, if it is bad or good, how I must do sex, what are the dangerous things to do etc. So, I got in his office and I saw all these saints and Virgins in his walls and I said “we are fucked!”, and I said here it is not... I have no reason to come out to every fascist [...] and I said “we are fucked up”, I will also be fingered by him and he will notice that I am penetrated, so I said that the situation is not good at all, and he was saying “as Greeks we are the best nation in the world”, and “all these stinky foreigners”, and I said “Woe! Woe!” now he will give a finger to me, so I said nothing to him but I told him about the blood result of PSA, and he made an ultrasound in my belly and a rectal examination, but he said nothing, I imagine since he was an experienced doctor he could tell, even if it is narrow he can tell that my anus is not intact, right? (Alex, 51 years old, gay man)

Alex had chosen to visit this particular doctor because he would be able to use his health insurance for free of charge health services as the doctor was working in an Educational Hospital and he was well known for his extensive clinical experience. As Alex did not feel comfortable to discuss all of his health concerns with his doctor, he decided to actively search a gay friendly urologist so as to also ensure continuity in treatment. Alex sought a referral by asking a doctor who was experienced working with people who live with HIV and he happened to know him from an ex-partner. Unfortunately for Alex he was referred to a private practice doctor but as he was reassured that the doctor was gay-friendly, he preferred to pay rather have similar experiences again.

Professional neutrality appeared to be expected but only as a compromise for those who could not ensure or pay for positivity towards homosexuality or gender transition. Overall, health care settings appeared to be contexts where positivity towards homosexuality was not perceived as being important explicitly display. This appeared to be true for both private and public health care settings. In particular, all LGBT participants said that they had never seen a poster, a leaflet, an official medical or hospital site that included pertinent information or other positive messages to LGBT people. In this context, it was within the actual safety strategies of many participants to actively search for doctors that where publicly known to be leftists or feminists since these were appraised as implicit indicators

for LGBT friendly treatment. This came as no surprise given that the Left both in Greece and internationally is seen as a natural ally of the LGBT communities.

In fact, the LGBT movement both in Greece and internationally emerged from and with people who had close ties with the Left movement (Riedel, 2005, Hekma et al., 1995). For example, the Stonewall riots in '69 emerged through LGBT rebels who were coming from the Left movement and they were actively participating in the radical and antiwar organisations of that period (Hekma et al., 1995). Unfortunately, the history between the Left and the LGBT movement in Greece has been only fragmentally described. Nevertheless, the first foundation of an LGBT organization in Greece named "AKOE" in '77 by activists who were coming mainly from the Left movement is indicative and constitutes the closest reference point to the Stonewall riots. Nowadays, the Left movement appears to have retained strong ties with the LGBT community in Greece, most of its political parties and groups support, at least publicly, the demands of the LGBT community while there is a traditional and continuous opposition to LGBT rights by right-wing and liberal political parties.

In this climate, it was the political openness of a doctor rather than his/her political neutrality that allowed at least to some of the participants some sort of safety in health care settings even when these doctors, similarly to all others, also appeared to ignore the sexual orientation of their patients. Indeed, it appeared that along with the ideas of sameness of all people and the consequent ideas that there are no medical reasons for doctors to know the sexual orientation of their patients, the ignorance of what it means for LGBT patients to feel safe in health care settings prevailed. This ignorance was appraised by some participants to be part of the privilege accorded to heterosexuals to feel unconditionally safe in society. In the below quotation Irene, a 34-year-old bisexual woman, reflected on her bitterness for not being affirmed by her friends in relevance of her worries about safety in health care settings and her decision to choose doctors on the basis of their political ideologies and anti-fascist attitude in particular.

I was in my friend's house along with other people, my friend and her brother knew that I am bisexual, I don't know if they had told this to the others, maybe my friend had already told them, or maybe they had suspected it, I don't know... I referred to my visit to this gynecologist

and I said that I was satisfied both medically and ideologically by the doctor and she was surprised that one can choose a doctor for his/her ideology... I told them that I care about doctor's ideology, I care if this person is a fascist, I wanted to say gay friendly but I didn't want to dwell on this issue in front of the others, I imagined that by using the word fascist my friend would understand what I mean but she didn't.... I didn't say anything more, to be honest I was annoyed and I thought that heterosexuals are not in our position where we think that doctors could treat us badly or to worry about doctors' reactions and thoughts, they don't even enter on this situation, they don't have this anxiety, but when we go to a doctor we are worried about our health problem, we are worried about how the doctor will treat us, we are worried about doctors' personal opinion, we are worried about what kind of person we will meet and how this person will react and if we will meet other people we know in doctor's office and expose ourselves to others, a bunch of problems ,right? Namely, there is a lot of thinking when we visit a doctor, a heterosexual doesn't have to think all of these issues and they dare to tell you "you are overreacting", ok! Try walking in my shoes and we will talk about it, but they don't, so she said that I was overreacting but I didn't say anything, I just let them believe that I choose doctors according to their ideology, yes, I choose them according to their ideology because I don't want to open my legs to a fascist

The heterosexual privilege appeared to be perpetuated at least partially by the belief that freedom is undisrupted to LGBT people despite that most of the doctors also acknowledged that the societal homophobia and the stigma, associated to LGBT identities, make their LGBT patients fear to disclose information on sexual orientation. This seeming contradiction lied on the perception that each person has the full responsibility to ensure their own benefit which practically means that each person has to find their own power to transcend the social conditions that are restrictive for their freedom. In this sense, most of the doctors felt responsible to primarily respect individuals' assumed incapability or unreadiness to transcend homophobia, heterosexism or transphobia in order to be able- usually this meant to be courageous- to disclose their sexuality or gender identity to their doctors. For example, Leonidas who was a psychiatrist expressed his certainty that many LGBT people who visit a psychiatrist in order to deal with anxiety or depression do not disclose information of their sexual orientation. He also supported that the fear of homophobia and the fear of rejection are probably related to these mental health problems. Therefore disclosure of information of sexual orientation would be meaningful for these

patients for full support and not a quick subscription of a medicine. However, he argued that it is beyond doctors' power to be involved on patients' decision to come out and intervention would mean an intrusive act against one's bed.

There are many persons who come with symptoms that are related to their sexual choices, namely to their fear of being rejected or their fear that someone will know against their wish, but they say nothing to us or maybe they choose another professional to speak with, and they come to ask you for a prescription for an anti-stressful medicine, or an anti-depressant... maybe because they think that "I don't trust this doctor, I don't know him", so they think that they will take a medicine and they will get helped, and they just stop there" [...] what can you ask him if he doesn't say it on his own? No, no, you can't do this, you have no right to intervene, and everyone is free to do whatever he wants in his own bed

The ideas of sameness in health care needs of patients seemed to be strengthened when doctors perceived that their primary obligation to their patients was to provide an accurate diagnosis and an appropriate treatment which was often equivalent to the meaning of an appropriate medication. Socrates, a 35-year-old pathologist, supported that information on sexual orientation has only limited usefulness in medical treatment and an epidemiological interest for HIV. This seemed to be related to ideas of sameness of all humans but also to the limits of his intervention which was characterized by him as being "mechanical". He said:

As doctors we are more... at least speaking for myself, I am more mechanical, namely "what do you have?", "you are going to do this and this and this", I do my job as a pathologist and beyond that point I don't touch too much, in the psychological domain I try to be polite, I approach the patient in a good manner but I don't get involved any further

Overall, ensuring a safe environment for patients including the safety that is provided through a patient-doctor relationship appeared to be perceived as a secondary responsibility for doctors and as such it was sometimes excluded from the notion of quality of health care. As a consequence, no measure appeared to be taken in health care settings in order to ensure that LGBT patients feel equally safe to disclose sensitive personal information and enjoy the same access to the

appropriate health information according to their specific needs. Interestingly, even doctors that appeared to appreciate the value of patient-doctor relationship and the qualities of cultural awareness for the effectiveness of a treatment these would be finally absolved from the meanings of health quality. For example, Ariadne, a 42-years-old pathologist, supported that making a patient feel comfortable entails doctors' ability of cultural awareness and the ability to build a trustful patient-doctor relationship. She mentioned that these qualities remain unreasonably a simple "cliché" in medical schools although they ensure the accuracy of a diagnosis and the success of a treatment. She particularly said:

Only when a patient feels comfortable can I have the information that I need, this is very important and it is also important because after you figure out what this person has then the therapy is a matter of cooperation, it is not "I told you to do this so do it", you and I must understand each other, and you must believe me that what I am saying is the best thing for you to do

Nevertheless, later in our discussion while we were discussing issues of discrimination in health care settings against minority groups, Ariadne made a statement where she clearly delimited the value of quality in health care by excluding the emotional impact of doctors' behavior to LGBT patients. Once again the meaning of sameness in treatment where LGBT people receive was in the foreground as evidence of equality in health care:

I don't believe that the quality of health care that is provided to gay people is different than this provided to others, of course there must be some exceptions too. But the quality of health care, I refer to the strict notion of health care not the way that the doctor will make you feel, I mean the medicines that I will give you and if I will make you well, these do not differ

To summarise, equality in health care was assumed to be ensured when human differences were neutralized especially when these were perceived to be related to the social identities of a person, which were respectively perceived as irrelevant to medical practice. The view that the processes that are common to discrimination are the same for all diversity strands made doctors believe that

general ethical principles such as those imposed by the Hippocratic Oath are sufficient to guarantee “same” treatment. As a consequence, this would often mean that patients were dealt as if they were the same. Within this context, LGBT specific health needs and concerns as well as the meanings of safety were totally ignored. Furthermore, arguments for the sameness of all humans usually entailed unexamined heterosexist ideas or assumptions and together made homophobic language or attitudes to be more easily communicated to LGBT patients or LGBT medical students. The argument of sameness was interrupted by a commonly held agreement that overall LGBT people are stigmatized. Nevertheless, the individualized understanding of stigma seemed inadequate to support a proper responding to the particular health care needs of LGBT participants as will be shown in the next section.

3.4 The individualization of stigma and its role in the invisibility of LGBT people

In this section the focus is on stigma as part of a shared knowledge among the participants that people who identify as LGBT are burdened with society’s negative views about non-heterosexual behavior, identity and communities. In addition, I focus on participants’ perceptions about the ways that stigma is enacted and on the processes where stigma played a determining role on the invisibility of LGBT people in health care settings. Specifically, LGBT participants’ decisions to rarely reveal their sexual orientation and/or trans identity to their doctors and respectively doctors’ decisions to not prompt disclosure will be discussed by drawing insights on theoretical perspectives of stigma (e.g., Herek et al. 2007; Meyer, 2003).

The invisibility of LGBT participants in health care settings appeared to be decidedly related to their many efforts to avoid the enactments of stigma, the hostility and discrimination associated with the identification of being LGBT, or when they wanted to preserve the privileges and protection ascribed to heterosexuals like in the case of visitation rights in hospitals where same-sex relationships are not acknowledged in Greek hospitals (Fish, 2006, Mason,

2002a). The metaphor of the “closet” here which substantiates the experience of invisibility is crucial (Mason, 2002a). Equally important is Goffman’s theoretical construction of a major safety strategy for protection from enactments of stigma, namely the use of practices and techniques by stigmatized individuals to convince others that they do not belong to the stigmatized social category (Herek et al., 2007, Goffman, 1963).

Similarly, the notion of the “closet” is a defining structure of oppression for LGBT people, but simultaneously it is a strategy of survival from the negative impacts of living in a heterosexist world (Mason, 2002a, Fish, 2006, Ryan, 2003). Therefore, invisibility can take the form of self-surveillance, as it precludes the voluntary effort of individuals to hide their homosexuality. The idea of the voluntary character of the closet, however, usually directs the attention mainly to intrapersonal processes (Whitman et al., 2000). Although the coming-out process is undoubtedly the central experience of LGBT’s consciousness, it is also a life-long process that entails the everyday negotiation of visibility and it is dramatically dependent on structural factors, predominantly those related to heterosexist assumptions and gender binary (Fish, 2006, Mason, 2002a, Whitman et al., 2000). As Gluckman and Reed (1997) point out, the individualistic perception of the coming-out process creates the myth that if every homosexual person came out, the oppression of LGBT people would end. In this view, it is the many ways in which homophobia and heterosexism are institutionalized and reproduced that are ignored. Indeed, as Fish (2006) argues, LGBT people often become targets for attack especially when they are visible in public. Besides, it has been evidenced that the places where LGBT people can enjoy high visibility (e.g. gay villages), are often the places with higher rates of homophobic assaults and attacks (Dick, 2008, Fish, 2006, Herek et al., 2002, Pritchard et al., 2002).

Although in varying degrees, all LGBT participants and doctors agreed that LGBT identities are stigmatized and consequently this prohibits individuals from revealing information relevant to their stigmatized status within health care settings. Despite the apparent agreement there were significant differences between doctors and LGBT participants about how they perceived the sources and intensity of the stigma. For the majority of LGBT participants, being cautious when coming out and being vigilant for possible homophobic and transphobic

insults were part of their everyday lives and perceived as rational and justifiable given mostly the external, often institutionalized, homophobia/transphobia and their perception that they live in a significantly homophobic/transphobic society. This is also consistent with the findings of Dendrinou (2008) ethnography on gay men experiences in Greece finding that staying in the closet was seen by most interlocutors as a strategy for survival and the closet as a place protecting them from homophobia and discrimination. In contrast, the majority of doctors perceived stigma mostly as a result of an internal fear of LGBT people to be rejected which was often perceived as irrational given the perceived societal tolerance and acceptance of LGBT identities. Moreover, this internal fear was often equated with the meaning of internalized homophobia/ transphobia and as such it was assumed to be eliminated once a person accepts oneself.

The absence of important (protective) legislation that could ensure equal treatment and legal protection, the homophobic and transphobic violent attacks and verbal insults in public spaces including schools and universities, the derogative depiction of LGBT identities in the mainstream media and TV shows, the unchallenged homophobic and transphobic public speech by politicians and the church leaders, as well as the prevalence of invisibility as part of the lives of many LGBT people in Greece were only a few of the examples that LGBT participants mentioned to express the ways they experience societal hostility. Trans participants highlighted particularly the pathologisation of gender identity, their exclusion from employment, education, their difficulty finding a house to rent and the brutality of transphobic violence in public spaces as the main reflections of societal hostility. Nevertheless, the majority of LGBT participants did not totally detach societal hostility from the ways they feel about their sexual and gender identities. In the following quotations, Sofia's and Angelo's accounts of societal and statutory hostility towards LGBT identities were clearly linked with issues of self-acceptance and psychological wellbeing. Their words echoed Pharr (1997) who defined homophobia as the social disease which places such negative messages and condemnation to homosexuality that LGBT people have to struggle throughout their lives for self-esteem.

The issue of our rights is very important, if for example we had a law for gay marriage this would help our everyday lives because it would

break some stereotypes, but since you have a State that implicitly says that being a homosexual is...is... it is the State that stigmatizes you, so if the State makes a law, even this Cohabitation Partnership, the State will show you that you are equal among equals, so first of all if you are not stigmatized from the above then the people will stop stigmatizing you and we can have our rights, it is totally psychological, it is not that I will be helped if I get married, I don't care about this, what I care about is to be treated equally (Sofia, 32 years old, lesbian)

I always knew that I was a woman, and there was no single day to think that I could have sex with a woman, so, this is how I always knew it about me, I had accepted this but people surrounding me did not allow me to accept it (Angelo, 18 years old, trans person)

Furthermore, negativity and hostility towards LGBT identities were not assumed by LGBT participants to be less prevalent in health care settings than they are in Greek society at large. Therefore, for the majority of participants controlling and concealing information on sexual orientation and/or trans identity in health care settings, when possible, was a significant part of their overall strategy to ensure safety. Overall, the majority of LGBT participants avoided disclosing information on their sexual orientation or gender identity especially when they believed their health issue was irrelevant to their sexuality and gender identity or when they thought they could find the appropriate health information via a web resource. When LGBT participants felt that it would be impossible to pass as heterosexual or cisgender persons they often actively tried to find a doctor where his/her positivity towards LGBT identities was more likely or somehow ensured which usually led them to postpone or even neglect visiting a health professional. The following argument by a gay activist is characteristic of the way stigma determined the visibility of LGBT people in the health care settings, and despite any arguments about the relevance of sexual orientation and gender identity to health care:

Because of the intense social stigmatisation here in Greece I don't think that every time you see a doctor you should come out, but I think one must have at least one doctor who knows this, it should be a person that you trust and tell everything, like the institution of family doctor where all family members say their history and.... namely you should be connected with a doctor who knows everything about your

sexual practices, what you are doing so that the doctor will be able to consult you accordingly, namely you are able to take appropriate consultation on issues that are related to the fact that you are gay (Orestis, 30 years old, gay man).

Inconsistently with the ways LGBT participants' experienced societal hostility, the majority of the doctors believed that LGBT people in Greece have attained at least societal tolerance and sufficient statutory protection that ensure a friendly environment for disclosure. Stigma was mentioned by doctors mainly as a personal unreadiness for self-acceptance, an individualistic perception that was often underpinned at least by the ignorance of the current situation in terms of homophobic and transphobic attacks in public spaces and diffused generalizations and stereotypes about LGBT people. For example, Leonidas, a 56 year old psychiatrist, challenged the idea of societal hostility towards LGBT people and supported his argument by referring to the field of arts which was assumed as a space where LGBT artists are totally free to express their sexuality and even privileged for career development:

I don't believe that society is hostile towards homosexuals, I believe that the attitude of society on homosexuality is way different than years ago, I don't even discuss this, I mean.... You can see it particularly in the arts, in the movies and in the theatre... yes, in the arts, I don't even discuss this, in the arts it is a privilege to be homosexual (Leonidas, 56 years old, psychiatrist)

In the quotation above, the doctor did not make any explicit comparison between the fields of arts and health care, however, his comment was to support the idea that LGBT people have no reason to feel threatened within health care settings because of the societal hostility and his reference to the field of arts was to support this assumption. The idea that the LGBTs with an artistic occupation enjoy freedom from any kind of discrimination or oppression on the basis of their sexual orientation was shared among the majority of doctors and many LGBT participants. Interestingly, from those who held this idea, only LGBT participants acknowledged that there is a discrepancy between the assumed freedom in the field of arts and the actual small number of LGBT artists who have disclosed

publicly their LGBT status along with the relatively large number of assumed LGBT artists that actively try to publicly pass as heterosexuals. Yet, this acknowledged discrepancy did not challenge the very idea of freedom in the field of arts. Instead, it was mainly interpreted as a result of the detachment of LGBT artists from the LGBT community and their consequent unwillingness to pay an assumed small cost for the benefit of the LGBT community.

Another example which is characteristic of how differently LGBT participants and doctors perceived sexual and gender non-conformity stigma is the way they viewed homophobic and transphobic violence. With the exception of two psychiatrists who had personal experience at treating LGBT patients with post-traumatic stress due to the experience of homophobic and transphobic violence, all other doctors appeared to believe that violence against LGBT people belongs to the past and as a social problem has been resolved by the growing societal acceptance of homosexuality or by legal and statutory protection. Again, this idea was often meant to suggest that LGBT people have no reason to fear disclosure within health care setting.

Once in Greece when you saw a homosexual you would stone him, now things are different, there is a law that protects them, of course the State should protect them like everyone else (Lucas, 56 years old, pathologist)

Homophobic and transphobic violence were not only assumed to have been eliminated or to happen only in extreme cases, but in one case a doctor supported that homophobic violence can be provoked by the defiant character of gay men who pursue self-assertion rather than just their right to visibility. In the quotation below the doctor used an interesting metaphor to support that when a gay man acts like a fanatic football fan (Paoktzis⁴) and declares his sexuality within the stadium of the opposite team which is full of equally fanatic fans, hostility should be reasonably expected. The doctor specifically said:

I told you that defiance is something intrinsic in gays, they have this trait, this is why they want to come out, do you understand? Namely they shout it loud like if they want to exculpate it with this way, namely

⁴Paoktzis is the word used to name the fans of the football club named PAOK who are reputed to be fanatic supporters of their team reaching the levels of hooliganism.

something like “I am right”, something that I find.... You know, ok, I understand that because of the fear of marginalisation one needs to shout it loud but I don't think it is necessary anymore, I don't know, of course you may say that not everyone is open like me, so they are forced to act like this, but I repeat, since I am Paoktzis I would never go to Karaiskaki's stadium⁵ to shout that I am Paoktzis, why do such a thing? To be beaten up? Namely, I am Paoktzis, so what? Do you understand what I am saying? I am Paoktzis, why should I tell this? Why should I say this here in Piraeus? (Thanos, 45 years old, endocrinologist)

Although the doctor did not intend to mean that the context where gay men come out is hostile towards them it was implied in his metaphor. It was also implied that gay men somehow intrude in a context (Karaiskaki stadium) in which they have no place in it as it is an unchallengeable property of a crowd of football fans who belong to an assumed opponent team. The metaphor of the Karaiskaki stadium can then be seen as a social space which is structured by societal forces and norms (Taylor, 2007). This view enables an understanding that humans and particularly those who occupy marginal and stigmatized identities have to negotiate their access and their visibility as their mobility is subjected and controlled by the societal forces and their intersections which dominate that social space (Taylor, 2007).

Contrary to the doctors' views, LGBT participants experienced homophobic and transphobic violence along with the indifference and inaction of authorities and mainstream media which do not pay any particular attention, as the prominent reflections of societal hostility. For example, five gay men and three trans women of the overall number of the interviewees had been victims of homophobic or transphobic attacks and/or verbal insults usually while in a public space by a group of people, typically their classmates or police squads at least once in their lives. Many of these attacks and insults happened in the last two years or even a few weeks before the time of the interview. In addition, even those who did not have a similar personal experience of being attacked feared homophobic/transphobic violence and some of them stated that this is part of a chronic anxiety. For example, Evie described her fear of homophobic violence:

⁵Karaiskaki stadium is a football stadium and a home ground of the football club Olympiacos.

I have a fear during these years, it is something that I have it in my mind sometimes, usually when I am out in a public space, although I don't come here in Gazi very often, but sometimes I fear that maybe it [a violent attack] will happen to me too, I don't know, maybe while I am with a friend.... This is something that scares me inwardly... it is not an intense fear, I just think of it sometimes, we hear and read so many incidences against gay couples and I am afraid that it can happen to me too... anyway... you never know (Evie, 44 year old lesbian)

Crucially, Evie's account suggests that homophobic violence, despite its emotional, physical pain and long-term psychological distress, has the potential to collectively affect the communities and the social groups that these people belong to (Mason, 2002a). This suggests that within the repercussions of homophobic and transphobic violence, the emotional and health responses of LGBT people to the possibility of a hostile or violent reaction should also be accounted (Mason, 2002a). Therefore, homophobic and transphobic violence or the fear of it, although not always explicitly stated, may also influence LGBT people's disclosure decisions

The ways that doctors perceived stigma affected the context in which LGBT participants negotiated their visibility within health care settings. With the exception of one psychiatrist who had some working experience with LGBT patients as well as a short education on LGBT issues as part of his specialty training, none of the doctors were taking active steps in order to facilitate the disclosure of LGBT patients within health care settings. In the previous paragraphs I have described the factors that appeared to construct this reality, including: the individualistic perception of stigma, the degradation of societal hostility towards LGBT people, prejudices and stereotypes about LGBT people along with the heterosexist assumption that appeared to pervade in medical practice.

Doctors who equated stigma with the meaning of internalized homophobia or transphobia saw their primary responsibility towards LGBT patients to ensure their freedom to disclose or conceal information relevant to their LGBT status according to their wish. The prevalence of this idea was so intense that doctors rarely believed that their attitudes may influence the disclosure decisions of their LGBT patients. As mentioned earlier, only Panagiotis, a 47-year-old psychiatrist,

believed that by consciously trying to minimize his heterosexist assumptions in his practice, he provided the appropriate space for his LGBT patients to disclose information relevant to their sexuality and gender identity. Although Panagiotis was not asking openly his patients about their sexual orientation, his tactic was to avoid using gender specific pronouns when referred to their partners or sexual relationships. By reflecting on his experience with LGBT patients, Panagiotis supported that coming out to a health professional is a very stressful event for LGBT patients and they come out only when they feel safe enough and usually during the third or fourth session. Panagiotis described:

It seems that they [LGBTs] cannot easily discuss these issues, it is easier for them to do it here, maybe because it is calm here? Or maybe because there is no kind of moralism here... But they will check the environment first, because the majority of them will refer to their homosexuality during our second, third, or fourth session ... or after more sessions... they will usually refer to sexuality in general first, but I also try to not refer to any specific gender when we discuss issues on sexuality, namely to refer to a particular gender when we discuss about their relationships, so during the third session they start saying something about this, and they are usually very careful and scared... they are afraid of the reactions

Panagiotis' observation that LGBT people "check the environment first" before they decide to come out is in absolute accordance with the ways that LGBT participants described their strategies to ensure safety for disclosure within health care settings. Importantly, this finding provides further evidence to support the study of Eliason and Schope (2001), which was conducted in US health care contexts and who found that more than 95% of the LGBT participants monitored their doctors' behavior for signs of acceptance, which finally influenced their disclosure decisions. These safety strategies will be discussed in section 3.7 in detail. For the purposes of this section, however, it is important to note that one of the most important findings of my study is that all LGBT participants appeared to always closely observe the verbal and non-verbal signals of positivity and negativity towards LGBT identities within health care settings and particularly the attitudes of their doctors. Yet, while these signals often played a determining role in their decision to disclose or not their LGBT identities, the doctors who participated in my study seemed to be disengaged from any effort to respond to the particular meanings of safety for LGBT patients. This was at least partly

constructed by the heterosexual and cissexual assumption which makes doctors not think about LGBT identities unless a patient would come out (Fish, 2006). Furthermore, making patients feel uncomfortable during medical examination and medical interview was appraised by all doctors as incompatible with best practice. Since stigma related to LGBT identities was primarily related to internalized homophobia and transphobia, any question on sexual orientation or gender identity was perceived as intrusive and regarded as a trigger for the enactment of felt stigma or internalized homophobia/transphobia of LGBT patients.

In this section my purpose was to describe how stigma and its various meanings appeared to construct the unwritten yet firmly placed norm of “don’t ask, don’t tell” policy in health care settings. Homophobic and transphobic ideas appeared to be the underlying forces that affected the very meanings of stigma and reinforced an individualistic perception which profoundly leads to the erasure of the contextual understanding of the oppression towards LGBT people. This is particularly important because even if the potential negative health effects as a result of the LGBT invisibility were acknowledged, LGBT people were still expected to take the full responsibility for their invisibility and therefore the responsibility for their own victimization (Fassinger and Miller, 1997). Defending a contextualized understanding of homophobia and transphobia is not about overlooking the influence of internalized homophobia/transphobia to the level of disclosure of LGBT people. Research has shown that although disclosure is primarily an issue of stigma management rather than an issue of identity development, it is influenced by the degree of internalized homophobia (Herek et al., 1997, Ross and Rosser, 1996). Nevertheless, what constitutes the individualistic understanding of homophobia is the usage of internalized homophobia and transphobia as an excuse to justify the abandonment of any effort to ensure that the health care settings are safe environments for LGBT people to disclose information relevant to their sexuality and gender identity. However, this reality appeared to be also influenced by the depersonalization of health care services which will be discussed in the next section.

3.5 The invisibilizing effect of depersonalized health care services

Fear was not always prevalent when I discussed with participants the issue of disclosing information on sexual orientation to health care providers. Some participants made jokes on the idea to make statements on their sexual orientation especially when they believed that their health problem was simple enough to necessitate nothing but a quick examination:

I went to a dermatologist, I had a nevus, I never thought to tell her “hallo, this is my nevus, and I am gay, I don’t know how you are going to deal with my nevus” (Alex, 51 years old, gay man)

It doesn’t make sense to tell the doctor “hey, I have a cough, is it because I am a lesbian?” (Natassa, 26 years old, lesbian)

Nevertheless, participants’ expectation of quick medical examinations appeared to reflect not only the perceived simplicity of a health problem but most importantly their adaptation to low standards of quality in health care. With an often joking but more sarcastic tone some participants questioned the quality of health care when compromised to be a depersonalized quick procedure that entails nothing but a quick diagnosis and a proposed medicine or laboratory tests. In some cases the participants argued that the medical history taken by their doctors entailed nothing but their name, therefore, disclosing sexual orientation was out of question anyway. This was particularly evident in the case of the annual gynecological examination that the majority of both lesbians and bisexual women had or believed they should have as part of checking their overall health. In public health settings the annual gynecological examination appeared to be strictly synonymous with a pap smear which was held under rapid visits in which a doctor–patient relationship was clearly not a prerequisite. Evie, a 44yearold lesbian, by referring to her last visit to a gynecologist, characterized her communication with her doctor as being exhausted in the doctor’s command to “open and close your legs”. Although Evie appeared to be clearly dissatisfied with the quality of received health care services she did not complain to the doctor as she thought that this was an unavoidable cost of her decision to choose a free of

fees gynecological examination in public health services rather than pay in private practice. She also said that choosing public health services for gynecological examination also entails the compromise not to be able to maintain a stable relationship with a gynecologist as doctors are usually overburdened with heavy workloads and it is not easy to find an appointment with a preferred doctor. This appeared to be a broader issue relevant to the way that NHS in Greece is organized, possibly affecting the quality of health care services of heterosexual women too.

In Evie's story the doctor appeared to have followed up her initial claim for a pap smear very hurriedly but this resulted in the reduction of a gynecological examination into a screening test. The complete absence of medical interviewing and history taking resulted in neglecting of important aspects of Evie's health care including: no data taken for early detection of possible health threatening issues or identification or risk factors for diseases, neglect of clinical examination of her breasts and absence of any kind of consultation on issues that would possibly be of Evie's interest (e.g. education on how to perform breast self-exams).

Arguably, medical history and the doctor-patient relationship along with their integral component of medical interviewing have been characterized as cornerstones of appropriate health care (Roter and Hall, 2006, Goold and Lipkin, 1999). Besides doctors' obvious responsibility to appropriately diagnose and treat, a trustful doctor-patient relationship is the prerequisite environment in which a person can fully express and disclose all of their health concerns including emotionally charged concerns and fears that are difficult to share with a complete stranger. It has been also argued that by and large, patients often have questions they would like to ask but do not. Roter and Hall (2006) argue that this is part of patients' anxiety not to appear foolish or inappropriate especially when doctors do not leave space for patients' questions. For LGBT patients this may be even more troubling particularly when this necessitates disclosing information on sexual orientation which presupposes a sense of safety from homophobic treatment, reassured confidentiality, a sense of reasonable intimacy, ease and trust with a doctor. As these characteristics of an appropriate health care environment may not be fulfilled during a first visit, it is within doctors' responsibility to ensure

continuity and time for the development of a trustful doctor-patient relationship (Goold and Lipkin, 1999).

Evie was among the many participants who argued that they already pay a lot of money for health insurance but is still obliged to pay out additional money for appropriate health care including dental treatment, diagnostic tests, appropriate gynecological examinations, digital mammography etc. Her statement below is representative of similar other voices:

Ok, at some point you say that this money is for my health, but I think it is unfair to work and give all these money for health insurance and be obliged to pay more for private practice, but sure, if you ask me, from now on I would definitely like to go to a good doctor, namely to avoid the services provided by my health insurance

In fact, the NHS in Greece has always been characterized as quite a “privatized” system, particularly because of public underfinancing (Siskou et al., 2008). This fact was only to be exacerbated after the implementation of austerity measures which brought severe funding cuts in NHS (Ifanti et al., 2013, Kondilis et al., 2013). Furthermore, the social health insurance funds primary and secondary health care costs in private health providers, however, coverage and benefits limitations often result in considerable out-of – pocket payments (Kaitelidou and Kouli, 2012). In a country whose citizens incur strong income reductions, out-of-pocket payments increased as a percentage of total health expenditure from 27.6% in 2009 to 28.8% in 2012 (Economou et al., 2014).

Evie characterized herself as neglecting her gynecological health issues primarily because of her compromise to a poor quality of gynecological examination that was described above and despite her proactivity to have a digital mammography that she also had to pay in a private diagnostic clinic as her public health insurance covers only film mammography. Evie was also one of the four lesbians who had turned to homeopathy, which is provided only in private practice, and maintained a long term relationship with a homoeopathist with whom she discussed a variety of health issues including psychosomatic health issues

related to stress such as headaches and rapid heart bits, weight control and diet issues.

Overall, the majority of the lesbians and bisexual women suggested that besides a gynecologist's necessity to know their sexual orientation so that they have an appropriate checkup, they found no important medical reasons for coming out to other specialties. Some of them argued that since people share only some minor aspects of their lives with their doctors, sexual orientation was only relevant mainly to issues around sexual or mental health problems. Nevertheless, this understanding was expanded by the four lesbians, including Evie, who actively sought their health to be holistically approached and for this reason they had turned to homeopathy. These women argued that although their doctors did not monitor sexual orientation within their extensive medical history, they all had disclosed their LGBT status right from the beginning. In the following quote, Stefany, a 34-years-old lesbian made a clear link with her decision to always disclose her sexual identity when her health is to be approached in a holistic way:

I generally prefer homoeopathy, so far I have changed three homeopath doctors and I was coming out right from the beginning, this is of course because homeopathy is a holistic medicine, so it has to do with many things, it is not like if you say "ah, I have a problem in my foot so there is no reason to tell the doctor I am a lesbian

Although a holistic approach of medical care encouraged these women to disclose their sexual orientation to their doctors, this did not necessarily ensure safety from homophobic reactions and homophobic interpretations of health. For this reason, two lesbians had to change two or three doctors after their first visits in which doctors reacted in an explicit homophobic way after their coming out as lesbians. For example, Antigone, a 53-year-old lesbian, described her first visit to a homeopath whose immediate response to Antigone's coming out was to relate her chronic headaches with her lesbian status and compared it with the presumed healthier heterosexual familial lifestyle. She said:

Before finding my current doctor I went to another doctor whose name I regret not remembering r because I want to disparage him, he is an outrageous animal! He was speaking to me while he was smoking his pipe, anyway, I said to him some things about myself and of course

about my sexual life and once I told him this he said “this is why you have these problems”, I said “what? I don’t understand”, and he said “your brother is perfectly fine in the village, he is married, and has children”, I regret paying him, we had a fight and I went out, I paid him and I just didn’t go again

Undoubtedly, the inherent derogatory and disrespectful character of homophobia and transphobia when infused in the health treatment of participants eroded every benefit that could be attained by the holistic approach of health care and often marked the termination of any effort to build a trustful doctor-patient relationship. For some others, though, being respected as a whole person by a doctor was not part of their expectations for the doctor-patient relationship. Again, this appeared to be an outcome of the structured depersonalization of health care and the domination of biomedical approach to health/disease.

In short, it seems there is a strong link between the holistic approach in health care, its prerequisites of sufficient time, doctor–patient relationship and the norm of “don’t ask, don’t tell” in health care settings. In particular, the decisions of LGBT participants to not disclose information relevant to their sexuality or gender were associated with what have been characterized in this section as depersonalized health care services. It is anticipated that this has broader implications for the general population. Such depersonalized health care services appeared to confirm the invisibility of LGBT people. In the following section I focus on the effects of this invisibility on those who identify as bisexual or non-binary.

3.6 “I would confuse her if I came out as pansexual”: The erasure of bisexual and non-binary identities in health care

The invisibility of bisexuals appeared to be related to the inability to read sexuality beyond fixed categories of heterosexuality and homosexuality. Although bisexuals are as affected by heterosexism and homophobia as gay men and lesbians, they also have to contend simultaneously with biphobia and its invisibilizing effects (Greenfield, 2008). The majority of the participants believed that health professionals are unfamiliar with LGBT sexual identities and LGBT

health issues mostly because of heterosexist assumptions. Some participants who identified as bisexuals referred to an additional worry that bisexuality is not equally validated with other non-heterosexual identities. As a result, they came out either as gay or lesbian in order to be understood by a health professional. The two participants, who identified as pansexual wishing to oppose to the binary implied by the “bi” in bisexuality, did not present themselves as such when they were in contact with health professionals.

For example, Georgina, a 22-year-old pansexual woman, decided to visit a psychologist after a hurtful break up with her girlfriend while she was dealing with her grief. She thought that since she wanted to speak about a same-sex relationship it wasn't necessary to come out as pansexual, however, part of her decision was her expectation that the psychologist would not be able to comprehend her identification as pansexual. She said:

I went to a psychologist; we did some sessions together for about a couple of months. Overall she was very good, I came out right from the beginning ... I told her I was a lesbian, I didn't want to confuse her a lot

Georgina expressed overall satisfaction with the provided services as her same-sex attractions were affirmed by her psychologist. Despite the fact that she came out as a lesbian, she said that this did not lessen the quality of the services. Her primary claim was clearly related to her need to be able to speak about a committed relationship with a woman and freely reflect on her emotions about her loss. Georgina did not know in advance if her psychologist would be affirming to same-sex relationships, therefore, she was pretty alert when she came out as lesbian and was “testing her reactions” to ensure she is not homophobic, as she said. However, Georgina did not feel reassured that her identification as pansexual or bisexual would be equally affirmed. What could be potentially confusing to Georgina's psychologist is that due to negative stereotypes bisexuality is often assumed incompatible with and decontextualized from loving, intimate, and committed relationships (Browne et al., 2014, Weinberg et al., 1994). Therefore, negative stereotypes about bisexuality could potentially limit Georgina's experience and the emotional intensity of her loss.

In fact, bisexual identities appeared not to be always affirmed in mental health contexts. For example, when Helen wanted to visit a mental health professional, she asked for a reference by a lesbian friend who was a mental health professional herself. Helen was referred to a public mental health center in which a gay mental health professional was employed and he was known to be referred all the LGBT service users of the center as, according to Helen's friend, other professionals were not competent at working with LGBT people. Helen felt that it would be inappropriate to ask to be served by a professional on the basis of informal information about his sexual orientation; therefore, she never asked to know his name in the first place. She said that she was almost certain she would finally be serviced by this gay mental health professional. Her certainty was related to the fact that the mental health professional appeared to be not only positive on LGBT identities but informed and familiar on LGBT issues including those related to bisexuality in particular. According to Helen, this was also reflected by the fact that he confidently made questions that, although they could be characterized as sensitive, they reflected his awareness of the ways biphobia may be replicated in intimate relationships. Helen explained:

He seemed to accept my identity without showing distrust like other people and he made some questions somewhat more personal when I spoke to him about my boyfriend who is also bisexual but I felt that he was very familiar with these issues so I was very happy with him

Helen said that she was unfortunate as after their first session the mental health professional decided to refer her to another colleague due to his heavy workload. Her dissatisfaction with her new counsellor was exclusively related to the fact that he was not affirmative to her bisexual identity and due to his overall reluctance to discuss issues related to Helen's bisexuality. She said:

He keeps a safe distance on these issues, but he is not judgmental [...] he didn't make many questions on this except of questions such as "you mentioned that you had relationships with girls too, did this ever cause you any problem?", or "how do you feel about this?", something like this but nothing else, he never said the word bisexual, I was struck by this, it seems that he is reluctant to use this word, maybe he believes we don't exist

Helen's last phrase of her sense that her counsellor might believe that bisexuals do not exist coincides with my sense when I started coding the interviews with doctors. Bisexuals were rarely mentioned by doctors and when they did, it was exclusively when I triggered a response on issues that were raised from my communication with bisexual participants. Some of these responses are indicative of how negative stereotypes about bisexuality construct bisexual invisibility. For example, Thanos who was a 45-year-old endocrinologist argued on the existence of two sexual categories, these of heterosexuality and homosexuality. The latter hypothesis, he said, could be proved if gay community did not defensibly hinder the medical study of the causes of homosexuality. I then asked him whether this hypothesis is problematized by the existence of those who identify as bisexuals. With a response that encapsulates biomedical explanations and the stereotypical assumption of hypersexuality ascribed to bisexuals, he rejected the idea that bisexuality is a sexual orientation:

There are gays, there are straights, there are gays who are super sexually active, there are equally straight who are super sexually active, it is the same thing, there is a system on the brain which is the system of dopamine, the system of rewards, there is no way you know these things, this system makes some people more prone to addictions, I believe that one part of these people who are super sexually active they need a lot of partners, and they become bisexuals because they are addicted to pleasure

Despite the myth of hypersexuality, bisexuals were never mentioned in my discussion with doctors about HIV/AIDS or any other issue on sexual health. In addition, even when sex with more than one gender was implied this was exclusively ascribed to gay men and particularly to those who are closeted and maintain a heterosexual lifestyle (e.g. being in a heterosexual marriage) while they secretly have same-sex relationships. This was specifically evident when a doctor reflected on his perceptions about the relatively newly introduced term in Greece of MSM (Men who have Sex with Men). In particular, while Dimitris was reading the informal letter of my study in order to sign the consent form, he made an early comment that I should update the term "LGBT" as the letter "G" denotes "gay" or "homosexual", terms which are not formally used by doctors and he suggested that I replace it with the term "MSM".

MSM is the term we use in the conferences, this is why I told you to use it [...] because this man may have sex with men but he may also do other things, he may be married, he may date with other women as well, this is why we put all these cases in the category of MSM, to be honest I never asked about this definition so as to be sure, but this is how I perceive it, but when I was talking with my Manager in the special infection unit I was asking “Mr.X is he homosexual or is he a drug user?” I wasn’t using the term MSM, we were using the word homosexual in our everyday language” (Dimitris, 46 year old, pathologists)

Similarly, Kosmas clearly defined MSM to be the “oppressed homosexuals” and he interestingly predicted that the term MSM will finally vanish as society will be gradually accepting of homosexuality. He explained:

I believe that they [the MSM] are the oppressed homosexuals, and it is not a coincidence that they are older at age, during the '70 and '80 they used to be bullied and humiliated, not even a parent could accept that his/her child is homosexual, so this child was enforced to get married, let's say to show a “normal” behavior, so he used to his family but he had also a second life which in reality this would be more “normal” for him, this is what he should do right from the beginning. I believe the term will be vanished in the future, namely you can see this through the young men at their 20s, they come out directly to their parents, namely, the masks are dropped

Dimitris’ suggestion that the term MSM can stand as an appropriate substitute for the umbrella term LGBT is indicative of the invisibility of sexual minorities especially within the context of HIV/AIDS where the stigma that haunts particularly gay men still pervades. Furthermore, while the LGBT term is clearly an identity-based term, the theoretical construction of MSM was a behavior-based term to connote an understanding of sexuality which differentiates sexual identity from sexual behavior and attraction and would signify a neutral stance on the question of identity (Young and Meyer, 2005). What is clear from the quote above is that in practice the term may have failed to connote anything else than the gay identity and despite the theoretical construction of MSM, homophobia and bi-invisibility continue to permeate cultural understandings of the lives of those who are classified as MSM (Miller et al., 2007). This is particularly important as these cultural understandings may remain unchallenged if they are masked

together with the sexual identities which the generalized and theoretical term MSM intends to mask. In fact, the term MSM has been highly criticized for imposing a biomedical understanding of sexuality which disorients the interest in the social dimensions of sexuality by separating individuals from their contexts; undermines and disregards the identity descriptors that individuals apply to themselves; and is therefore unclear for the purposes of harm-reduction in that it describes sex in relation to partners' gender (Miller et al., 2007, Ford, 2006, Young and Meyer, 2005).

In a similar vein but from a different stand point, Browne et al. (2014) argue that bisexual invisibility is the main problem that bi people confront when accessing health services and criticize queer theory for deconstructing and contesting identity categories of people who are already invisible and marginalized in the name of a more insistent politics of difference.

'Queering' does not necessarily act as a panacea to this problem-queer deconstructions can fail to acknowledge the importance of identity in service provision. Where heterosexist institutions fail to recognize bi and other minority sexual identities, naming can be a powerful and important act [...] Identification as bi and naming this category can do more than normalize or regulate, it can be a political act in the face of Health's 'silent B'. (Browne, et.al 2014, pp.65)

Bi-invisibility was evidenced also in the context of preventive care and sexual health of bisexual women. Under the wrongful assumption that sex between women is risk-free from STDs and without the worries of unintentional pregnancies, bisexual women, who were mostly young at age (18-23 years old) were not disclosing their sexual identity and same-sex behavior to their gynecologist or they never visited a gynecologist while they were in same-sex relationships. In fact, in one case a first visit of a bisexual woman to a gynecologist was determined by the first sexual intercourse with a man after a long period of unprotected sexual intercourses exclusively with women. In particular, Katerina, a 19-year-old bisexual woman, said that although her sex life started at the age of 16, she started to think about safe sex and she decided to have a Pap smear immediately after her first intercourse with a man. Without challenging the heterosexual assumption of her doctor, Katerina did not disclose

her bisexual identity and consequently the questions and the information attained from the visit were exclusively on safe sex with male partners. In the following quote Katerina explains:

I think it [the Pap smear] is connected more with the male penis...in the sense that you can catch anything by it, this is why I got so scared this year, but if I was with a girl I wouldn't do it

Similarly, Helen, after displaying some symptoms, she decided to visit a gynecologist and was diagnosed with an Ureaplasma. At the time, she was dating a man so she found no reason to disclose her bisexuality. Interestingly, Helen appeared to be certain that she could not be possibly misinformed since her doctor's heterosexual assumption would not be immensely misleading of her current sexual life. This, however, appeared to be also constructed by her already compromised expectations from doctors which were expressed with cynicism while she was commenting that apart from her doctors' heterosexist assumption the only question she was asked in terms of her sexual history is whether she is sexually active.

The only thing he asked me is whether I have sex, what kind of sex he meant nobody knows! [...] he gave me a medical cream, this is the treatment he gave me and he told me that I should give the same to my partner as well, of course he assumed that there is penis-in-vagina penetration, I don't know if this cream would be the appropriate if I were dating with a woman, it could be, I don't know... maybe it would be better for a woman to have an antibiotic, right? Since there is not an immediate contact of the genitals

The two above examples are indicative of how heterosexist and monosexist assumptions obscure the appropriate information that lesbians and bisexual women need for their sexual health as well as the appropriate medical consultation and treatment they receive. Sexually experienced adolescents appeared to be more vulnerable to misinformation as their sexuality was silenced both to family and to health care environments. Following, the focus goes on the strategies that LGBT participants used in order to ensure safety for disclosure in health care settings.

3.7 Ensuring safety for disclosure in health care settings

Homophobia and transphobia are painful for all LGBT people, and the avoidance of being exposed to pain should be viewed as a healthy response especially when people are in the vulnerable position of being a patient. In addition, when acceptance of LGBT identities is not expressed or indicated in a way, or even worse when degradation of LGBT identities is somehow felt, the stress associated with the disclosure decisions of LGBT people may be increased including the stress which is related to the undue process of challenging the heterosexist assumptions of a health professional (Eliason et al., 2009, Fish, 2006, Whitman et al., 2000).

Being misclassified as heterosexual was part of participants' expectations even before meeting a health professional, therefore, a strategy to deal with this assumption would often be already planned in order to minimize the feeling of discomfort. When participants felt that the information about their sexual orientation was relevant to their health issue the strategy was often to make an early statement about their sexual orientation before any inappropriate question. A decision to come out to a doctor was often, if not always, planned and incorporated in a series of safety strategies and coping mechanisms that will be discussed in detail in this section. When the participants' decision was to control information about their sexual orientation, the strategy to minimize the feeling of discomfort due to the heterosexual assumption was often to avoid dispelling their assumed heterosexuality by quickly responding often with a lie or avoiding further questioning in order to actively not disclose any information about their sexuality.

The heterosexual assumption was clearly an early indicator of an unsafe environment to disclose information about sexual orientation and usually intensified the fear of enacted homophobic reactions especially when the assumption was communicated with an explicit sexist tone. As others argue, expectations of certain gender role behaviors interact with expectations about heterosexuality that often encompass inferiority ideas about homosexuality (Greenfield, 2008).

This was exemplified by Alex, a 51-year-old gay man, who argued that a Digital Rectal Examination (DRE) can be easily become a traumatic experience for a gay man when the heterosexual assumption sets the ground for insensitive treatment of gay men which often includes communicating sexist meanings of masculinity. He particularly referred to a friend who was rudely asked by his doctor if he is able to 'fuck' while he was under a DRE:

A friend of mine visited a urologist in a hospital for a DRE, and during the examination the doctor asked him "do you fuck?" Hey dude! I may not fuck! You know, he felt bad, he felt his internalized homophobia to be fired up, I may take the dick! If I tell you this what are you going to say? WHAT ARE YOU GOING TO SAY? As a doctor you must be ready for this, and you mustn't say that this is unnecessary information because you are a doctor and if you are a good scientist this information is not at all unnecessary, as a urologist you have things to tell me about my prostate.

The way that Alex invoked the notion of internalized homophobia in the example above indicates the complexity of the differentiation and the analysis of the factors which intervene and interact as regards the disclosure decisions of LGBT people. In particular, Alex seemed to support that his friend's internalized homophobia was intensified because he was exposed to a sexist comment which is derogative to gay masculinities. This idea challenges conceptualizing internalized homophobia as being intrapsychically embedded homophobic ideas, which progressively disappear and do not re-emerge while one moves through the various stages of identity development, namely from the early stages of shock and denial to the healthier stages of self-acceptance and pride that usually reflect an individual's readiness to be open with others. Alex's interpretation of his friend's experience may provide further evidence in favour of Greenfield (2008) argument about the dynamic character of internalized homophobia and the possible re-emergence of old negative feelings about oneself as they can be triggered by new life events or attempts to come out to a new person. This is particularly important since internalized homophobia is usually discussed merely as a pre-existing and a more or less contextually independent, stable factor that prohibits self-disclosure rather than as a dynamic factor that may emerge during the process of a person's disclosure decision in a particular context.

It has been highly stressed, particularly from those who have developed theoretical models of gay identity formation, that failure to disclose one's sexual identity is an indication that the individual has not confronted his or her internalized homophobia (Schope, 2002). Indeed, those who are in the early phases of the coming-out process are unlikely to disclose information about their sexual orientation or gender identity to others including to health professionals (Eliason et al., 2009). However, coming-out to a stranger, including a health professional, can entail excessive stress even for those who do not struggle with internalized homophobic and transphobic ideas about themselves. As Fish (2006), Whitman et al. (2000) and Seidman et al. (1999) argue, even those who have integrated their sexual identity in their personal lives do not necessarily routinely disclose in institutional settings, especially when people are at their most vulnerable and their bodies, behaviors and personal life are subjected to sometimes intense scrutiny.

Emotional responses such as shame, anxiety, embarrassment, fear, discontent may be commonly experienced by LGBT individuals whether they may derive from internalized homophobia or other stressful sources such as the experiences of prejudice and hostility, expectations of rejection, concealing and other ameliorative coping processes or even by the process of disclosing information of oneself (Meyer, 2003). In the example above, Alex subsumed his friend's emotional response under the concept of internalized homophobia. Yet, given that the exposure and the experience of heterosexism may have the same emotional responses as internalized homophobia; it remains unclear if internalized homophobia was actually involved after all, either as an outcome of heterosexism or as an exacerbated factor that interrupted the disclosure decision of that person.

Overall, disclosing information on sexual orientation to a doctor entailed much emotional difficulty for the majority of participants. In fact, some LGBT participants agreed that an open question on their sexual orientation or gender identity by a doctor would not make them less uncomfortable than heterosexual assumptions do. In the quotation below, Sofia, a 32-yearold lesbian, described how persistent can be the stress felt during a disclosure process:

It [coming-out to a gynecologist] was very much stressful for me, in fact, every time I have to come out to a doctor who doesn't know it I have a lot of stress, I was blushed, greened, namely this moment I probably had high blood pressure, namely, even now, after all these years when I come out to a doctor I have a lot of stress, it is not like before but still I have a lot of stress

LGBT participants used a range of strategies and coping mechanisms in order to minimize the felt stress that a decision to disclose information on their LGBT status to a health professional encompassed. When a decision to disclose information on sexual orientation was already made, the most commonly used strategy was to ameliorate the possibilities of a homophobic reaction after coming-out, which was ensured by choosing a doctor who would be most probably friendly to LGBT identities. The attributes of doctors who were assumed as affirmative were doctors who identified as LGBT, knowingly LGBT friendly doctors, knowingly leftists and feminist doctors, and doctors who had studied abroad. The choice of a doctor with an LGBT identity was particularly important especially when disclosure would also entail an examination of the genitals, such as in cases where gay men asked for therapy for anal warts. In the two following quotations Alex, a 51-year-old gay man, appeared to be more comfortable with being examined and open to talk about anal warts with a gay doctor and accordingly Mary, a 41-year-old lesbian, to be examined and talk about her sexual life with a lesbian doctor.

Alex:

I had anal warts, it was after an anal intercourse but it appeared much later, I think it was during 2000, and I went to a gay dermatologist in Athens, he was gay so I didn't have any problem, I initially thought that it was cancer or something like this, now I have a hemorrhoid, and I am afraid of cancer, I cannot diagnose myself so I must go to an urologist, I don't know what to do.... I rarely have hemorrhoids, so hopefully it is not cancer, pray it is not cancer....So, I went to this gay doctor, namely I knew him as he was a known figure in the gay scene of Athens, he was going to gay bars, I didn't know him personally but I knew he was gay (Alex, 51 years old, gay man).

Mary:

I found a lesbian gynecologist, I was searching in websites, I am not sure though how I finally got her name, maybe by word of mouth? I think I asked a friend of mine and she told me that “She is one of us”, you know, with these passwords (Mary, 41 years old, lesbian)

Finding an LGBT doctor or an LGBT friendly doctor was not particularly easy as there were no transparent resources or publicly shared lists of affirmative doctors, and the main root where LGBT individuals could get such information was by word of mouth or when LGBT doctors participated somehow in the gay scene. Importantly, LGBT organisations and those who held the administration of LGBT websites were reluctant to share publicly and widely information of affirmative doctors as they feared that such practices would be perceived as advertisement and an unfair blocking of healthy competition especially as regards those health professionals who practiced privately. This was also the case for LGBT organisations or groups having a legal status (e.g. NGO) and their websites, whose function was based on funding (e.g. advertising), or when an official institution was somehow involved. For example, Yiannos, the Manager of the “Positive Voice”, the association of people living with HIV, told me that an NGO could never publicize a list of affirmative doctors especially of those who were working in the public sector as these are evaluated by the official bodies of the state and such lists would be a form of evaluative process that NGOs have no authority to make especially to the public sector. Similarly, Panagiotis, the founder of gaysexualhealth.gr which is one of the three websites that are focused on a range of sexual health issues of gay men (the other two are particularly concerned with HIV), told me that one of the most common requests from gay men who communicated with him via the website was to have a referral for an affirmative doctor.

There were many questions that were related to the concern of finding a doctor who would be open to our issues, they were asking for venereologists, dermatologists, all these specialties... there were some men with sexually transmitted diseases, they were writing “something dripping from my urethra”, and the first thing they were asking was “do you have someone to recommend me?”, of course I could not make any referral [...] you can be easily accused of preferring particular people. Namely, it would be easier if there was an NGO of people who

would say that we are gay friendly doctors. But it is difficult to refer someone to a particular doctor, there is a danger to be told by the person that “I found this doctor very expensive and I am not sure whether you earn money from this”

An exception to the way that overall LGBT groups appeared to deal with the potential of publishing a list with affirmative doctors was Queer-trans, a grass-root group, which is one of the two leading groups of the trans community. Queer-trans through its web-forum (<https://queertrans.espiv.net/forum>) and meetings freely circulates health information that is useful to its members, including names of doctors who are friendly and educated to trans health issues and accordingly names of doctors that members of Queer-trans suggest to be avoided. In fact, four out of six trans persons and one intersex person who participated in the study had used the health information and the list of affirmative doctors provided by the forum of Queer-trans in order to ensure appropriate health care practice for their transition. Importantly, none of these participants declared being members or had close ties with the group.

Against this background, the LGB participants appeared to search mostly for indirect signals of positivity towards LGBT identities when they searched doctors. As mentioned earlier, doctors who had studied and therefore lived in countries where LGBT people favored societal acceptance and they had pro-equality laws were assumed friendlier, at least in comparison with those who have studied and lived in the Greek context. Choosing a doctor that would probably be friendly to LGBT identities was an important trait regardless the final decision to disclose information on sexual orientation. For example, when Orestis decided to search a dermatologist to take treatment for a dermatological problem he had, he ensured safety for disclosure by searching the CVs of doctors via their websites and he eventually chose one who had studied in the US. Orestis told me that knowing that his doctor is probably friendly to LGBT identities was important for him to know although he believed that disclosure of his sexual orientation would not be essential at present time. Indeed, during his visit to the doctor Orestis did not reveal his sexual orientation but as he felt that the doctor is probably affirmative to

LGBT identities he felt reassured that coming out to him would be an option in the future.

He seemed a person that will not have any problem when I decide to come out to him, he had lived in US for many years, I searched him on the internet, I saw his CV and he had studied in US, so I said to myself that he is more progressive (Orestis, 30 years old, gay man)

Besides the pro-active strategies used to limit possible homophobic or transphobic reactions, the majority of the participants seemed to be very attentive to the immediate verbal, non-verbal and body language signals of doctors while they were coming-out to them. Facial expressions indicating repulsion, disgust, shock, discomfort and distance signaled to the participants that their sexuality or gender identity is rejected. On the other hand, a totally blank face was often perceived as a positive message of acceptance. In the following example, Mary, a 41-year-old lesbian, describes the attentiveness of her partner to her doctor's reactions when she decided to come-out to her.

Before I start visiting her [the gynecologist], Nana was going to her alone, and at some point she came out to her, and the doctor did not even blink her eyes, so, she didn't have any problem with it, and overall I never had any problem with a doctor, but this is a huge issue indeed

"No-problem" verbal responses after coming out that were sometimes expressed by doctors were rarely believed unless they were followed by consistent positive comments, body language or facial expressions. This appeared to be associated with the fact that many participants had experienced in their lives the most homophobic ideas to be expressed after a "no problem" declaration. By reflecting on his experiences of homophobia in the school environment expressed by his classmates, Nick a 19-year-old bisexual man said:

Basically, no matter how much they try to say that "we don't have any problem with gays", they continue by saying that "at least they should not show it to us since they know that we are straight", this was annoying to them, overall I think that they [his classmates] are very homophobic persons, at least most of them, there were only a few who were nice and kind to say that "I don't care if he is gay as long as I can

trust this person”.

In a similar way homophobia appeared to be experienced also in the health services. For instance, Antigone, a 51-year-old lesbian, after an inappropriate question by her partner’s doctor she decided to come-out and despite his immediate “no problem” verbal response, his attitude signaled that he continued to not acknowledge her as being his patient’s partner and his body language signaled that he wanted to keep distant.

He was absolutely onerous! He asked “are you sisters?”, I said “no”, he looks at me and then I said that she is my partner, “ah! Ok, ok, no problem”, and he stepped back. So, I was just waiting there, she had a cardiogram, an x-ray, she had bronchitis, he said to my partner that it is not that serious but since we came-out he was very distant ,and I was very pissed off with his style.... anyway

Not surprisingly, Antigone said that the homophobic reaction of her partner’s doctor was the reason they decided to find another doctor to follow up the treatment subscribed. This returns the discussion to the initial argument of this section that homophobia and transphobia are reasonably avoided when this is possible. In fact, nine other participants declared that they had changed doctor due to homophobic or transphobic attitude of their doctors. Three of them did so after their doctors’ immediate homophobic reaction following the disclosure of their sexual orientation.

In this section I described the ways that participants used in order to ameliorate the possibilities of a homophobic or transphobic reaction by their doctors as well as to minimize their anxiety that disclosure entailed. Within a context of absence of published lists of affirmative doctors, participants appeared to search LGBT doctors or LGBT friendly doctors through their personal contacts and the gay scene. In some cases, doctors who had studied abroad, or who were leftists and feminists were preferred as they were assumed to be positive towards LGBT identities and therefore a safe environment for disclosure. Participants also appeared to be very attentive to non-verbal and body-language signals of positivity/negativity since they had many times experienced homophobia to be

expressed after “no problem” declarations. An additional concern of the participants in relevance to their disclosure decisions was confidentiality which will be discussed in the following section in detail.

3.7.1 An intersectional analysis of the role of confidentiality to disclosure decisions

Confidentiality was a major concern of LGBT people which influenced their disclosure decisions in health care settings. Despite commonalities in the ways that issues of confidentiality were involved in the health care experiences of LGBT participants, marked differences were found when deploying the intra-categorical framework of intersectionality. These were associated with differences in place of residence, age and refugee status. Adopting an intersectional approach here provides insights into how the meanings of being “LGBT” are permeated by people’s multiple identities accounting for diversity within the wider LGBT community (Fish, 2008).

LGBT participants who wanted to disclose information on their sexual orientation or gender identity in order to ensure that confidentiality would be maintained by the doctor, they usually chose a doctor that practiced in an area away from their homes. Living in a different social environment than that of the chosen doctor was a tactic that provided LGBT participants who lived in Athens with some sense of security that the doctor will not gossip about them or spread the information of their sexual and gender identity to people that may have links to their parental, working or other social environments.

I considered that I should come out to him [to the doctor], so I decided to choose a doctor who lives away from my family, at that time I was even more worried about my parents’ knowing nothing about me, so I chose a doctor who was quite far, you know, just to be sure... so I came out to him (Sofia, 32 years old, lesbian)

Finding a doctor that was unlikely to share the same societal environment with LGBT participants was a challenge particularly for those living in rural areas because the options they had in choosing a doctor were extremely limited, dual relationships with doctors were not uncommon, and everybody knew each other

in a small town environment. As many of the LGBT participants were closeted to their parents and relatives, their concern of confidentiality was mainly related to their need not to be outed to family members. However, even students who studied away from their hometowns and, because of this, generally had a chance to live more openly as LGBT in the towns they studied, they seemed to perceive health care settings as environments that confidentiality is not within the standards of professional practice. For example, Stavros, a 22-year-old gay activist explained why he would not consider coming out in health care setting of a rural area:

I would never come out here, truth be told, the hospital and the health centers here and in small towns in general are like huge huddles, all doctors know each other, and we all know that nurses gossip... Every time I went to the hospital for a serum the next day the nurses were asking me curiously "what did you drink last night? What did you drink?", so, I imagine what happens in more.... in other situations , what they say to each other , so it is a matter of stigmatisation especially for people who are closeted ,or gay, bi individuals and lesbians who are more introvert characters

Overall, LGBT people who lived in rural or provincial areas appeared to be more vigilant and they controlled extremely more carefully the information relevant to their LGBT status in contrast to those who lived in Athens. When confidentiality was not ensured it was unlikely for an LGBT person to reveal information relevant to his/her sexuality even when the doctor developed with his/her attitude a trustful and caring atmosphere for disclosure. For example, Irene, a 34-year-old bisexual woman was satisfied to find a gynecologist who provided much time for the development of a trustful relationship with her. As they discussed various issues not particularly relevant to her health problems, Irene felt that she could trust her doctor and felt comfortable to reveal information about her sexuality. However, her fear not to be heard by other persons in the waiting room prohibited her disclosure:

I was her last appointment but she didn't have a good sound insulation, even while we were discussing these political issues we were talking in a low voice because outside there was a health visitor, if I was really the last person I would have not a problem at all to come out, she was a very nice doctor, imagine that she spent more time to talk with me

rather than examine me, ok, she examined me all right but then we talked a lot, she seemed to be caring and I think she would be interested in knowing about this issue as well, anyway she was a real doctor, and someday when we will be alone I will come out to her

As indicated above, doctors' trustful behavior was not the only guarantee for confidentiality. The presence of other persons in waiting rooms especially when doctors' offices did not ensure privacy of information, was a barrier for disclosure even when LGBT participants expected that the doctor would be affirming towards homosexuality/gender transition. In the example below, Natassa, a 26-year-old lesbian, expressed her worry for the insufficient measures of confidentiality that do not allow her to freely discuss her health issues in order to ensure the appropriate health information. In particular, Natassa referred to her wish to be informed about lesbian parenting issues along with her concerns on how she would negotiate her visibility as a lesbian mother within a context, in which same-sex parenting is not only stigmatized but also legally prohibited.

Out of bad luck, one of his patients takes her hormones from the hospital and spreads the information that I am a lesbian, because usually this is the place where all women take their hormones, and this woman is totally homophobic and she happened to hear a conversation I had with my doctor, I will be stigmatized, I will not be stigmatized by my doctor but from another person, so, it is another case that we must discuss very seriously if it is wise to disclose to our doctors the fact that we are lesbians and we want to become parents. Maybe it is better to go as a single person, as a single-parent family and say that since I cannot adopt I want to bring my own child, this is why LGBT organisations, an LGBT group should have some counselling and information which would say that this is Dimitra, she is a doctor, a gynecologist, she is homosexual and she knows how to deal with these issues

In a context that same-sex parenting is not legally recognized, regulated and normalized by medical procedures, a commitment to confidentiality by doctors to lesbian couples entailed many more things than the commitment to ensure their patients' right to have a total control over what happens to information about them. It crucially entailed a commitment to actively get involved into lesbians' struggle with discrimination, which in turn required a good knowledge of the perils and the challenges of lesbians who become mothers in a society and a medical

system where their sexual identities are viewed as incompatible with parenthood. In the quotation above, Natassa expressed her fear that she could be denied hormonal therapy by a prejudiced health professional in a hospital if the information about her lesbianism, even by accident, was somehow spread to homophobic people.

For the LGBT youth and especially for those who were underage, their right and need for confidentiality appeared to be constrained as parents were allowed and even encouraged by doctors to take part in the medical interviewing and examination. Ironically, this appeared to be at least partially an advert outcome of guidelines by the Ministry of Health in collaboration with the Greek Ombudsman and the Hellenic Society of Child & Adolescent Psychiatry for the protection of underage population. The guideline provides the right of children and adolescents to be accompanied by their parents in any medical act they are submitted to, as an effort to limit their vulnerability, fear, anxiety, and felt discomfort when under medical examinations and interviews by health professionals. Although adolescents' right to express their wish for a private medical interview or examination is acknowledged, practically adolescents must express their wish in front of their parents since the directive allows parents' presence at the outset of their communication with a health professional.

Angelo's story is revealing of how important confidential time with a health professional for LGBT youth is. At the time of the interview, Angelo was 18 years old and self-identified as a gay man although he said that this identity does not accurately describe the way he experiences his gender identity. He supported that he always felt being a woman but since he was assigned as male he kept this sense of selfhood a secret. He had chosen a female name but he asked me not to use it in my paper nor during our discussion. He maintained a connection with the trans community via web forums of trans organizations but mostly as an observer of what others say, he was searching information on gender transition and videos uploaded by trans persons describing their experience of transition but he had never met a trans individual in person. His friends were mainly straight girls and he had a gay friend found via Facebook. He had never verbally disclosed to anyone the way he experienced his gender but he had come out as a

gay man both to his friends and his parents. However, he was experimenting with female dressing, make-up and he expressed being happier when he was socially assumed or treated as female. His non-verbal disclosure of his gender identity was often met with extreme transphobic insults and violent behavior from his parents, close friends, classmates, teachers and strangers. Angelo was extremely vulnerable to transphobic violence clearly because of the lack of any supporting environment. However, Angelo was also vulnerable to homophobia and homophobic stereotypes as he had also embraced the gay identity at least as part of his social interaction with others.

During this crucial and early stage of his identity development, Angelo had his first sexual experience with a gay man with whom he got in contact via Gay Romeo (gay dating site). In the following excerpt Angelo describes what followed his first sexual experience as a result of the stereotypical and homophobic connection of gay identity with HIV/AIDS, with the public image of HIV perceived as a dreadful death penalty and information on sexual health provided in health care settings being insufficient. Angelo's story is revealing of how challenging the sexual life of LGBT youth can be as their early experiences are traumatically affected by societal negativity and denial of LGBT sexualities.

He treated me alright, but afterwards I ran to have a test for AIDS because my parents had scared me about this issue, they were saying that all gay men are dying from AIDS and all these things, so I was feeling very bad, I was certain that I will die from this [...] I went to the hospital with my father, he didn't know that I had sex with a guy but I told him that I want to have this test because I was scared from something I had read in school, now I want to have a hormonal test to check if my hormones are more female, I don't know, what do you think? I don't feel like I am well informed [...] when I took the test my father was there, other people were there as well, a nurse was around all the time with bloods and staff, it was a wide open room, I wanted to get informed if I can get AIDS from saliva and ask some other things as well but what could I ask in front of my father?

Like Angelo, many other LGBT youth participants argued that they were rarely informed and educated about sexual health issues by health professionals especially in public health care settings. This is also consistent with the findings of Donaldson et al. (2013) study conducted in the US, which identified health care

providers as being least involved in the delivery of sexual health information to sexually experienced adolescents in comparison with parents and teachers.

In Angelo's story, the disinclination of health professionals to take the opportunity of an HIV test to assess an adolescent's need for sexual health information seemed to be reflected by the whole setting in which the HIV test was administered. Angelo told me that during the whole process he was just asked in a rather indifferent way the reason he would like to have an HIV test but his answer did not have any response. Although it is not clear if the hospital had available private rooms for health professionals to provide counselling services to Angelo, it seems that the absence of privacy did not allow the assessment of the referral, counselling and support needs of Angelo. What Angelo also made clear in his last phrase is that his father's presence discouraged him to request sexual health information. Importantly, this should be seen in relation to the fact that Angelo had decided to conceal from his father that his worries about HIV were somehow related to his sexuality and gender identity, something that was clearly part of his effort not to validate and reinforce his father's negativity towards his gay identity.

Like in the case of LGBT youth whose right to confidentiality was constrained by the presence of their parents in their communication with health professionals, asylum seekers' right to confidentiality was similarly compromised by the mediation of interpreters. Data from my interview with Margarita, a social anthropologist who worked in an NGO which provides housing and social support for asylum seekers and immigrants, provides some insight from the particular challenges of asylum seekers who have been prosecuted and tortured due to their sexual orientation or gender identity in their countries of origin. In relevance to confidentiality, Margarita said that due to the language barrier, monitoring the health and social care needs of immigrants and asylum seekers is possible only with the mediation of interpreters that are usually immigrants and asylum seekers themselves who have received a short training on how to perform interpretation. This means that those who managed to escape persecution because of their sexual orientation or gender identity in their home countries find themselves in the vulnerable position to share their stories to interpreters that come from their own country of origin. This is problematic not only because this form of dual

relationship between the asylum seekers may constrain the interviewer's ability to ensure confidentiality but also because asylum seekers may continue to protect themselves by hiding and denying their sexual orientation or gender identity (Randazzo, 2005). Margarita argued that this is a crucial obstacle to her communication with asylum seekers especially when the information that she wants to monitor triggers the cultural attitudes of interpreters towards homosexuality or gender transition. She referred to an example where she had a meeting with Nina, who was a transgender woman and an asylum seeker from Pakistan, in order to take an intake social history and monitor her needs. In the following excerpt Margarita describes how the transphobia of the interpreter was communicated to Nina during their interview:

I had an interpreter, so before we started I told him that Nina is a transsexual woman so I wanted him to be serious because he sometimes loses his professionalism, and he said "yes, sure!", so we started our meeting and I realized that he was calling her sir, of course she didn't say anything to him but during our conversation she was persistently saying to me "I am like you, I am a woman, it is just the others who do not understand this", but he was calling her "aga" which means sir, so I stopped him and I told him not to call her "aga" but "hanum", and she later showed us some pictures where she was dressed, she was wearing a wig, she had make-up, and the interpreter said "I don't like this, I don't want to see these pictures anymore", so I took him privately and I told him that it was not his job to say if he likes the pictures or not and that this should never happen again

Not surprisingly, Margarita said that after the above incidence she became even more vigilant and reluctant to ask her service users questions that were relevant to sexuality and gender transition. Yet, since there are no translation services in NHS of Greece, the interpreters who are employed in NGOs to serve asylum seekers play a significant role in monitoring the health and social needs of asylum seekers and immigrants in Greece.

In this section I argued that confidentiality is a contextually bound factor that decisively affected the disclosure decisions of the participants. Limitations of confidentiality appeared to be relevant to the presence of parents in the cases of LGBT youth, the involvement of interpreters in the cases of asylum seekers and the unavoidable intimacy of rural life. In addition, the absence of legal recognition

of LGBT parenting appeared to extend the meaning of confidentiality to an active alliance between doctors and lesbian prospect parents against discrimination. In the following section the focus goes on the ways that LGBT participants appeared to manage issues of visibility/invisibility when they negotiated their visitation rights in hospitals.

3.8 The impact of invisibility on LGBT same-sex couples and carers in hospital settings

Visitation rights for the same-sex couples appeared to be dependent mainly on the condition of “don’t ask don’t tell” unwritten policy in hospitals and the most commonly held active non-disclosure strategy of lesbian and gay couples to render the essential features of their relationship invisible. Within a context of a generalized absence of any written and transparent guidelines of visiting rights in Greek public hospitals for both heterosexual and LGBT patients, those two strategies appeared to be perceived by the participants as being effective enough in cases when they experienced hospitalization of themselves or of their partners. However, visitation rights and the ability to maintain the status of a “next of kin” to a partner were persistently mentioned by the majority of the participants and it was linked to the absence of any measure of legal recognition of same-sex relationships in Greece until 23rd December 2015.

Moreover, an emergent hospitalization of a partner often entailed the immediate exacerbation of felt insecurity on whether it would be possible to maintain closeness to the hospitalized partner. However, in such emergent cases and risky health crisis what has hitherto been loose in terms of visitation access is replaced by a stricter attitude by health professionals and open questions about the status of the visitor therefore breaking the unwritten policy of “don’t ask don’t tell”. Within such an uncertain environment, maintaining the right to remain close to your hospitalized partner appeared to necessitate the emotional readiness to be alert and embattled so as to quickly change strategies when necessary. When I interviewed Tania, a 50-year-old lesbian, she told me that the hospitalization of her partner Rena “was not a time for revolution”; therefore, ensuring her access

in the health care of her partner was a priority even at the cost of the invalidation of the true nature of their relationship within the hospital environment. For the time being in a pathology clinic she introduced herself as Rena's sister and this status was sufficient to have access to all information about Rena's health and treatment while she was able to partaking in the nursing care of her partner and stay overnight. However, when Rena's health deteriorated and she was moved in the Intensive Care Unit (ICU), Tania was suddenly under a different situation where she had to negotiate access once again with new doctors. In her first contact with her partner's new doctor the status of a sister appeared to be insufficient for entrance in ICU and the doctor insisted that allowance for visitation and information about Rena's health would be granted only to a husband. Tania told me that at the moment she got determined to not draw back at any circumstance and once she managed to enter Tania's room she immediately changed strategy by clarifying the nature of their relationship and by adopting a rigid attitude to leave no room for being challenged. In her own words she described:

I told him I was her sister but still he didn't allow me to enter... he eventually allowed me to enter but he asked me "doesn't she has a family?", and I said "it is me, I am her sister", "no, I mean...", this is what was happening, they were asking me "who are you?", I asked if someone can inform me about Rena's condition, "Can I see the intensivist?", "doesn't she have a family?", "of course she has! I am her sister", he said "No, I mean doesn't she have her own family? Doesn't she have a husband?", I replied "No" and he then allowed me, but once I got in the room I made them clear that I wasn't leaving anyway, they got wind of it which was good because after this point it was the only way so as not be obligated to wait their permission

In another story, Antigone, a 53-year-old lesbian, said that during her negotiating efforts to ensure involvement in the health care of her partner she ended up becoming physically violent to a doctor. In particular, after a traffic accident, Antigone and her partner were transferred in hospital and while Antigone was allowed to leave as she only had a few scratches, her partner was more seriously hurt and she was admitted to the emergency clinic. The doctor who was responsible for her partner's treatment insisted that entrance should be allowed only to persons of first degree relationship with the patient and Antigone felt

immediately challenged and frightened that she would be restricted to stay close to her partner. She said:

I wanted to be close to her, to fondle her because she was screaming out of pain, I saw that I only had a few scratches, the doctor did not allow me to be close to her, I started to yell in the hospital, “you don’t allow me because you think I am not well? I could understand this more”, he said “no, only first grade relatives”, I WAS SCREAMING! I grabbed him by his collar, he also grabbed me and although I am short and not that strong I had him in my hands and I was screaming “I will kill you, I am not leaving” ... but they took me out, and he was just staring at me and he was saying “No, only her father”, so eventually her father got in and said “let this woman get in, I will go out”, this is something I really liked, so this is how the doctor backed down and after this I didn’t have any problem.... But this was the first time.... I didn’t want this, namely, I was 38 years old and I had never imagined this, and we said “what will we do if something more serious happen?”

Antigone described her story as a traumatic experience, though balanced by the intervention of her partner’s father, which was experienced as an affirmation of her relationship with his daughter. Nevertheless, it remains problematic that the acknowledgement of same-sex partners and their visitation rights are dependent and easily challenged by blood relatives who may wish to ban same-sex partners from various aspects of health care including visitation, decision making, planning of health care, health information on the risks and benefits of treatment and information in relation to patients’ progress.

Despite the many barriers caused by insufficient recognition of same-sex partners in law or hospital regulations, some couples with hospitalization experiences appeared to be disempowered less by direct legal prohibitions than by the silent operation of homophobia. In many cases, it was in the middle of a health crisis that managing coming out issues with parents and blood relatives were foregrounded since hospital rooms hosted two separate worlds: blood relatives and parents, and partners and LGBT friends visiting and caring the patient at different hours of a day. This was the case for LGBT participants who were closeted or whose LGBT status was not fully accepted by their family of origin. As a result, some participants had withdrawn, or restricted their visiting rights in order to conceal their relationship from relatives. Perceived as a freely chosen strategy to manage their personal lives, participants did not express any

kind of distress, dissatisfaction or sense of injustice in the way they experienced their visits to partners or LGBT friends. This is consistent with the ethnographic accounts by Dendrinis (2008) who argues that Greek gay men, in order to maintain closeness and the ability to participate in family-life, separate their sexual life, their lovers and their gay friends, effectively excluding them from the social, affective network of the family. Staying “in the closet” was seen by these men as a way to preserve the well-being and, above all, the unity of their family.

I myself found it extremely difficult to comprehend the ways that homophobia restricted the visitation rights of these participants until I met Tania whose words and tears of happiness made me reflect on the cost of invisibility and homophobia in more profound ways. In the following quotation, Tania describes how the experience of her hospitalization and the period of her recovery became the chance to enjoy the integrated and unconditional support of her partner and her parents.

When I was a patient myself, namely when I was diagnosed with cancer it was very nice... anyway, I had cancer which is not nice but my parents were here and Rena was here and she was taking care of everything, I was shocked with the cancer but it was a chance for my parents to see how I lived with Rena. Of course they knew her, they appreciated her, they liked her but... ok... they had the chance to really meet Rena and see how great Rena is to me but also as a person, so they were sitting in the hospital and they were saying “the doctor is coming” and then my mother was saying “leave it Vassilis, Rena will go”, “where is Rena?” [...] and then I started chemotherapy and my parents would visit us every week and they brought us all the goodies, they have a wonderful garden [...] at that time Rena was also working in our store, and at some point my mother said to us “you should hire a person in your store because Rena is not made of iron”, they said this to help Rena, and they said “and we will pay this person”, and indeed they were paying for some months a part-time employee for our store, so we had an employee who was paid by my parents because Rena was not made of iron. This was very nice, very-very nice, they came and I could feel their love, Rena’s affirmation, they applauded my choice, I had never lived this again, I don’t believe that there are many persons who can live this... this was a great... namely to hell with cancer, this was a great thing! All these things made me feel very optimistic

The majority of the participants appeared to be tremendously emotionally affected by the level of acceptance they had from their families of origin and Tania’s story

was unique in this respect. The rule was segregation to some extent between the life that entailed affectionate relationships, role and responsibilities with the family of origin and the life that entailed an affectionate relationship, roles and responsibilities with a same-sex partner or the LGBT community at large. Consistent with the patterns described by Ritter and Terndrup (2002), the majority of LGBT participants appeared to either maintain a rigid emotional distance with their families of origin or maintained an unspoken agreement in which all parties agreed to not even talk about the personal life of their LGBT members. This form of fragmentation was often the necessary price for the maintenance of some sort of connection with the family of origin. For example, Nelie, a 23-year-old lesbian, was emergently hospitalized and operated as one of her ovarian cysts was ruptured and she suffered from internal bleeding. As Nelie was a student in a town far away from the town her family of origin lived, her parents involved in her health care two days after her surgery. However, Nelie was not alone. She had her partner who accompanied her in the emergencies as well as her lesbian friends who provided immediately their practical and moral support to the couple. Nelie described as incredible the moment when she came out of the surgery and she saw her partner waiting for her. As her partner was a health professional herself she was immediately allowed by her colleagues to have full access in Nelie's health care by simply introducing herself as being Nelie's relative and she faced no other questions on the nature of their relationship. However, once Nellie's mother arrived, her supportive network completely changed with her partner and lesbian friends leaving from hospital in order to not trigger questions that would make Nellie feel uncomfortable to her mother as she was closeted to her. As Nelie had a quick recovery, she did not have to stay more than four days in hospital and she quickly returned to her regular life. Nelie expressed being just happy that she had the chance of her partner's support during the first critical days and since she wanted to remain closeted to her mother losing the support of her partner and her friends during the last two days of her stay in hospital was a relatively small cost.

Nevertheless, right after the narration of this experience Nellie said that one of her plans in the near future was to leave the country with her partner so as to live their lives in a country where "things are more free" for lesbian couples. In fact,

many of the LGBT participant youth were comforted with an idea that unresolved homophobic issues in their families of origin will stop being emotionally disturbing if they left the country to build their future in a more progressive country where they could both live freely and build a satisfactory career. By contrast, unresolved homophobic issues in family of origin appeared to become more persistent and emotionally intense in adult life or when LGBT participants had organized their lives in Greece and had no plans to live abroad. In such cases, feelings of distress, isolation, loneliness, lack of support, and feelings of being disrespected by the family of origin were not uncommon. These feelings appeared to be exacerbated when LGBT participants were taking care of a family member, usually a hospitalized parent. In fact, two participants appeared to be the primary carer of a hospitalized parent since they were treated by their siblings and close relatives as if they were single, and therefore without family responsibilities. For example, John, a 49-year-old gay man, was appointed to be the primary carer of his father when he was about to be hospitalized after a quick decision by his sister on the basis that since John is single and unemployed he is free of responsibilities while his personal life appeared to be completely ignored.

We were not talking with my father, but at some point my sister called me and she said you have to stay with our father, he is ill, your brother is here and I cannot take care of two men... So, I stayed here, and they arranged my father's surgery to be held at 7th of July [...] at some point I called them to come over, I couldn't stand this on my own! My sister, who is in charge, helped us a lot. I am very obligated to my sister, she had to work because I also had to live somehow here, for fucking I had my friend and I was going out to see him

While John was in the hospital to take care of his father he was completely alone without any supportive system. At the time, the only supportive system John could have was his partner but, as an unspoken family rule, he had to keep his personal life out of the family life. John was not allowed to ask his partner's to support him while he was in the hospital. John did not appear to complain about this probably because it was part of a "taken-for-granted" pattern that probably provided some balance between him and his family relationships, which he did not want to change. Nevertheless, later in our discussion he expressed feeling rejected and disrespected by his sisters. He said:

My unmarried sister doesn't accept me at all, the other, who is married, although she accepts me, she doesn't respect me. While I am performing a drag show, you just have this impossible stare at your face [...] no matter how many times you call me a day I don't like you, I want you to respect me for who I am, and when I asked her what would happen if one of her children was homosexual she said that she wouldn't like that, so I told her "you deserve what your destiny will bring to you because you have no love inside you"

Similarly, Sofia, a 32-year-old lesbian was the primary carer of her father while he was hospitalized. At the time being, Sofia had a long-term relationship with a woman but as both were closeted to their families she could not enjoy her support within a health crisis especially when her father's health and care was a priority. As Henderson (2001) argues the emotional component of the experience of taking care of a person can be intense. The experiences of LGBT participants, who were carers of their parents when hospitalized, are indicative of how their emotional burden may be intensified as a result of living in a homophobic environment. Lacking the support of a partner in difficulties because of the enforced invisibility of same-sex couples in homophobic environments prohibit LGBT individuals to fully and wholly enjoy the benefits and support of an intimate relationship. As Connolly (2004) argues, same-sex relationships in homophobic environments are invalidated especially if the couple maintains the relationship as a secret and they are involved in bond-invalidating activities. This can be enormously stressful for both partners as their sense of "family" is distorted and may even experience loss around the heterosexual privilege (Connolly, 2004). In the quotation below, Sofia describes her emergent fear of loneliness that was triggered by the view of a loner older masculine woman who was hospitalized in the emergencies. Sofia said that the emotional impact of this experience was so intense that made her feel that she lost the ground under her feet and in order to overcome these feelings she sought support from a mental health professional.

I was impressed by the fact that there were older people in the emergencies who were not accompanied by someone, namely they were in a very emergent situation... there were people screaming out of pain, they were in the emergencies, they were in a terrible state [...] and there was a lady who had no one, and she was in pain and she was screaming, and this upset me, and do you know what I noticed? Ok, this may be irrelevant but I think... she was a little bit... you could

not tell if she was a man or a woman, namely in the beginning I thought that she was a man and I asked another person «what is the problem with this man?» and they told me that she was not a man, she was a woman, she was a masculine woman, so you know, at that point I felt that I could be in her position when I reach her age, namely because... because I don't want.. at least for now I cannot have a family, so I was thinking that these people who are aged, unfortunately they are ... namely you may end up to be all alone in such a difficult situation, so while I was there and I had to take care of my father I was also thinking of this, namely I was freaked out with this

It is acknowledged that the carer is an integral part of a person's health care, since it is a valuable resource and as such the carer should be supported. The burden of the care task may bring potential risks to the carer's mental well-being and LGBT carers may have additional issues and worries as a result of the experience of homophobia and stigma. Both John and Sofia in the examples above experienced loneliness and lack of support while they were caring for their fathers in hospital but neither their needs were assessed nor were they provided some short of social, emotional or moral support from the health and social services of the hospital. It is also very likely that the needs of LGBT carers as well as LGBT couples are prone to remain unseen and unrecognized within contexts where all appear to subscribe to the "don't ask, don't tell" approach of homosexuality and LGBT issues at large (Connolly, 1996).

To sum up, because of the citizen status inequalities and the societal homophobia, hospital contexts can become the places where LGBT people may experience unnecessarily significant emotional pain. In this section, participants' experiences in hospital settings were used in order to illustrate the need for hospitals to recognize the legitimacy of same-sex relationships so that loved ones are not kept apart especially at a time when they most need each other. However, because of the more silent functions of homophobia and the possible unresolved homophobic issues within families, health professionals and social services have to go beyond their normal routines and responsibility and advance their cultural competence in order to facilitate in a sensitive and knowledgeable manner the health care needs of LGBT hospitalized patients and carers.

Conclusions

In this results chapter my attention was on how processes of invisibility and visibility help us to understand the nuanced dynamics of subtle forms of social exclusion experienced by LGBT people in health care. As many other authors have also highlighted, participants' experiences are indicative of how heterosexism, as a primary source of the invisibility of LGBT people, is perpetuated in health care settings with mechanisms similarly used in other domains, including: the heterosexual privilege; the heterosexual assumption including the assumption that sexual orientation does not affect the health care of patients; the public/private divide; the invisibility/silence of sexual orientation issues; the idea that LGBT people have the same health needs as heterosexuals; ideas that portray LGBT people as moral threats (e.g. in the HIV/AIDS epidemic) etc. (Fish, 2006, Butler, 2010, Institute of Medicine, 2011, Evans, 2001). The depersonalization of health care seemed to also reinforce the invisibility of LGBT people and had an immediate negative impact on the doctor-patient relationship, although in most cases this relationship was already damaged as LGBT participants were prevented from being open and honest to doctors.

Participants' narratives also revealed the vicious circle of stigma and invisibility: the stigma as a source of shame, fear, distorted identities and super-surveillance and invisibility itself as a factor that exacerbates the damaging effects of stigma and ensures its reproduction. As a result, the enforcement of "don't ask, don't tell" unwritten policy deprived LGBT participants of their fundamental right to embrace their sexual or gender identity within healthcare settings. Doctors appeared to unproblematically assume the gender and the sexual orientation of their patients, and LGBT identities were assumed to be strictly social identities with no effect on medical treatment and the quality of the provided services. Under these assumptions, health issues and concerns of LGBT participants were often precluded from their discussions with doctors. Moreover, assumptions including that all people are equally treated in healthcare could result in LGBT participants' exposure to homophobic and transphobic jokes or gossip that were meant to derogate LGBT people in the corridors of health care settings.

Drawing on the premise of intersectionality to reveal “within-group” differences, in section 3.6, I highlighted challenges experienced by bisexual and non-binary participants in health care settings. Research findings regarding their inclusion indicated that their health care access is impeded as a result of prejudices, usually involving ideas that bisexuals do not really exist or that bisexuality is the result of hypersexuality. This is particularly important given that there is a long history of marginalisation of bisexuals by the lesbian and gay communities (Monro and Richardson, 2010), and the tendency of research studies to subsume bisexual persons into the LGBT acronym but without providing any particular attention to their special health care concerns and the effects of bi-invisibility (Miller et al., 2007). By focusing on the issue of confidentiality in health care, in section 3.7.1, I also highlight some of the ways in which the LGBT community is structured along a range of axes other than sex/gender, including age, rural/urban living, and refugee status. In particular, findings indicated that worries about confidentiality were exacerbated for people who lived in rural areas, but also for LGBT youth and LGBT immigrants/refugees because of the presence of parents or interpreters during medical interviews.

There is a growing awareness in UK and US that unless we overcome the invisibility of LGBT people in the health care system it is simply impossible to hope that the health inequalities of LGBT people will be eliminated (Williams et al., 2013, Institute of Medicine, 2011, Potter et al., 2008). However, combating the “don’t ask, don’t tell” norm in health care settings in Greece is not easy as it represents a status quo embedded in all mainstream contexts where LGBT people function. Encouraging doctors to ask the sexual orientation and the gender identity of their patients before they make any assumptions about them is indeed a critical goal to battle invisibility. Yet, this presupposes proactive strategies and measures that ensure that healthcare environments are really safe and welcoming environments for LGBT people and health professionals are knowledgeable not only to appropriate questioning but, crucially, to respond to the particular health needs or issues that might affect the lives of LGBT people (e.g. homophobic or transphobic violence).

CHAPTER 4 THE PATHOLOGISATION OF LGBT BODIES AND ACCESS IN HEALTH CARE

Introduction

Grounded in the ethical principle that everyone equally matters, access to health care is a fundamental issue of social justice. Ensuring equal access to health care is about distributing health care in relation to need and removing barriers that prevent the effective and appropriate use of services for all people. As Neuberger and Coker (2002) note, equal access to health care is about addressing health care needs in a way that each person will come away with a level of personal satisfaction with what is provided and how it is provided.

In a more operational conceptual framework that was achieved through a systematic literature review, Levesque et al. (2013) framed health care access as the opportunity to identify health care needs, to seek healthcare services, to reach, obtain or use health care services, and actually have a need for services fulfilled. This conceptualization corresponds to five dimensions of accessibility: a) approachability; b) acceptability; c) availability and accommodation; d) affordability, e) appropriateness. Drawing on this framework, this chapter discusses the participants' experiences of discrimination as well as the structural pathologisation of LGBT bodies and sexual practices and its consequences in their health access.

Specifically, in the first four sections I discuss the ways in which the pathologisation of LGBT bodies and sexual practices are manifest in the realm of health care provision across multiple levels, shaping participants' access to care. In the last section, by drawing on participants' experiences, I focus on the role of the LGBT community as a factor that moderates some of the barriers in health care for LGBT people. I also provide a detailed examination of the connection between the effort of two participants to find a place within the LGBT community and their health needs, by illuminating some of the social dynamics that appeared to interfere.

4.1 The pathologisation of non –penetrative sex and its impact on lesbians' access in health care

The dominant idea that sex is strictly a penis-in-vagina intercourse constructs non-penetrative sexual practices as inferior to what is socially perceived as sex. In this way, non-penetrative lesbian sexual practices such as oral sex, finger-to-vagina contact and genital-to-genital contact become aspects of the stigmatized status of lesbians. This was clearly reflected within the context of the interviews where some lesbians, although they easily self-identified as lesbians, they later found themselves in a position to decide upon a second coming-out, this time a difficult one: to reveal that they do not have penetrative sex. One of the most characteristic examples is the way that Stefany, a 34-year-old lesbian spoke about this:

The gynecologist is a painful story... well...eh.... this is not easy to say but I will say it [she laughs], I have an issue with my vagina, namely with penetration [...], No, I don't perceive this as a usual issue, we have spoken many times about sexuality in our group but I never heard another lesbian having the same issue as me

With the stereotypical assumption that all the important issues are already discussed within the LGBT organisations I myself was surprised to experience Stefanie's difficulty in her revealing this information to me. Stefany was a lesbian and a feminist activist with more than 10 years of experience, being actively involved in the LGBT movement and a founding member of a lesbian organization. Given that minority individuals, who are involved in collective processes of the movement, are often assumed as less vulnerable than non-activists, Stefany's experience is revealing on this respect.

The feelings of shame for lesbians who were doing sex exclusively with non-penetrative activities and their consequent pathologisation was in one case exacerbated with an idea which suggested that penetration ensures good health in women's bodies. In particular, Nelie, a 23 year-old-lesbian, was told by a gynecologist that penetrative sex can be viewed as a preventive method for cervical cancer. Nelie in her own words said:

I know that women must have penetrative sex because they preserve themselves from cervical cancer in this way, and that it is overall very good for your health for many reasons, it is because your womb bleeds through penetration sometimes and this is good, this is what my gynecologist told me one day, that it is very good when my womb bleeds because it doesn't allow cancer to develop

Vaginal bleeding after penetrative sex or postcoital bleeding, as it is clinically defined, can be considered normal especially for younger women or when there are no medical conditions detected through Pap smears or pelvic exams. Sometimes, though, postcoital bleeding is a sign of a STD or even more serious conditions such as cervical cancer (Rosenthal et al., 2001). However, the above example is indicative of how heterosexist ideas can distort our understanding of medical symptoms and lead to misdiagnosis and misinformation not only for lesbians but also for heterosexual women. However, challenging stereotypes generated through medical 'expertise' has not been easy. Although all lesbians believed that doctors are completely ignorant of lesbian sexual practices and therefore incompetent to provide any relevant lesbian health-care information. In fact, one of the lesbians who spoke about the incompetence of doctors on lesbian health care was Nelie. In the quotation below, Nelie describes one of her visits to her gynecologist in which she appears to educate her doctor on the existence of lesbians and their sexual behaviors:

I remember I was discussing with a gynecologist who is in this hospital for many years, and she literally knew nothing! So, she took me in her office and we were discussing on how two women do sex, she was asking me and I was answering, and she was saying "this is not possible", and I was saying "yes, it is", she just couldn't realize it, for example she didn't believe that a woman can be sexually satisfied by her partner's hands, or she couldn't understand how it is possible to choose a woman instead of a man, she couldn't believe the whole process and that we don't necessarily use dildos, and I told her that I am personally not a fan of dildos because if I wanted a dildo I would go with a man [...] she was my doctor for a year and at some point I came out to her because I thought that I can't continue like this, doctors should know what is happening, because I was going to her for a year just for a check -up but later my problems with my polycystic syndrome became worse

The invisibility of lesbian sexual practices appeared to dominate the ways that lesbians were dealt with in the health care system, particularly in relation to gynecologic health care services. As a result, especially the lesbians whose sexual practices did not involve vaginal penetration were extremely uncomfortable at disclosing information about their sexuality to their doctors and unlike Nelie did not involve themselves in educating their doctors. In reference to the doctors' inability to provide safe sex information to lesbians, Mary, a 41-year-old lesbian, said that trying to figure out what medical consultation is applicable to both heterosexual and lesbian sex is one of the ways that lesbians try to cope with their invisibility as patients:

Doctors do not know the sexual practices of lesbians and they say things that are relevant only to heterosexual couples... oral sex is easier because you can have an oral sex with a man as well, so you can ask "what about oral sex?" and whatever answer he will give you it will be the same with... every time you must do the equation, like in math, to see what is happening in your particular case. Doctors are not informed, even if you explicitly ask them they don't know... even lesbian doctors may don't know as there are thousand ways to do sex and they may have not a personal experience

Another coping strategy was that some lesbians were presenting themselves as virgins to their doctors in order to avoid explanations about lesbian sexual practices. Some others implicitly referred to their assumed imperforate hymen with phrases such as "I am closed down there". Nevertheless, the invisibility of lesbianism, along with the cultural tradition according to which the hymen is a sacred tissue that should remain intact until the first penis-in-vagina intercourse, made doctors very cautious. In particular, they appeared to protect the assumed virginity of lesbians and their assumed unruptured hymen from medical procedures such as the Pap test. None of the lesbians, who participated in my study including those who had disclosed their sexuality to their doctors, were ever asked by their doctors about their own views on virginity and their hymen.

As virginity and hymen are associated with emotionally and culturally charged beliefs and stigmas, the lesbians who self-identified as virgins or who were

assumed to be virgins by their doctors were subject to such cultural connotations when they asked for preventive health care. In the following quotation, Mary described how she felt the stigma around virginity particularly since she was feeling too old to present herself as virgin:

...and I was going to the doctor, because I still cannot come out, and it is this word “virgin” which is very bad particularly after a certain age, namely I was feeling like a freak... namely it is difficult to even say this word, even if you are not a lesbian, it is difficult to say that you are at this age and you have never had.... So, I said this once to this particular doctor and I had an abdominal ultrasound, but it was liberating when I finally could have normally a Pap test

The prevailing idea that virginity is lost when the hymen is ruptured along with the fact that some young lesbians did not know what to expect from the procedure of a pap test, often resulted in a traumatic experience especially during the first Pap test. For example, Mary at age 25 was prompted by her mother to have a pap test. As Mary had no idea about the exact procedure she did not consider speaking about her sexuality to her doctor therefore allowing her doctor to make her own assumptions. The doctor proceeded with taking the test without explaining the procedure first and without taking any sexual history. However, when she saw Mary being uncomfortable with the process she asked her whether her hymen was ruptured or not. When Mary replied negatively her doctor immediately stopped the test as she perceived that the medical procedure of a Pap test would turn to be a rape if the hymen was stretched open by the speculum. In the quotation below Mary described this experience:

One day my mother was going to have a Pap test and she told me to go along with her to have the test too. But I had no idea how they do the Pap test, my mother never discusses these issues, we hadn't discussed this, so I went there and the doctor told me to put my feet there, and she tried to insert the speculum, she told me to relax but I couldn't, and then she asked me “what is happening? Aren't you open there?” and I said “No”, and then she yelled, she made me feel so bad! She told me that “you almost make me rape you” and things like that, namely she had a very nasty reaction, she was shocked and she made me feel very bad

Consistent with the findings of the UK National Lesbians and Health Care Survey, the fact that health professionals who administered the Pap test omitted to provide details on the procedure of the test and their inability to make lesbians relax made the whole experience a bad one (Fish and Anthony, 2005). Mary's bad experience of the Pap test was not only constructed by her doctor's heterosexual assumption but crucially because she assumed that Mary already knows the important information relevant to her health care through her peers or her mother. Nevertheless, at the time Mary had her first Pap test she was overall closeted, she had few lesbian friends and she actively avoided involving her mother in her gynecological issues in order to not trigger her involvement to sensitive information about her sexuality.

Moreover, Mary's experience is indicative of how the sexualization of the Pap test and by extension of the women who were examined was becoming the source of embarrassment and the root cause of an adverse experience for lesbians in health care. Specifically, it appeared that Pap test was often inappropriately compared to sexual conduct. This resulted in the sexual objectification of lesbians which is part of the dehumanization of women within sexist cultures (Liss et al., 2011). Turning a lesbian's Pap test into an educative process for 15 trainee doctors at the same time and asking sexist humorous questions which humiliated the patient's feeling of pain by the speculum were also indicative of the sexism and lack of sensitivity in health-care settings. Antigone, a 53-year-old lesbian, described her experience:

I went to a hospital to have the Pap test and I was very much in pain, and there were 15 trainee doctors watching, and I was saying "it hurts, it hurts", and one commented: "Doesn't it hurt when you're doing it?" and I yelled so much that the whole hospital almost heard us, I never went there again

Drawing from the theoretical perspective of ambivalent sexism, the hostile sexism expressed by the insensitive way the Pap test was administered and the insensitive response to Antigone's pain appeared to coexist with benevolent sexism (Glick and Fiske, 2001). In this particular case, benevolent sexism appeared to be expressed by the humorous question of the doctor which reflected

his anticipation that Antigone would enjoy her sexualization and that of the Pap test procedure. This probably came along with doctor's (hetero)sexist belief that heterosexual sex is one of top sources of happiness and enjoyment in life, therefore, pain during penetration is just a small price for it. Moreover, Antigone's clear and sound resistance to doctors' sexist behavior provides further evidence that women and particularly those who do not fit the narrow and heterosexist definitions of femininity do not enjoy and are not benefited by their sexualization or benevolent sexism (Glick and Fiske, 2001).

We propose that HS and BS are composed of

With the dominance of heterosexism in the health care settings and the consequent misreading of lesbianism as virginity, nobody bothered making lesbians feel comfortable with the whole process of the Pap test. In addition, the idea that some lesbians believed themselves to be in low risk of STDs along with their discomfort with the speculum and their reluctance to come out made to postpone or even opt not to have a Pap test. In fact, all the above mentioned factors have been reported as barriers in the access of lesbians to cervical screening (Fish, 2009). The way that Sofia, a 32-year-old lesbian, experiences the Pap test is a characteristic illustration of the above:

I feel completely uncomfortable with the speculum; it is very irritating, I get crazy, especially if you don't come out to your doctor he will probably think you are insane [she laughs]. Maybe straight women are more comfortable with some things, I never had sexual intercourse with a man, so I am completely uncomfortable with penetration, so ... you know... the speculum is a nightmare.... to the point that sometimes I say that it is better not to go, but ok, I know that I must go, but most gay women do not visit a gynecologist for the same reason. Namely the gay women I know have the same psychology as I do. But there is also the wrong idea that gay women have no fear of coming down with an STD, except if they say it as an excuse, but some do say that since we are gay there are no many possibilities of getting an STD so there is no point in visiting a gynecologist, but I believe this is wrong... ok, it has some truth in it, but it is basically wrong

Despite Sofia's consideration that lesbians would avoid having a test-Pap anyway even if they considered themselves at risk of getting a STD, all of the lesbians and bisexual women including Sofia who participated in my study declared that

they had never practice safe sex techniques when they had sex with a woman. The below excerpt from the group interview with three bisexual women is representative of how lesbians and bisexual women viewed the need for safe sex when they had a female sex partner:

Elina: overall, when I am with a man there are many things I worry about, I have no worries when I am with a woman, it is impossible to get pregnant [she laughs]

Popie: it's perfect!

Elina: we don't need to worry about protection [she laughs]

Popie: yes, first of all lesbian sex is cheaper, but when I was with a man for two years I was very worried because I also have polycystic ovary syndrome and my periods are not very stable, so I remember once I didn't have a period for two months and I was very worried, but I had a pregnancy test and I wasn't pregnant

Katerina: yes, lesbian sex is more convenient

STDs are bodily-fluid borne, and transmission requires contact with fluids such as semen, blood, and vaginal secretions. Therefore, all ways of doing sex can be a possible medium of transmission for micro-organisms such as penis-in-vagina intercourse, penetrative sex with hands or sex toys, genital-to-genital or digital-genital contact and oral sex. In addition, HPV transmission only requires skin-to-skin contact which suggests that women who have sex with women are equally prone to the virus with women who have sex with men when they have unprotected sex (Marrazzo et al., 2000). However, as Daskalakis et al. (2008) argue, both the medical community and lesbians and bisexual women as a group hold the misconception that women who have sex with women (WSW) have a lower risk of contracting STDs than their female heterosexual counterparts. In this study, the misconception about the presumed safety of sex between female partners was underpinned mainly with ideas that the non-involvement of semen guarantees safeness and non-penetrative sexual practices are harmless. Theano even recalled an ex female partner believing that she could detect STDs in women through eye-contact:

When I first went to Katerini I met a woman and she was my first female sex partner, she said that she knew everything about lesbian sex, and she cleaned everything with chlorine, and she said that she does gynecological tests to her sex partners and that she could see

whether a woman has an infection or not, and I asked her how can you see this? What is this bullshit that you are saying? “I can see this”, how can you see this? Anyway... and I know many lesbians who have never visited a doctor, Chloe for example is 33 years old and she has never visited a doctor, and she says “I am careful”, but this is meaningless, what does this “I am careful” really mean?

In two occasions, the misconception of the presumed safety of sex between women was eradicated by a personal experience of being infected by HPV or by the experience of having a female partner being infected by HPV. In both cases these women had no history of sex with men. Beyond beliefs about the safety of sex between women, lesbian and bisexual women who participated in the study perceived safe sex practices found on internet resources, such as the usage of dental dams and latex gloves, as being non-practical and significant barriers for enjoying sex. Moreover, all lesbians and bisexual women reported that they had never been assessed of risk and risk-taking sexual behavior, nor had they been consulted on safe sex techniques by a doctor.

To recapitulate, in this section I shed some light to the barriers that limit the accessibility of lesbians in health care. The dominant idea that sex is strictly a penis-in-vagina intercourse appeared to establish the invisibility of lesbian sexual practices. As a result, lesbians whose sexual practices did not involve penetration were misperceived as virgins by their health care providers. Lesbians were enforced to undergo the cultural connotations of virginity in decisions that were related to their physical examination, were reluctant to share with their doctors their discomfort with the speculum and were deprived of any relevant lesbian health care information. In two cases, the inappropriate sexualization of the Pap test became the root cause of the adverse experience of lesbians. In addition, although lesbian sex was regarded as impossible, lesbians' experiences evidence that lesbians are not immune to STDs, yet, lacking the appropriate safe sex information and attention by the health care system.

4.2 The pathologisation of anal sex and its impact on gay men's access in health care

As I briefly exemplified in Section 3.3, the stigma around anal sex between men emerged as a strong issue among gay men and doctors who participated in my study. This was not a surprise given that, overall, anal sex is still considered taboo by many societies and although anal sex is a sexual activity that is neither universal among gay men nor restricted to them, people do not easily discuss it publicly (Goldstone, 1999). As Scarce (1999) explains, this is because there is a dominant scientific and cultural belief that the vagina is the only natural, healthy and normal organ of sexual receptivity in contrast to the anus which is perceived as a poorly chosen substitute for the vagina. Gay men who are receivers in anal sex are particularly vulnerable to stigmatisation as traditional meanings of masculinity dictate that only women can be sexually penetrated. Therefore, gay men who enjoy being anally penetrated are viewed as being feminizing their bodies and for that are stigmatized as deficient and deviant (Scarce, 1999).

By focusing on the findings of this study, the cultural norm that it is offensive for a man to be penetrated and its consequent homophobia appeared to be prevalent within the health care services. Such norms, for example, seemed to have an effect on the gender-specific manner in which a doctor performed the digital rectal examination to his patients. In particular, Kosmas, a 38-year-old GP, argued that while women who are rectally examined need a witness so as to feel reassured that the doctor does not sexualize the medical procedure, men need secrecy and discretion when being rectally examined. Kosmas said:

When I want to make a digital rectal examination of a woman this must be done with the presence of a nurse, for example when I suspect gastric bleeding in a woman who is 60 or 70 or 80 year old and I want to check if she has black stools, right? or something else, then I want to ensure that during the examination a nurse is present because the examination can be perceived as a sexual harassment, this is the guidance, now... if I want to check the prostate of a man , then I don't need the presence of a nurse [why not?] Why? Yes, I could also have a witness in this case too... but in this case a man may feel bad because I examine his rectum... and men do not want other people to witness this, ok, there is no guidance on this but for the digital rectal examination of a lady there is a guidance that a nurse must be always present

Moreover, the embarrassment of the majority of doctors when speaking about anal sex between men was obvious. In one case, this was explicitly verbalized by a psychiatrist who located his internalized homophobia specifically to his difficulty in speaking with his gay patients about anal sex. The uneasiness of all other doctors was expressed in implicit ways such as by lowering their voice, and/or by their nervous laughter. A GP even projected his embarrassment to speak about safe anal sex and asked me in a humorous tone: “Aren’t you embarrassed to ask such questions to doctors? Or is it just me you are asking these questions?”

Despite the difficulty of doctors in speaking about anal sex, they all identified it as the most effective medium of transmission of HIV. However, this contradiction was shadowed since most doctors appeared to believe that educating on safe sex was a straightforward process focused primarily, and often solely, on encouraging their patients to use condoms. This is why most doctors seemed pretty confident to provide adequate safe sex consultation when asked by their patients. One of the most apparent outcomes of the narrow definition of safe-sex consultation was evidenced by a doctor who seemed to compromise with his patients’ safe-sex practice of the “double-bagging” technique: that is using two condoms at the same time. Crucially, most safe-sex educational programs and information suggest this technique as counterproductive to safety from HIV, as it can cause friction between the condoms.

We just encourage them to be more alert on using a condom, you are right, there are some particular condoms for anal sex, we call them high endurance condoms, but since it [anal sex] is not very popular... anyway, the point is that they must use a condom, some even report wearing two condoms, but ok this is not something... we just must encourage them to use a condom because the danger is higher [is it safe to use two condoms?], ok, it is not, meaning that it is not recommended in the guidelines, but theoretically there are two protective membranes instead of one, but like I already told you, what we do is to highlight the danger... ok, no sexual activity is fully safe but in this case, there is an additional reason, that is they are a high risk group for HIV

For the gay men participants, anal sex appeared to be an integral part of their sexual relationships, yet talking about it without embarrassment was infrequent even only in safe from homophobia environments. None of the participants

reported being ever consulted by a doctor on safe sex or asked for it. In fact, most of the participants perceived sexual education as being beyond doctors' responsibilities and their expertise being minimal on safe sex issues. In a society that sexual education programs in schools were scarce, random and strictly focusing on heterosexual sexual intercourse, the majority of the participants, including gay men, positioned this lack as one of the most important factors that perpetuated societal homophobia and the invisibility of LGBT people. Panos' response on the matter is representative:

Whenever they came in my school to talk about sexual education they were speaking about condoms, they were talking about preventing pregnancy, about contraceptive pills, and overall the speeches of these professors, who were in fact all university professors, were clearly about straight people and straight sex. The only thing mentioned in one presentation was written on a slide of a power point, with a whole school attending there, was just a tiny phrase in a slide indicating the sexual practices: vagina sex, anal sex, oral sex, and near the word anal they had written in brackets that anal sex can be also between homosexuals, that's it (Panos, 19 years-old, gay man)

Given that sexual relationships of men were clouded by homophobia, many gay men delayed seeking medical care and/or did not ask for relevant information when they feared that their sexuality would be revealed somehow because of their medical condition. This was evidenced through the personal stories of some gay men but also reported by most of the gay activists who participated in my study (see also section 3.3). For example, Lambros, a 35-year-old gay activist who was a pioneer activist in a rural area in Greece, referred to the lack of any public interest in LGBT health issues. He recalled being many times a reference person for many gay men who asked for consultation on their health problems as they were reluctant to go immediately to a doctor.

They should pay more attention on gay health issues, a gay man has completely different health problems to deal with from a straight man, it is a matter of anatomy, and a matter of sexual practices. Bottom gay men, in particular, need different health care and have different issues of accessibility in health care, especially in terms of the health issues of the anus...but even the top gay men have the same issues, I will give you an example, a lot of young gay men came to me having a steep tear on their penis and they should visit a doctor, doctors can understand that this kind of tears are impossible to be done within the

vagina of a woman, they can tell that the penetration was held in a more narrow place, so a top gay man may have his frenulum torn by anal sex. If these men are not involved in the health sector like I am, if they are not informed on these issues or if they are not comfortable with their sexuality they will not easily deal with this, they may even not visit a doctor, they will probably not visit a doctor because they are scared that their sexuality will be revealed, so in this way they let their health problem get worse

To make things worse, Vaggelis who was also a seasoned gay activist reported that there are many gay men who are implicitly denied services by their doctors as a result of their negativity towards homosexuality. By reflecting on a personal experience, Vaggelis described going to a doctor to get treatment for an anal pain he had. In order to ensure an accurate diagnosis, Vaggelis talked openly about his sexual behavior. His doctor's homophobic response was to merely recommend he should just stop doing anal sex without giving any further explanation, advice or information on the issue. Further, the doctor blamed Vaggelis for asking for many doctors' opinion on the same health issue interpreted his doing so as a rejection of experts' views and explicitly asked him to never visit him again. In reference to others' experiences, Vaggelis claimed that gay men are refused services by doctors on the pretense that the treatment they need is complicated.

At some point I had anal pain and I went to a doctor, so I started to discuss this issue with him but I realized that he was homophobic when he said that "I am not sure what you want from me, why you came here, I can see that you have already visited other doctors as well, which means that you are changing doctors so as to hear what you would like to hear, so you don't have to come here again". From the discussions I have with other gay men the same is happening for the treatment of HPV, doctors try to get rid of the patient, they say that they don't need to visit them again or that in order to deal with their health issue they should collaborate with 5 other specialties, they need a surgeon, a gastroenterologist, a priest [he laughs] or they say that all this procedure should be held in a hospital. They present this as a huge issue which makes you think "My God! What am I going to do? Will they do anus transplantation, brain transplantation? Is all that stuff for a wart?"

Not exactly equivalent with the examples above, but during my fieldwork I myself had an experience with a doctor which is indicative of how hate speech is communicated in the health care sector. Specifically, when I started to interview doctors I decided to invite doctors working in a rectal center located in Athens. The clinic was in a modern building with huge advertising labels promising high quality services for anal healthcare. In the reception hall I was told that I should see the chief doctor and manager of the clinic first and they immediately called him to book me an appointment. The receptionist presented me as a researcher asking his participation in my study and he immediately accepted to see me in his office. I went out to his office and after 5 minutes of waiting I saw him coming with a welcoming smile. While we were still in the corridor near the waiting room of patients he asked me the topic of my study. I handed him the informal letter and I began to explain my topic. However, when I verbalized the word gay his welcoming smile vanished, he got serious and annoyed, he angrily gave me back the informal letter and I received an explicit homophobic response to my invitation: “for faggots? No way!”

Unfortunately, it is not only that I did not have the time to somehow respond as he quickly walked along the corridor and left, but also that I was so stunned and immobilized by this traumatic experience that I felt completely incapable of challenging his behavior. It was not the first time I was the receiver of hate speech. As an open lesbian social worker who lives and works in a rural area of Greece, being ready to deal with hate speech is part of my every-day reality. Yet, in a private clinic in Athens I anticipated that the market values of the clinic would ensure not only welcoming smiles for the researcher but would enforce some respect for the people I was researching too. Undeniably, I also felt that what was so brightly advertised as a site of advanced anal health care was also an abusive environment for gay men.

The raw data described in this section provide some insight into the nature of the health care discrimination against gay men which is specifically rooted to the historic pathologisation of anal sex and its restricted correlation with gay identity. The doctors' embarrassment to discuss anal sex along with the gay men's reluctance to reveal that anal sex is integral part of their sex life establish anal health care as a source of shame, misinformation and exclusion. This is also

counterproductive given that anal sex is identified as the most effective medium for the transmission of HIV. In the following subsection, the focus goes on the data illustrating the barriers of accessing health care, especially as regards HIV positive people.

4.2.1 VIP patients or contaminating bodies? The health care of people who live with HIV

In the context of societal negativity towards homosexuality, HIV-seropositive gay men appeared to be extremely vulnerable at being submitted to a health care system which reduces their human nature to their being infections. This was clearly reflected by an example brought up by a doctor who had worked many years in an Infectious Disease Clinic of a Greek public hospital. In particular, Dimitris, a 46-year-old pathologist reflected on the epidemiological interest of medicine in monitoring the sexual behavior of patients who are infected by HIV. He argued that knowing the sexual orientation and behavior of HIV-seropositive patients has no positive impact to the treatment and care of patients other than providing facts to epidemiology so as to maintain some ability to control the disease. Nevertheless, the example below in which a doctor appears to treat his patient unethically and violently by lying on important health information is a clear illustration of what many commentators have argued that the “war on AIDS” has often been meant to be a war on people who live with HIV/AIDS (Waldby, 1996). Moreover, drawing on Waldby’s (1996) arguments on the structural violence of biomedical practice in the field of HIV/AIDS, the quote below from Dimitris’ interview is also indicative of how the power to govern is often presented as a power to heal.

One day at a conference a colleague told me that there was a manager who was trying to make gay patients reveal their sexuality by asking them “tell me if you are homosexual or you have been infected through blood transfusion”, all patients say that they were infected through blood transfusion, “tell me if you are homosexual because I will give you the appropriate pill for homosexuals, otherwise I will give you the appropriate pill for those who are infected through blood transfusion”. This is unethical but this is what he used to do, and the patient would say “ok, I am not homosexual but sometimes... I do

this... as a top of course”, and the manager was saying that it doesn’t matter if someone is top or bottom and that it is the same thing, so the patient confessed that sometimes he was the receiver” (Dimitris, 46 years old, pathologist)

Furthermore, the quality of services to HIV-seropositive patients appeared not to be affected only by cultural ideas on sexuality. Ideas on social order and justice appeared to be equally absorbed in the health care system despite allegations on the principle of political neutrality. A typical example was the HIV “witch hunt” which emerged during 2012-2013, perpetuated by the state and the complicity of the Hellenic Center for Disease Control & Prevention (ΚΕΕΛΠΝΟ), which allowed forced HIV screenings (see also section 1.3).

In a more silent way, HIV-seropositive gay men, during the so-called economic crisis, started to be portrayed as unfairly privileged patients that enjoy a disproportionately large disability allowance at a time when the Greek society suffered from poverty. This was despite the fact that changes of the statutory regulations that prescribed the assessment and determination criteria of what constitutes disabilities excluded many HIV-seropositive people from being eligible for the disability allowance. In the following excerpt, Ariadne, a pathologist reflected on her experience of working with HIV-seropositive gay men and her difficulties at communicating with these patients. By referring particularly to her patients who were HIV-seropositive gay men, Ariadne argued that they usually had an overtly aggressive behavior that made it difficult and unpleasant for her to deal with. Ariadne believed that the root cause of her patients’ aggressiveness was the double stigma of HIV and homosexuality attributed to these men and the fact they lived with a chronic and serious illness. However, she also expected that HIV-seropositive gay men’s behavior would be different and more “easy-going” if they regarded themselves as financially privileged:

They were aggressive; they had a yahoo attitude, a strange thing. And the excuse I gave is that it is because they have a very serious health problem. Although this was true only for few years ago, because nowadays the medicine that HIV-seropositive men take, gives them the opportunity to make plans for their lives. It is completely different to hear that yes, you have an illness but it is highly possible that in the

next 30 years nothing bad will happen to you, right? So, if you also consider that in this time of economic crisis, and this is very important, when you have your financial living solved, because HIV-seropositive patients take the welfare benefit of 700 euros, it would be good if they calmed down a bit and see what is happening around them. Inwardly I believe that their behavior is a matter of the disease. They are chronic patients and confessedly, with an illness which is stigmatized, and if you add to this the fact that, in my opinion, within the gay community there are only a few men who can truly get along with themselves, all these things make a very strange thing

Not surprisingly, Michael felt being one of the ‘disliked’ patients as a HIV-seropositive gay man on the basis of the “privileges” he enjoyed like the disability allowance he was eligible to or his being treated more carefully in the health care system. Michael interestingly described HIV-seropositive patients as “VIP patients” as they enjoyed high quality services in comparison with other patients. Michael argued that the quality of health care services for the HIV-seropositive patients in Greece are so advanced that patients do not have to wait or pay for any medical treatment they need, they have the absolute priority on appointments with doctors, their health is highly monitored and they are notified for preventive tests they need without having to remember any of these for themselves. Nevertheless, by reflecting on his experience as an activist, he recalled numerous incidences where HIV-seropositive persons were systematically denied services, mainly by dentists but also from other doctors who do not work in Infectious Disease Clinics. He also commented that gay men who are HIV-seropositive search more often to find HIV-friendly doctors rather than gay-friendly ones. Not surprisingly, Michael himself actively resisted being reduced to a diagnostic category in health care settings by resisting the frequent public exhortation to reveal his HIV diagnosis.

Despite the fact that it is super good, I always feel this insecurity. In the last four years I have visited EOPPY a hundred times because my ears are completely fucked up. I suffer from otitis 7 times a year, and I never disclosed that I have HIV to my unlikeable doctor. I will never disclose it to him! I didn’t even when the seventh time I went to him he said: “But how is this possible? Why is this happening to you again and again?”. He will never know because he doesn’t have to know this. My

doctor and I will determine if the antibiotics that this doctor will give me are compatible with my medication or not and that's all. And I don't give a shit! He is unpleasant, an old dirty man, I hate him! Good bye! Leave me alone! And if I had the money I would choose another doctor, so, yes! I just use him to live a bit better and more decently [...] there are many HIV positive persons who want to disclose their HIV status to their doctors, I am not sure why, maybe because they have an issue, maybe because they want to be fair and honest, others because they care too much for their doctors and they don't want to impose him to a risk. I am more cynical on this and I believe that a doctor should be attentive 100% with all of his patients, and he must always have a clear judgment, this is not my problem. But even among those who share my opinion there is a wide variety, it is like an accordion, there are some people who are very absolutists on this issue and others who are more flexible... it depends, each person see it differently

The exclusion of HIV-seropositive patients from health care treatment was also witnessed by a doctor who had a long experience at working in an Infectious Disease Clinic. Dimitris particularly argued that HIV-seropositive patients postpone or even miss out surgical treatments as a result of being denied the health care services by surgeons. Dimitris in his own words said:

What is difficult for an HIV positive man is to ask from a surgeon to operate him. Namely, even for small issues like a cholecystitis, they have a huge problem if other doctors know that they are HIV positive. The surgeons deal with them in a very negative way, many patients are banned from surgeons, and they don't operate them because many doctors are still not familiar with it

The data above provide further evidence of the exclusion of HIV-seropositive patients from health care services which has also been confirmed by the Greek Ombudsman with a report released in July 2007. The report refers to 13 complaints of HIV-seropositive individuals within a two-years period, 7 of them being related to denied health care services including emergent ones (e.g. coronary angiogram after ischemic stroke), 3 cases related to breach of confidentiality, HIV testing of a patient without his consent, inappropriate announcement of HIV test results and one case of being fired from the Army Forces after the announcement of seropositivity to HIV.

In a context where there is a complete lack of systemic actions for the implementation of anti-discrimination policies in health care, it is reasonable to believe that the numbers above undervalue the actual frequency of such discriminations towards patients who live with HIV/AIDS. Such an omission can also be counted as an important structural barrier that definitely prevents patients from pursuing formal complaints thus exacerbating their fear to be further victimized and bearing the consequences of the power imbalances between patients and staff. In addition, the HIV/AIDS stigma and patients' fear to reveal publicly their HIV/AIDS status, makes them be hesitant to participate actively in the elimination of such discriminating practices.

Against this background, the introduction of the Public Health law 39A in 2012, which imposed mandatory testing for HIV and other sexually transmitted infections for high-risk groups, became the fertile ground for voices from within the medical community to advocate for surgeons' right to know the HIV/AIDS status of each patient prior to any surgery. In the same period, Georgios Androulakis, a professor of surgery, publicly advocated for the mandatory inclusion of HIV testing to patients' pre-operational checkup (Androulakis, 2012). He supported his argument by referring to a story from his experience as a surgeon, which he defined as a counter story of that of the public humiliation of HIV seropositive women. In his story, a patient was administered in a private hospital and was provided a pro bono surgery after a request of the Orthodox Church. During the surgery a health professional was injured and the hospital decided to test the patient's blood for infectious diseases. The test result was positive for HIV and they determined that the patient was already under an antiretroviral therapy. The patient appears to leave the hospital only a few hours after the surgery due to his fear that his secret might be revealed. In the article the patient is characterized by the author as a pathetic and unfortunate fraud that had deceived all the people involved, including the Church. The author in his own words describes:

With surprise but also with affliction we found out that the patient was suffering from AIDS and he was in fact under therapy. After a few hours the patient escaped the hospital, because he probably suspected that we knew, and we never learned his real name as he

had provided us with false information. Namely, he was a pathetic and unfortunate fraud. As expected, the Patriarchate was not aware anything about all this, it was a victim of this person.

By referring to the same article, Michael, an HIV activist, appeared to interpret the author's argument about the mandatory HIV testing differently. He particularly said that the author was actually motivated to stand on mandatory HIV testing because of the catastrophic economic crisis in Greece which has led hospitals to be unable to maintain good standards of safety for health professionals. He also recalled the Association of people living with HIV "Positive Voice" to have reacted furiously on the article but when discussed in a forum with other people who live with HIV, opinions varied significantly. Michael explained:

Positive Voice NGO was FURIOUS with this article, absolutely FURIOUS! But when this subject was discussed in one of the «Me and HIV» forums, not all people had the same opinion. This is why many ask for an HIV friendly doctor because they want to be open about it, which is something beyond me. I said it only to the doctor that diagnosed me, which was actually the person who told me in the first place. And when I go somewhere else and I am asked "why are you taking this test that old ladies do?", if I see a friendly face, then I might say "because I have HIV" [...] But apparently there are many seropositive people who want to disclose it. And I think that as it usually happens with other controversial issues, every seropositive person has a different opinion about it. For some, it is matter of honesty, other may be considerably caring for their doctors and they don't want to put him/her in danger. I am from those very cynical who argue that every doctor must always protect himself/herself 100% every time they see a patient

Disclosing the HIV status only to a "friendly face" appeared to be a decisive factor for disclosure even for Michael who firmly supported that it is the doctors' full responsibility to take safety measures not only against possible contamination from HIV-seropositive patients but from all patients without exception. Nevertheless, the usual stories circulating within the gay community involved panicked health professionals who insensitively humiliated, abused, and breached the rights of HIV-seropositive patients. One of these stories was described by Paul, whose ex-partner was diagnosed with HIV. In his description Paul mentioned that doctors did not take their patient's consent in order to take the test for HIV but instead it was presented as a necessary pre-operation

checkup. Although Paul was happy that he was allowed to be present by his partner's side, he was not the only one allowed in the room when they received the information about the diagnosis. Paul described that the room was full of other patients and doctors, and along with the diagnosis the patient received nothing but nonverbal messages by staff that he was an educational course for doctors and an infectious body that could put others at risk.

The way that he was informed the diagnosis of HIV, the way in which the nurses behaved, everything was completely unacceptable! Ok, afterwards the attitude of some doctors was fine, but at first... for example, he was lying in bed and suddenly 10 doctors came in because the head of the department brought them... they were trainee doctors. I am not sure why he brought them in. To show them how to inform a patient who was just diagnosed with HIV? To let them see how he would react? I am not sure why he brought them. This was completely inappropriate right? So basically he just told him without any privacy, without any support, NOT AT ALL! And I saw the others just watching a man whose rights were violated, and they were taking notes... of how he reacts? I am not sure. I just cannot understand it. And afterwards the nurse brought him food by wearing gloves and by keeping distance.

The fear of health care providers to not be infected with HIV was experienced even from an 18 year-old-youth who just asked an HIV test as part of his worries about healthy sex. His claim for the test transformed him instantly into a possible carrier of the virus and he experienced the HIV-stigma through the touching fingers and eyes of the health professionals in the room.

Everyone was staring at you, not because they think you are gay, but because you may have this [HIV]... much racism all over the place, even the doctors are looking at you strangely, they touch you strangely

Not surprisingly, the majority of the participants declared they have never been asked for an HIV test in a public hospital because of their fear of inappropriate treatment. Instead, they would go to well-known private diagnostic centers or those related somehow to gay activism preferred to have HIV tests in "Checkpoints" which are the HIV preventive centers founded by "Positive Voice".

Some doctors also affirmed that because of the HIV-stigma they are reluctant even to recommend their patients be screened and that patients have stopped visiting them because they were recommended doing so. In the description below, a doctor who worked in a public health center in a rural area in Greece highlights the extent to which worries about confidentiality, particularly in rural areas, play a significant role in patients' decision not to be screened for HIV.

A man had come here who was suffering from various infections all the time and because I had taken his sexual history too and he was... he was straight but he was very... namely he didn't take any precaution or anything ... so at some point I directed our discussion to... you know I told him that we should also examineah... he instantly got completely shocked, and of course he never came back again. Although I subscribed him the test, and although I tried to explain him that just because we are talking about these things it doesn't mean that you are infected, and I explained that I just wanted to have a picture of his profile, he never came back again. I have no idea what he did after that, he might have gone to Athens to take the test, you know because here we are such a small community.

Worries related to confidentiality appeared to be not easily allayed in health care settings since the latter were strongly associated with HIV stigma and other social forces. One of the stories a participant shared was particularly relevant to illustrate the consequences of the intersection between structural homophobia and structural stigma of HIV within a health care environment. Elias was an openly gay nurse working in an infectious diseases clinic of a hospital located in a provincial area of Greece. His description below is a clear illustration of how challenging the working environment for an openly gay health professional can be when there are no clear anti-discrimination policies for patients and employees, and no efforts for training to address issues of sexual orientation and gender identity within health care environments. Elias was in a position to constantly experience how his sexual identity inevitably interacted with both homophobia and HIV-stigma. His sexual identity was often emphasized over his professionalism in covert ways by his superiors thus experiencing his gay status to be used as the basis of allegations of unprofessionalism. Not surprisingly, within such an environment Elias asked to change duties.

I felt bad at the beginning, I suppose they [the HIV-seropositive patients] were feeling bad too when they happened to know me from a club or something, e.g. they were familiar with my face, there were people whom I knew and of course when they saw me they left, they just left the hospital, of course they returned because they had no other option. But it was a shock for them because they believed that I could spread their personal data publicly, which never happened and I would never do this to anyone. But I was scared too. I was scared because I was openly gay and if something would go wrong with them I would be the first to accuse. It happened once and I was in a very difficult position. A doctor once accused me of spreading a patient's personal data. And I told him that this was a lie and I would never do this, and I told him "but who is he anyway? You can't protect him and leave me unprotected" [...] Because I was gay myself I was very comfortable with them, and I was caring for them too, although I was accused for this by a colleague too, he told me that I treat these patients better in contrast with others whom I don't treat very well... ok... eventually nothing happened, although he was superior to me, a manager, but ok nothing happened

4.3 The pathologisation of trans bodies and its impact on trans persons' access in health care

In this section, by following the presentation of some raw data on participants' experiences I examine some important topics explaining the practices and the structural omissions that prevent their access to health care. The topics are grouped in two subsections: a) the transition related medical care which is important for trans persons' effort to live their bodies as they choose, b) the quality of general health care provided in trans persons in primary or secondary health care settings.

4.3.1 Transition related medical care in Greece

The most crucial issue of healthcare access of the trans participants was the unavailability and the cost of gender reassignment treatments. This situation elevated trans participants' stress as all of them struggled for recognition of their innermost self and they wished to modify their bodies so as to express this inner authentic identity. As has been argued, the lack of adequate transition related

medical care subjects most trans persons to misrecognition both by others and by themselves, thus constituting a cruel form of oppression (Rubin, 2003). Nevertheless, this form of oppression is rarely acknowledged because transition is often misconceived as a form of transformation. Against this popular myth, trans persons do not change during transition but instead they come closer to who they are at heart as they repair the link between their bodies and their gender identity (Rubin, 2003).

The number of physicians who provided Hormone Replacement Therapy (HRT) which most of the trans participants desired, was extremely limited. According to all trans participants' accounts this was because the majority of the endocrinologists usually denied to offer such services while they were regarded to have the exclusive specialty to provide HRT. In fact, during the whole period of my fieldwork in Athens, there were only two endocrinologists that I recorded in my field diary. One of these doctors worked in the public sector and prescribed hormones if she had a letter of recommendation from a psychiatrist. Trans persons reported that when this particular endocrinologist was out of duty, their appointments were cancelled as the other endocrinologists of the hospital indirectly refused to see them by saying "you had better see Dr. Melou". The second endocrinologist worked in the private sector and she provided hormones without the necessity of the letter but her reputation was somewhat questionable as some trans persons expressed their concerns that she does not maintain safety standards for hormone dosages. Moreover, two of the participants who had asked for a HRT by randomly chosen endocrinologists were denied treatment as doctors asserted that they did not have the appropriate training. According to the participants' accounts, doctors did not provide a referral, which made participants once again seek this information through their network within the trans community.

Consistent with what has been reported by Alleyn and Jones (2010), doctors from varied specialties also appeared to actively discourage participants to start HRT or surgical reassignment. In the example below, Jason's experience is indicative of the ways in which lack of awareness of protocols related to trans health issues, especially when combined with transphobia, adversely affects trans persons' health care experiences and impedes their access to HRT:

My homeopath was pretending that she was supportive to me, she was prescribing medicines in a male's name since these medicines are not covered from my health insurance anyway but she was speaking to me with a female pronoun, for example I was with my mother there and she was saying "Girls" and I was thinking that either I would blow up and she will be scared, either I will ignore her and I will visit her rarely or I will try to make her understand somehow... but eventually she couldn't just get it and she used the wrong pronoun all the time. In addition she tried to scare me about the consequences of hormonal therapy, maybe she did this because she wanted to keep me as a patient but she didn't completely agree with the trans condition (Jason, 18 years old, trans man)

When I raised the issue of the unavailability of trans related medical care to the endocrinologist that participated in my study, his response was revealing. The role of structural transphobia and the commodification of health care as barriers in accessing transition seemed to mostly affect the related medical care. Thanos in particular declared being confident, knowledgeable on providing HRT and he was experienced at working with trans persons' transition related medical care. However, he admitted that he would not provide such services from the point he started working in private practice as he feared that he would lose his cisgender patients if they noticed that they are served by the same doctor who equally provides services to trans patients. He also believed that the underlying reason why his colleagues who are in private practice refused services to trans persons was the same whether they felt confident with their competence on HRT or not. Thanos said:

I will tell you what is happening... I believe that to this story it is really the prejudice which causes the whole harm. Because, although as a person, as a doctor, I have no problem to take care of them, to support them, but to do this in my private office? Do you know what will happen if people like this come here? Do you understand? The same goes if a prostitute comes here. You understand that the patients who are in the waiting room will be surprised, right? And as a professional I also look the numbers, right? Because I also have a family to feed, so automatically I become more conservative. I am lucky and I have the luxury to be also in the context of the university, so I would ask them to meet me there so as to take care of them more properly. I believe that

doctors in private practice discourage them. So far, it has never happened to me... I am not sure how I would react in a case like this... I think I would ask them to visit me in the university so as to get out of the predicament. But here, no way, do you understand? There are conservative people, old women who come here for their diabetes, and I have no problem with them but as a professional I also don't want to be provoking. I don't want to be provoking, right? Because I don't want... these people pay their visits right? I earn my bread and butter this way; can you understand what is happening? So... beyond that, in terms of the appropriate health care of trans people I think that it is also because these people, namely from my short experience, these people can never escape the logic of marginalisation. By contrast, I have seen that trans people abroad manage to get out of this, they manage to integrate, namely there is total acceptance and inclusion

Interestingly, Thanos was one of the very few doctors who strongly argued that there is nothing inherently wrong with being a transgender person. He believed that endocrinology provides the adequate knowledge and medical experience for a doctor to acknowledge the diversity of the human organism which makes impossible the existence of the binary of two sexes and genders. Yet, his blunt admission that he would deny to provide HRT in his private office undoubtedly constitutes a direct discrimination against the trans community and explains how the exclusion of trans people of the institutional world is structured.

All participants encountered serious difficulties in obtaining safe access to hormones. Despite the distress caused as a result of delayed access, all but one of the participants started taking hormones only when they had found an endocrinologist who was willing to provide the hormones under a regular monitoring of their health. Even Fanie, who had initiated hormones without being monitored by a doctor, eventually decided to find an endocrinologist in order to ensure safe dosages and protection from negative side effects. Nevertheless, two participants reported the circulation of hormones within the trans community as a form of solidarity to those whose options for getting access in HRT is considerably restricted. For example, Jason recalled being offered access to testosterone by a friend who had somehow ensured access.

If a child's parents are transphobic this will be dangerous for their child. It will be dangerous for this child to transition in a home like this. I believe that all children should have the ability to start their transition so as not to end up in the illegal and unsafe ways of obtaining hormones. A child may take uncontrolled dosages of hormones if s/he doesn't have the opportunity to be medically monitored. Namely, a child's exclusion from transitioning just because his/her parents disagree is the worst thing you can do. This is because the child can communicate with other trans persons who have the appropriate connections, s/he can easily find hormones, they can even give her/him their own hormones so as to help this child [has this ever happened?] I had a friend who volunteered to help me... he had access... that's it.... Overall, it is dangerous to exclude someone from health care, very dangerous, I suppose you already know this, this is your study all about, I believe you understand this (Jason, 18 years old, trans man)

Jason identified the trans teens who have not reached the legal age of 18 or those who have not secured the support of their families to be particularly important in making vulnerable in that they are made to get hormones through informal networks. This appeared to be linked with the tendency to withhold hormonal treatment particularly when it comes to trans teens therefore contributing to their psychological devastation as they experienced the full effects of their genetically and gonadal-determined puberty.

In addition, the shortage of available transition related medical care in public health care settings made trans persons feel considerably prone to exploitation as they allowed doctors to take advantage of their need to live their bodies as they wished and make profit from it. All interviewees and other trans persons with whom I spoke during my fieldwork declared being exploited by a doctor in private practice at some point in their lives, a psychiatrist, an endocrinologist, or a surgeon who provided follow-up medical care after sex reassignment surgery. For example, some trans persons reported being exploited by psychiatrists who maintained both a position in the public sector and a private office. My informants were promised a letter of diagnosis for gender dysphoria, stamped by the public organisation only if they agreed to pay private visits in doctors' private offices. Moreover, the private visits often exceeded in number what was initially agreed. Such experiences were devastating particularly when the quality of the provided

services was poor and the financial cost high. By referring to a friend who had phalloplasty by a doctor in private practice in Greece, Jason said:

You must have a lot of money to have phalloplasty, there is a doctor who is completely transphobic, he has a very nasty behavior, and he is asking whatever amount of money he wants from each person individually according to how much money he perceives each person has or how much desperation he detects. He is a private doctor of course. There is no doctor in public hospitals in Greece to perform such surgeries. And he performs terribly! I have seen it to a friend of mine , but he doesn't admit this because he says that all bodies are acceptable and that trans bodies don't have to be like the bodies of cis persons which is something that I agree, I completely agree, but this doesn't change the fact that the doctor has done a terrible job. What can I say? He has caused a huge scar! The stiches had opened up because he didn't stitch correctly. So, my friend had a fight with the doctor, he doesn't feel it properly, he feels numbed in a particular area, he didn't perform well, it is different to operate and it is different to slaughter someone. As far as I know this doctor doesn't perform good phalloplasties. Get away from him! (Jason, 18 years-old, trans man)

In a similar vein, Melina recalled being misdiagnosed by a doctor which made her travel to London so as to make sure that she could have an appropriate treatment for her health condition. Her dissatisfaction was associated to the unnecessary travel cost as a result of being misdiagnosed but also because she felt that the underlying motive of the doctor who examined her in Greece was the profit he could made by her. This suspicion was triggered by the fact that the doctor suggested an aesthetic surgery while he was also asserting that Melina's health was at risk by a serious postoperative complication:

After I had my surgery in London, I needed a simple check-up and I visited a doctor here for whom there is a kind of rumor that he performs such surgeries and this stuff, but I visited him for just a simple check-up and he told me that I needed to have an additional surgery because I wouldn't be able to piss in a week, so I was forced to travel to London to have a check-up by my own surgeon and I finally had nothing to worry about, so he did this just to make money out of me. He took me 60 euros, ok, nobody examines you for free but he also told me that we should also do something about the way it looks, bullshit! I don't give a fuck about how it looks, I just wanted to be ok [...] I was panicked and I said that instead of being operated by this slaughterer, it is better to travel in London (Melina, 29-years old, trans woman)

Except the multiple barriers to transition related medical care that were described throughout this section, the participants in my study reported barriers in all other aspects of health care, that will be discussed in the following section.

4.3.2 The primary and secondary health care of trans persons

All of the GPs and the pathologists who participated in the study declared being unsure, unprepared, or simply not aware on how to provide optimal preventive health care for trans individuals. The gynecologist declared to have never met a trans person before. He asked me whether I actually met trans persons during my research and, he wondered if I could notice that they are trans and if I saw trans women to have actually succeeded on developing big breasts.

To make things worse, when I invited Lucas, a 56 year old pathologist, to think about the possibility of encouraging a trans woman to have preventive health care for prostate cancer, I received one of the most explicit transphobic responses. Lucas immediately mocked my question as he depicted himself walking along a hospital corridor and asking patients to find out if they identify as trans. While he was speaking he never stopped laughing and his response was fueled by transphobic ideas and stereotypes about trans persons, including that sex is the only interest they have in life. He also used a male pronoun although he was referring to a trans-woman:

I can't go out and ask «who is the trans?» (he laughs) to ask him whether he has removed his prostate or not? (he laughs), he must come to me and say that he has a prostate, because if he has this gland he may be at risk of cancer... but has he ever thought about his prostate? (he laughs), he will probably think of other things, other things are in his mind [...] I can't ask a person «have you removed your prostate?», because if I ask this question I may be punched

As has been widely reported, the institutional indifference towards trans identities in the health care system was prevalent in the Greek context as well, fueled with transphobic ideas and gender stereotypes. The latter seem to be partially perpetuated by the lack of an incorporation of transgender health into medical school curricula or any other training on trans issues (Cruz, 2014, Alleyn and

Jones, 2010, Bauer et al., 2009, Namaste, 2000). One doctor clearly identified that the reason for this omission was rooted in the injustices and power dynamics, which in turn derived from the differences between minorities' interests and the interests concerning the dominant majority.

Not surprisingly, most of the trans participants felt that they were sources of information through whom health care providers could learn about gender identity, transition and trans persons' needs. This supports and adds to the findings of Grant et al. (2011) and Namaste (2000) who showed similar results. Fanie's account is representative on this respect:

Doctors don't know anything about us, they are informed by us individually, for example, my gynecologist didn't know exactly how to behave, this was the second one, ok, I dismissed the first one because when I first had a colposcopy she told me "Ah! It is like if it is a real one!", and at this moment I just wanted to punch her. I was with my legs open, the speculum inside me and she told me "Ah! It is like if it is a real one!". It is very bad to not feel safe a moment like this, the doctor I visit now is pretty much ok but I had to explain her that I don't have cervix because my vagina is a stunt in its edge, it is just like a reversed sock, but I can still develop HPV [...] doctors have no idea on these issues! They may even deny to do a colposcopy by saying that since your cunt is not real you don't need one, or to a trans boy I knew, his doctor invited him to give him a Pap test but in a completely unsafe environment, for example the doctor was speaking to him in a female pronoun

Overall, the trans participants were willing to educate their doctors as long as they were treated with a sense of understanding, respect and when they sensed that their doctors made efforts to change inappropriate language or familiarize themselves with the appropriate terminology. The pervasive lack of awareness in relation to appropriate preventive health care, made trans participants rely solely on information gained through their network, that is within the trans community and through internet resources whose credibility was sometimes questionable. The trans activists themselves were trying to control and limit the circulation of inaccurate and invalid health-care information within their groups. By elaborating on this matter, Fanie who was a seasoned activist argued that trans individuals

who maintain close ties with the trans community are well-informed not only about transition related health issues but also about the preventive health care they need. Nevertheless, the health information sought by participants through the trans community was mostly related to their transition. Other aspects of their health care appeared to be less frequently discussed, and as a consequence trans participants appeared to be less informed on issues such as the preventive screenings for genital cancers. The factors that appeared to construct this reality can be associated with: a) the lack of health promotion activities to the trans community, b) the doctors' discomfort to recommend screening particularly to their trans patients, b) the experiences of transphobia within health care settings which made trans participants to avoid medical care, d) the fear of inappropriate and transphobic management of the examination by the health care provider.

In the following excerpt, Melina's response on whether she had ever thought of having a Pap test highlights the need for the development of effective strategies that aim to increase the delivery of preventive services to the trans community:

Basically I do not have a checkup very often, it has been a long time since I had a checkup, I don't know exactly... even on this issue I don't really know exactly what to do [what do you mean?], I mean that I don't know.... I don't know to which specialty I must go... namely... because of my nature I am not sure to which doctor I have to go, so I guess just because I have a complete ignorance on this matter... you know, I am bit confused... normally, I must visit a gynecologist. Look, I have completely neglected this issue, I've never had a checkup. To be honest I don't even know if I will have to tell the doctor that I had a sex reassignment surgery, I don't even know if he will be aware of this.. What can I tell you? I don't know.. this issue is a bit confusing, I got confused now (Melina, 29 years-old, trans woman)

Melina's experience demonstrates that trans persons are left unsure whether they need to have to gender-specific examinations or not and are discouraged by the lack of health information promotion that concerns to them. In several instances, however, physical examinations made some participants feel uncomfortable anyway. Their discomfort was exacerbated by their fear that the medical examination might turn to be traumatic as a result of transphobia. Andreas' words are representative on this respect:

I've never had a Pap test and I will avoid having one because I am afraid that I will have to deal with tremendous transphobia, so this will be very awful to me. Maybe I must find a particular person to do this, but at the moment I don't think about this (Andreas, 23 years-old, trans man).

Unfortunately, Andrea's fear was also confirmed by all the rest trans participants' health care experiences. All participants provided ample examples of being treated in a transphobic manner by health care personnel including: repeated and/or deliberate misgendering, insensitive, indiscreet questioning on transitioning and sex-related body parts, staring and facial expressions of disgust, verbal brutality and expression of transphobic ideas, harsh and rude behavior, deprivation of support in hospitals, and direct denial of health care services. Despite the fact that some of the above types of discrimination seem to be less serious than others, it is impossible to differentiate the impact of discrimination on the life of trans people. As Riggs (2014) argues, this is because all of the aforementioned ways in which transphobia is enacted can be positioned on the same continuum that is shaped by normative gender binaries as they relate to embodiment.

The trauma of transphobic language and/or attitude was devastating for trans participants especially when this was communicated during a medical examination, which often entailed their voluntary physical immobilization. In the example below, Jason describes how the experience of transphobic and homophobic language used by dental health professionals though communicated in an impersonal way resulted in his decision to opt out from orthodontic care that was already fully paid and postpone the treatment of a dental health problem. Jason said:

I also visit an orthodontist, I had braces on my teeth and now she sees me once every year, but now I don't want to visit her again. I have changed, my voice has changed, my face has changed, and overall I have changed, but she doesn't know it... and she is not very comfortable about it, I have heard her making homophobic comments, I don't even discuss her transphobia. A similar thing has happened with my dentist, one day she was speaking about men who are totally perverts and they cut their balls, and she was saying how bad this is,

how dangerous this is and that one can die from bleeding, and I was under oral sedation with my mouth open and I was thinking “why is she doing this? Since she is so nice! So nice! She has no empathy! Nothing!”, as if they are doing this for hobby, as if they say “how can I spend my time tomorrow? Ah! Lets’ cut my balls!” [he laughs]. She was nasty! Yes... and now I am scared to visit her, one of my tooth hurts but I don’t want to visit her, I postpone it

Other participants described examples where the transphobic language used by the medical personnel was clearly intended to offend them personally. Fanie, for example, was insulted by an intern hematologist when she visited the blood donor clinic of a hospital in order to donate blood for her aunt who was about to have a surgery.

She [the hematologist] was filling out a card, she was asking and I was answering, so when she asked me whether I had sex with a person of the same gender in the last 12 months I got stuck for a second so she asked me “yes?” and I said that it is complicated, she initially pretended that she believes me and she made me believe that I would give blood anyway, so she continued ‘fishing’ but in a very nasty way, she told me “what do you mean complicated?”, so I told her I was a trans woman and I was dating with a woman, I told her that I was born a man, I told this in this raw way so as to help her understand, and she said ok, so she went to the Steward’s Office and when she came out she told me that the Steward wanted to speak with me. I went to her office and she told me that I couldn’t donate blood because they don’t accept homosexuals. I tried to explain her that except the fact that this is an outdated guide I wasn’t homosexual anyway and her response was “You had better try to understand first what exactly you are and then you come here and preach us or give blood. We will give your aunt a blood bottle and go away from here”. She told me this like if she was doing me a favor, like if I had asked her a favor... namely I left from there and I was trembling, it was awful

In this particular instance of discrimination, Fanie’s status as a woman was questioned immediately once she identified as trans. Despite the fact that Fanie stated that she is dating a woman it appears she was steadily misperceived by the medical personnel as a gay man. Unavoidably, this subjected her further to the medical policy that views gay men’s sexual behavior as a priori a risky behavior for the spread of HIV infection. Fanie’s story is just an example that indicates the arbitrary and incoherent nature of the policy that determines blood

donor eligibility. Given that all prospective blood donors must sign in the donor cards that they never had a homosexual relationship since 1977, it was not a surprise that the majority of LGBT participants felt that they are needlessly banned from blood donation programs. Fanie's presence in the blood donor clinic highlights the problem of the structural conflation of sexual orientation, sexual behavior and gender identity. However, Fanie was brutally characterized as being "flawed" and on the basis of this characterization she was directly dismissed from the donor blood clinic.

The data from my interview with Margarita, a social anthropologist who worked in an NGO which provides housing and social support for asylum seekers and immigrants, is also revealing of the inhuman treatment of trans persons with an immigrant or refugee status in health care settings. Margarita described an instance where the NGO was about to provide housing services to Ameera, a trans woman refugee from Pakistan. Ameera had to provide an entrance health certificate to the NGO and Margarita accompanied her to a public hospital so as to ensure that language would not be a barrier. Margarita argued that Ameera was constantly bombarded with transphobia from the moment they were sitting in the waiting room till when Ameera was physically examined by a doctor. She also believed that particularly because of Ameera's refugee status, health care providers and other patients in the waiting room unproblematically expressed their transphobic emotional impulses as if Ameera was not able to understand the non-verbal signals of hostility and disgust in the same way that she would even if she was able to understand Greek language. In the following excerpt Margarita describes her effort to provide some safety to Ameera from transphobia in the waiting room:

I was sitting next to her all the time, I was trying to chat a bit so as to help her feel more comfortable, but she had her head down all the time, and she was moving her hands all the time, she didn't raise her head not even for a second, she obviously could sense how others were staring at her and she was feeling very uncomfortable. She was sitting on my left side, I was sitting in the middle, and there was a woman who was sitting next to me. This woman was staring so shamelessly! I was putting my head in front of her so as to stop her from looking, or I glared at them to mean "why are you staring like this?"

Margarita argued that the health care providers not only did not intervene to ensure some sense of safety to Ameera but their own attitude was totally transphobic, insensitive and unprofessional too. According to Margarita's account the nurses were staring at Ameera in the exact way as other patients did in the waiting room and they were making questions out of curiosity about Ameera's gender status, which was irrelevant to her medical treatment. She also explained that the doctor who examined Ameera showed her repulsion toward Ameera's body and her voice tone was totally hostile. In her own words Margarita said:

When it was our turn, we entered the room and the nurses were looking curiously, and they were nodding me "what is this?".... and the woman who delivered the Madhya vaccine... I am not sure if she was a doctor or a nurse... she was very curious, she was the head of the clinic ... she was asking me "what sort of case is this?", she wanted to learn anyway... and I told her that I cannot provide all these details in front of my beneficiary, so she took me a little bit farther and asked me questions that would not make any difference to the whole process. She was just too curious and she wanted to learn [...] The doctor was treating her as a miasma! As if she was despised to touch her, she was speaking to her curtly and abruptly without any sensitivity, and with the same insensitive way she told her to undress

Another aspect of transphobia within the health care settings was trans persons' isolation in single-bed rooms when hospitalized. Although it has been reported by Schweitzer et al. (2004) that patients treated in single-bed rooms are more satisfied with their care than those in multiple-bed rooms, for some trans participants their admission to a single-bed room was experienced as a form of ostracism. Melina, a 29-year-old trans woman, was hospitalized in a General Hospital so as to have a planned weight loss surgery. At the time, Melina was in transitioning and she would later proceed in a sex-reassignment surgery. With these two surgeries Melina was hoping for a new beginning in her life after a long period of feeling uncomfortable with her body. When she was admitted in hospital, her doctor decided to assign her a single patient bedroom a hospital floor completely irrelevant with her health condition. The doctor justified his decision on the basis that Melina's presence in the hospital would cause a scandal:

It was prior to my sex-reassignment surgery, he [the doctor] thought that since he could not admit me neither to a men's clinic because of my appearance nor to a women's clinic because of my ID, he put me in a separate room.... This was not nice.... He said to me "don't you know that it is going to be a scandal?" I was not in the mood to go through all that because prior to the sex-reassignment surgery I had been emotionally very bad and I just accepted this [...] he could just put me in the women's clinic and he could write something with a note, to make something unofficially, it wasn't something terribly difficult, but it is exactly what I am telling you that people do not understand that trans women are women, most people, even those who are supposed to be fighting for human rights

Although Melina felt her assignment in a private room as a form of discrimination she did not complain as she felt too vulnerable to do so. It also appears that her disempowerment was held also by the fact that she was completely excluded by her doctor to participate in the decision of her room assignment. The guide for hospitals on best practices for the care of trans patients, produced in 2013 by Lambda Legal and the Human Rights Campaign Foundation in US, clearly indicate that the failure to grant room assignments to trans patients in accordance with their gender identity is a form of discrimination and an important barrier in access to health care. In addition, although the guide provides the option of the assignment of trans patients in single-rooms this should be provided only on demand by the trans patients themselves.

Similarly, Andreas, a 23-year-old trans man, when hospitalized for a night he had an accident, was assigned in a single hospital bedroom. Although Andreas noticed his isolation he believed that doctors reasonably decided this given his excited behavior which would unnecessarily disturb other patients. The issue of trans patients' isolation in single rooms when hospitalized was also raised by a couple of gay activists. One of them identified this practice clearly as a form of blatant discrimination and the other justified it on the basis that this is a usual practice given that hospitals in Greece are overcrowded and there are often no beds available in the appropriate clinics. In reference to this issue, the President of the Greek Transgender Support Association in her book argues that trans persons are often hospitalized according to the gender that was assigned at birth

and they are often harassed by the offensive attitude of health care practitioners and/or other patients and visitors (Galanou, 2014).

Summing up, in this section I discussed the various forms of discrimination experienced in the primary and secondary health care. The widespread provider ignorance about the health needs of trans persons appeared to considerably limit participants' access to health care. Other barriers in health care were the frequent transphobic language used in health care settings and the isolation of trans persons when hospitalized. In the following section, my focus is on the role of the LGBT community to the effort of alleviating some of the barriers in health care access discussed in the preceding sections.

4.4 Countering pathologisation and the supportive role of the LGBT community

In a context where there is no guidance on the hospitalization of trans patients, it was the LGBT activists and/or a member of an LGBT organisation who often intervened to ensure appropriate treatment of a friend, which seemed to be particularly important for those with no family support. Data from my fieldwork indicate that the interventions of LGBT activists usually aimed to inform the health care providers of the appropriate pronoun/ name they should use for the patient, signal their support and care for the patient, represent and/or advocate for patient's interests in health care providers, ensure the maintenance of high standards of health care. In the excerpt below Elias, a 47-year-old gay activist, reflected on the ways that the LGBT community, but also his dual identity both as a gay activist and a health care professional in the hospital, ensured a safer environment for a trans activist who was hospitalized.

I can see the treatment of trans persons now that Niki is in hospital... Ok, people are not familiar with this... People are secretly laughing... there are also these spicy, "humorous comments which of course are annoying and are at least less violent... But I was there for her right from the beginning, since her admission in the hospital, I work in this hospital, other people also came who are also related to the hospital, for example Jimmy came who is an activist and a member of Positive Voice which has close ties with the hospital... so , let's say we gave

our mark, we didn't leave Niki alone on this [...] I was going there for some hours, even for short visits of some minutes, but you always show your mark, let's say you show that you are interested in this person, you ask a doctor about her condition, you ask a nurse if she needs something for the patient... and our relationships here are different, they see me and I see them every day, I will serve them if they serve them immediately, namely there are some unwritten rules in here [...] we spread the word that they should call her Niki, namely this was already spoken, I hope they never embarrassed her, besides one cannot tell that Niki is trans

Overall, LGBT activists and particularly those who lived in rural or regional areas seemed to be community minded and many of their activities were focused on ensuring a supportive network for the members of LGBT groups. This created an atmosphere of closeness and mutuality among those who maintained membership of an LGBT group. However, the LGBT groups in the regional areas I visited during my field work were founded mostly by university students whose residence was temporary. They were not "locals" and therefore they were able to keep their activities within the LGBT community secret from their families. However, this was precisely what made two lesbians participants avoid membership of their local LGBT groups although they perceived themselves as belonging to the LGBT community at large. As a result, both felt alienated from the local LGBT groups since their status as "locals" restricted their freedom to be visible in contrast with the freedom that university students enjoyed. Moreover, the difficulty in building trustful relationships when people do not share the same contextual realities was also evident through my interviews with these lesbians. For example, Natassa clearly expressed her concern that LGBT students would be unable to fully understand and safeguard the social norm of "don't ask don't tell" with their attitudes, which ruled her life and her sense of safety in the context where she lived. In her own words Natassa argued:

[you know that there is a lesbian group here, right?] Congratulations!I can't... [do you know them?] No... I don't want to know them. I don't because they are not locals. They can be open here... do you understand? If I lived in any other city I would go to the lesbian group or to the LGBT group of the city....I wish I would have.... Look, if my family knew this I wouldn't be so blocked, since I am not...If my father sees me with the rainbow flag, he will fall off from the 313rd floor [...] do you know the "don't ask don't tell" that ruled in US? This applies also to the rural areas, right? You know, I know, we don't talk about it, but if you make the mistake and open your mouth you are dead

While the visibility of LGBT activists in rural and regional areas constituted a barrier for some LGBT persons to maintain closeness to the community it was also the lighthouse which signaled safety for some others. Lambros, a gay activist in a regional area argued that he was often the reference point of gay adolescents that lived in rural and were victimized by homophobic verbal and physical violence in their environments. Lambros argued that he often provided a shelter in his house for runaway youth, consultation and support via telephone communication and in one case where he witnessed a homophobic attack he actively intervened to support the person who was attacked.

The violent attacks are often... mostly in villages, kids who phone me, fourteen or fifteen years old, whose parents suspect/understand something, a behavior or something else that they perceive as fag, or they hear comments from siblings or uncles [...] first of all, these kids are supported because they experience in practice that they are not alone, no matter how many times I write on the website that they are not alone it has no effect. It is only through these experiences that these kids really understand that they are not alone. At this moment they report this, they keep this experience, it is imprinted to their brain and they start to feel a different kind of security

As it is clear from the example above, LGBT activists were also an informal mechanism for receiving complaints from victims of abuse. This often entailed the provision of practical support and the implementation of strategies to ensure safety to those in need. In other examples, LGBT activists often made themselves available to create a safe environment for disclosure for closeted LGBT individuals. This entailed the revelation of sensitive information and required a personal commitment to confidentiality from the part of the LGBT activists. More crucially, however, the role of the supporter was sometimes emotionally overwhelming and stressful for LGBT activists who were involved in the personal lives of individuals who sometimes asked desperately for support. For example, Orestis who was a seasoned gay activist recalled being a “counsellor” to a professor of psychology who wanted to disclose his homosexuality and the issues around it to a person that could understand him. The professor in Orestis’ story was described as a person who was carrying alone the emotional burden of hiding his homosexuality for decades. Orestis empathetically experienced the life story of this professor as an example of how cruelly where homophobia can

negate the class and the social position of a person. In the following excerpt Orestis described his experience and the ways he was emotionally affected:

One day a student I knew from the university called me because he knew I was in the movement, he knew a professor who was old, he was more than 70 year old, and he had realized that he is gay, but he was suppressing this for all of his life, and he basically needed a person to talk to, and when I was still in Volos I visited him and we talked, and by the way, he was a professor of psychology and we ended up becoming his counsellor... so, this man was suppressing his sexuality for all of his life due to his position and due to the whole social situation [...] It is shocking to see a 70-year-old man crying in front of you, right? In fact I also feel guilty due to my personal issues.... Namely at some point I wasn't very well, because in order to do this you must be able to do it, right? So at some point I moved away and now I have no contact with him anymore, and every now and then I am thinking of the fact that I left this person behind, ok, it was just 5 or 6 times that we met but it feels like..... like... like.... I don't want to say responsibility because responsibility sounds very.... I think it has a negative connotation.... But it feels like a responsibility, it is an extra responsibility, right? I don't know exactly how to express this... I feel... namely it is fucking unfair a person like him to be alone, namely you feel the unfairness and then you share it with him, do you understand? And this unfairness is so obvious that you feel it too

It seems that the experience of homophobia as a shared experience between Orestis and the professor formed a bridge between these two men who were otherwise different in many respects. This suggests that there is a collective consciousness of the oppression experienced by LGBT people which makes the LGBT community possible and explains why Orestis responded to the professor's claim in the first place. This community is at least partially constructed by the efforts of LGBT activists who both individually and collectively create safe spaces within which the expression of the homophobic trauma can be shared, legitimized and respected. The findings of this study show that many LGBT participants had turned to a mental health professional to share their deepest concerns and worries. However, examples like this highlight the importance of the LGBT community for the management of emotionally charged situations and in overcoming the consequent isolation.

In this section I explored the supportive role of the LGBT community in helping other members access health care. The participants' stories provide evidence

that community participation and community networks can have a major positive impact on maintaining good mental health and the ability to transcend important barriers when accessing health care. In the following sub-sections I focus on two participants' stories to show how power differentials may have exclusionary effects within the LGBT community, often resulting in the erasure of peoples' health needs that remain unacknowledged and unmet.

4.4.1 “They thought I was an alien”: Making a place for intersex persons within the LGBT community

Consistent with what has been extensively argued, the findings of this study reveal that the search of a community to affiliate with was a critical undertaking for developing a self-concept and a sense of belonging for the participants. This appeared to be particularly important for those who were eagerly still searching to label their sense of being different and desperately needed to diminish their sense of isolation. I will illuminate this point through Argyris story who I met during my visit to an LGBT group of a rural area of Greece.

Argyris was a new member and before I met him I was informed by Rania, who was my contact with the group, that Argyris is an intersex person. Interestingly, this information was shared to me while Rania was describing the story of their group from the point of its formation to nowadays. My feeling was that Argyris' membership was experienced as a hallmark, at least for Rania, and signaled the accomplishment of inclusiveness of the group along with the challenge of Argyris' integration. During the group interview, Argyris mentioned that he had “a genetic issue” that was related with the fact of being born with an extra chromosome, albeit without using the term “intersex”. He mentioned this while he was framing the meaning of health inequalities and particularly the injustice of paying more than 300 euros every 6 months for monitoring his hormones although he was insured in IKA which is the largest Social Security Organization in Greece. Apart from this, the discussion was primarily focused on the many facets of homophobia and its effects on the lives of the participants. Yet, as I wanted to immerse myself more in the life experiences of the persons whose gender is

considered socially and/or medically variant, I invited Argyris to an individual interview. Argyris happily accepted the invitation and from the very beginning of our interview he told me the story of how he was informed at the age of 26 by an endocrinologist that he was born with Klinefelter syndrome.

Argyris recalled that at the age of 26 he had a pain in his genitals along with other clinical symptoms, like severe headaches. After several medical visits and examinations he received a diagnosis of the Klinefelter syndrome to which doctors attributed his clinical symptoms. With the guidance of his doctors, Argyris obtained access to his medical records from his early childhood. He discovered that the information of the Klinefelter syndrome was known to his father since he was 4 year old as he saw his signature to the medical history of the hospital where Argyris appeared to have received a medical treatment for gynaecomastia and lactic fluid secretion. The revelation of this information brought a severe family turmoil as Argyris angrily turned against his father for maintaining secrecy to information that would so crucially affect his life. Strangely, Argyris described his mother as being completely unaware of all these medical information and equally shocked although she always had the first role in the overall care of her children.

Progressively Argyris started to search more information about the Klinefelter syndrome and medical care as he was advised by his doctors to have regular non-invasive hormone level testing. His sense of certainty in terms of his sex, gender and sexual orientation were completely disrupted. His XXY chromosome pattern, the prevalence of estrogen in his body, and the discovery of an ovary in his otherwise male body signaled that he could no longer consider himself as absolutely male. As a result, Argyris started to eagerly search for the appropriate specialist who would help him to fit into a single sex category. This was understandable given that the model of the two “opposite” sexes is an inscribed belief that dominates our ideas about sexual anatomy, sex, gender and sexuality in general (Fausto Sterling, 2000). Argyris perceived the Klinefelter syndrome as a genetic disorder that could be prevented if his parents sought an early intervention that could be possible with a medical modification of his DNA. With the belief that DNA modification is possible in childhood, Argyris felt considerably frustrated to have lost the opportunity not only to prevent his gender ambiguity but

also to prevent his homosexuality. This belief appeared to be reinforced by his doctors who after the diagnosis of the Klinefelter syndrome they immediately predicted that Argyris was gay.

My dad told me that he knew everything. If my dad had spoken openly about this when I was a child we could go abroad and do something about it. I could even be straight now; there was a solution back then. I could have an ablation of a chromosome and they would insert an additional DNA [...] Doctors are completely ignorant! The only thing they asked me since my diagnosis is if I am a homosexual. And I asked them how they made this conclusion, and they told me that these persons tend to be homosexuals

Three years after the diagnosis of the Klinefelter syndrome, Argyris developed testicular cancer and was treated with chemotherapy and a surgical removal of the testicle with cancerous cells. At the time of our interview Argyris was recently diagnosed with ovarian cancer and had already a fixed medical plan to remove his ovary and once again receive chemotherapy. Both cancers were attributed by his doctors to the Klinefelter syndrome. Once again, Argyris believed that doctors had failed to maintain some control over the negative effects of the syndrome to his body. Argyris argued that prior to the diagnosis of ovarian cancer his prolactin levels were considerably equal high, to those of women who breastfeed, thus suffering from severe headaches, sleepiness and reduced sex drive for two years. According to Argyris, his doctors' decision not to intervene medically to his hormone levels on time was a bad call which was exacerbated by their fear to not cause him osteoporosis but most importantly by the lack of a coherent and specific medical plan.

However, Argyris' frustration was not solely related to the cancer and the inability of doctors to prevent it. His frustration was equally rooted to the fact that he was advised to advance through regular injections his testosterone levels right after the removal of his ovary. However, Argyris wanted to maintain his femininity which was manifest in his thin voice and hairless body that could be probably changed if he complied with doctors' advice to start testosterone replacement therapy.

Argyris had a strong belief that the combination of internal and external genitalia along with the predominance of female or masculine hormones in one's body is what determines his/her sex and gender. The existence of an ovary in his body was not solely a source of confusion but explained his sense of an inherently integral female part of himself and was known to him. For Argyris the fact that his body naturally produces high levels of female hormones meant that he could probably be destined to be raised as a woman. After the revelation of the existence of an ovary, Argyris had started to embrace his female characteristics more positively and considered that a male to female transition could be an option for him. However, his mother, with whom he was very close, was considerably negative to a gender transition. In his words, Argyris described:

Look, I can sense that my female hormones prevail, I experience this every day throughout my life, I have a hairless body, a thin voice, I feel alright, OK I don't dress so as to go to the other extreme but... I am a more mental type of person; I can see it to myself. And I have spoken with many of my [female] friends. Even gay men are loose, they are not exploring their mental self, and you will rarely find a gay who is exploring himself that way. Namely, when I search for a partner I look first what he does to me mentally, I don't care about his outlook, I am not interested about it [you mean that women are interested more about the mental characteristics of a person while men...] to be explicit, men are thinking only with their penis. And it is not only the emotional part of myself, for example I write, I search, I read... how can I say this... for example women are more dynamic in their jobs in contrast to men, I have all these [...] At my 40s maybe I will have to do the transition anyways because my testosterone will have stopped completely and then I will have to take injections or whatever, but I think this is foolish, so.... I started to discuss the possibility of transition. But my mother is resolute, she doesn't accept it. She says ok I accept you as a gay man but not if you transit. So, I now want to discuss it with a psychologist to tell me what to do. My mother suggests pushing it as long as it goes, but she doesn't see my psychological cost because she is afraid of what the society will say. OK, she is right, Volos is a small town, however she is afraid of our relatives more than the society at large

Argyris was struggling to form a stable sense of selfhood which was at least partly troubled by the societal demands of conformity and the dominance of sexual dimorphism, which presumes male and female as two clear-cut identities (Fausto Sterling, 2000). In his struggling with identity questions, Argyris was feeling that

his doctors were not supportive. He felt being treated as a “guinea pig”, as the only thing his doctors did was to monitor his hormones, report some diagnostic information albeit without embracing his worries and questions to their medical services. This is clearly expressed in the following excerpt:

I have told them many times, I told them directly that if it is a matter of money they should tell me, I asked them if I should go abroad so as to get better informed on this and they said no, why should you go abroad? But you don't give me enough information, I need to understand what I need to do, I don't want to live with this doubt. Am I a boy? Am I a girl? Should I change my gender? Must I change my gender? Namely, I need to know, and they told me no, we continue as planned, but when they say this, it means that they are completely ignorant. So, how can you move on with this? They just do what they need to do, they just monitor my hormones and beyond this nothing.

The above quotation suggests that Argyris' dissatisfaction with his health care was related to the fact that his doctors never incorporated into their services frank discussions of ideas on gender identity. This is particularly important as intersex persons try to develop a positive identity within the prevailing culture that sees intersex persons as rare and abnormal (Fausto Sterling, 2000). Furthermore, although it has been consistently argued that communities are critical to the process of identity development, Argyris' doctors appeared to offer no support on helping him get in contact with other persons with similar experiences and support groups (Korell and Lorah, 2007, Ritter and Terndrup, 2002, McCarn and Fassinger, 1996).

Fortunately, Argyris had already established contact with the LGBT community when he was studying in a university of the capital as he wanted to socialize with other gay men. When he returned to his hometown in a rural area, he maintained some of his personal friendships with other gay men and lesbians and he continued to maintain contact with the virtual LGBT community through internet. With the diagnosis of the Klinefelter syndrome, Argyris once again tried to find other people with similar experiences, however, this time it was a much more difficult endeavor. This was because Argyris appeared to need to renegotiate his place in the LGBT community as though his self-identification as a gay man was not sufficient anymore. In addition, the messages he received through the LGBT

community was that there were not known intersex persons who have enmeshed themselves in the community or who have come out as intersex.

The fact that Argyris had not embraced a social term (e.g. intersex) to identify himself but, rather, he used the medical term of the Klinefelter syndrome and medical information to introduce himself, appeared to provoke doubts as to whether Argyris has actually a place in his local LGBT group. This may be related to the fact that LGBT groups who politicize sexuality and gender identities are usually very critical of the medical categories which are used to define identities and sexual desires. As Roberts (2011) argues, historically, medicine has produced medical terms and categories which have caused the unnecessary pathologisation of biological and social diversity, thus contributing to the production of societies characterized by intolerance of those who do not fit well into established categories. Therefore, it seemed that membership in an LGBT group presupposed the readiness of a person to depart from gender norms and concepts which were assumed to reproduce the pathologisation of sexual minorities. In the following excerpt, Argyris described how he negotiated his membership to the local LGBT group:

Truth be told, Rania was the first person who wanted to meet me. However, when we first met I didn't feel very comfortable to tell them all the details of my story so I just said only a few things, and the guys got confused, the whole group got confused. They thought I was an alien, they even told me that. They thought that what I have is a medical condition. Nevertheless, when I spoke with Rania and Daphne in private they understood what was going on. They told me that they were also confused at first; that maybe they didn't understand what I was trying to explain, but they understood it later. So, I got closer with Rania and Daphne. They are more open, they are more... Now you tell me why I said all these things the other day... They didn't know anything... The guys didn't know... [did you regret it?] No, I didn't, I wanted to speak so as to allow all members to know...truth be told I feel that somehow I cannot go hand-in-hand with some members. They didn't like me since the beginning, I don't know why

Within LGBT community, Argyris had found a place where he could at least articulate and share his ideas about gender as well as hear others' interpretations and meanings of identity issues. The local LGBT group in which he had recently acquired membership was connected with other LGBT groups and well-known

activists both in the capital and in Thessaloniki. The latter were willing to contribute to public discussions on gender and sexual orientation issues. Through this supportive network Argyris had also the chance to meet other LGBT individuals and activists and develop his personal contacts. Nevertheless, the fact that Argyris had never met a person with similar experiences determined his identity formation process to be a lonely path. This is clearly reflected to his own words:

There must be other persons like me but they don't appear, I have searched even through internet, I generally search for others, I ask people, I asked the trans who came from Athens if they know anyone in Athens, to tell me what s/he is doing, how s/he deals with it, and they told me that there is no one. When we started to ask questions [in a public discussion], when the girls came from Athens I had some specific questions and I asked them, they were very knowledgeable and they said that it is one in 1500 people, these people are too rare, but they didn't imagine why I was asking

4.4.2 “There is no collectivity, there is no group, there is nothing”: Experiences of multiple oppression and exclusion: social class and age

In this section I want to put class, age and LGBT status together, as three interlocking and inseparable spheres that appeared to construct the exclusion of a participant from both the LGBT community and health care. I focus on a single participant's story because the richness of his descriptions allows an in-depth understanding of the intense way in which some intersections may shape not only the everyday experiences of LGBT participants, but, crucially, for the purposes of this section, their exclusion from health care too.

Although there is much debate on the ways that class can be categorized, measured or even defined, there are some class markers that are usually used in order to facilitate discourse around class and the social divisions it produces. In particular, the usual indicators of class used are: income, education, occupation and place of residence (Wilkinson and Pickett, 2010, Galobardes et al., 2007, Graham, 2006). These indicators construct various schemes of class rather than neatly divided categorizations which in turn affect differently each social group

(Taylor, 2007). For example, it seemed that unemployment and poverty were differently experienced by participants as a result of divisions produced by differences in educational level. Those unemployed participants who were highly educated appeared to enjoy more social support, especially if their origins were from middle-class families, in comparison with those who had dropped out of school or had few educational qualifications. The social support they favored was often related with their involvement in LGBT organizations, political parties, occupational or other associations and the fact that they appeared less prone to homophobic violence in their neighborhoods. By contrast, one of the participants who had abandoned school and was unemployed appeared to lack social support at least partly as a result of his exclusion from social structures such as the LGBT community and the homophobic hostility experienced in his neighborhood. In particular, through John's story I will highlight some important insights of the intersection of class, age and sexuality in health care.

John is a 49-year-old gay man who lives in social housing in a deprived area in one of the largest rural cities of Greece. At the time of the interview, John was long-term unemployed although he worked occasionally in his sister's small business by which he earned only some pocket money as he was not officially registered as an employee. He had not finished school and related this with the fact that during his early school years he had encountered his first incidences of homophobic violence which made him abandon school. He also related his gay status with the fact that he occasionally worked as a sex worker. He particularly said that during late '80s, when he first worked as a sex worker, there was no difference between the stigma surrounding gay identity with that of a sex worker. At that time, according to John, sex workers earned a lot of money and with an already spoiled social identity he easily accepted a proposal by a sex worker who worked in a brothel to enter the field of sex work:

I did her shopping for some pocket money, and after a while she said to me: "John, why don't you come and work in the brothel? You don't give a damn about your family. You shake and move your body, you are yourself, and what else are they going to name you? That you are a faggot? You are going to earn money", so I went to work in the brothel for the first time and she taught me what to do

The first time I met John was few years ago in a Pride parade held in Athens in which he participated as a supporter of a gay group that was doing its first steps in the city where John lived. As this Pride parade was also one of the first gatherings of this newly founded LGBT group that sprang out of a web LGBT forum, I remember his enthusiasm and joyful mood that I suspect played a role in meeting each other in the first place. During my fieldwork, I met John again in a protest against homophobic violence. The latter was organized after a brutal attack by Golden Dawn against LGBT activists, in the city where John lived, while they were promoting an LGBT event. He was sitting alone and when I asked him if he kept contact with the members of the LGBT group he said he knew no one. Not surprisingly, a few weeks later when we met again for the interview he expressed the feeling of being isolated from the LGBT community and disappointed to be excluded despite his desperate efforts to get involved in the activities of the local LGBT organization. Reflecting on his effort to connect himself with the LGBT community he referred to an LGBT event where he went alone and felt invisible because nobody talked to him during the whole night:

I went to see this film but nobody paid attention to me, there is nothing, my love, we just protect ourselves, there is no collectivity, there is no group, there is nothing. We are all alone, this is final! We are all alone! Listen to me! And I am not poor and miserable, I am not getting miserable, my love, not at all, I am not getting miserable

In the quote above, John repeatedly tried to dis-identify himself initially from being “poor and miserable” and later from being “miserable” alone. In Greek language, the word miserable (μίζερος) is linked with the word misery (μίζηρια) which is strictly associated with being poor and means to be excessively deprived, as a result of poverty. Yet, the word miserable is usually used to characterize a person who is inherently and constantly in a bad mood, grouchy, stingy or people who neglect themselves and their appearance. However, the meaning of being poor and miserable are not always neatly separated as poverty often results in characteristics similar to those of a person who may be characterized by others as being miserable. I believe that John by repeating that he is not miserable he was trying to dis-identify himself from the negative stereotypes attributed to the poor and at the same time he implicitly stated the reasons of his exclusion from

the LGBT community. Another strategy that John appeared to use in order to resist the negative stereotypes of the poor was to show he is happy, out-going in an always joyful mood. However, these characteristics were assumed by John to contradict with the intellectual, political thinking and serious attitude that he should also exhibit if he wanted to fit in the frame of LGBT activists. In the following quote, once again John described his sense of being invisible to the people who he himself identified as his own tribe. This time he explained his exclusion from the LGBT group as a result of being misunderstood as a person who lacks the seriousness that would enable him to fit in the scene of gay activists.

I went to a meeting, and I spoke to a boy and he said to me “I remember you”, you remember me, ok, you remember me, I didn’t come to fuck you or you to fuck me, approach me! I am an old man, don’t you see me? I am here! I am here with my tribe, you should approach people! You see that I always laugh, my friend, but if I get serious.... If I get serious! I am telling you I can get serious, but I need a person to pull myself together, I can stop messing about when inappropriate and I can still mess about to have some fun

Crucially, in the quote above John also reflected on his distress of not being approached by the youth activists as he felt they did not acknowledge their common sexuality status despite their age difference but also his vulnerability because of his age. In fact, LGBT communities are not immune to ageism. Empirical studies have shown that ageism is pervasive in the LGBT communities and it is an important barrier for older LGBT people to relate to the younger members of the community. It is because of ageism that older LGBT people may find it difficult to feel like they belong to the community which is dominated by the youth centered culture (Hughes, 2007, Brotman et al., 2003). Furthermore, divisions of class may also become harsher as people grow up and change the way they incorporate their class identities in their life.

LGBT activists did not deny that within the LGBT community exclusions which undermine its core moral principle that “everyone should have a place within the community” may be produced. As most of the LGBT activists had personally experienced the negative consequences of being deprived of social support

within a homophobic and transphobic society, they were particularly sensitive and active to respond on the demands of inclusiveness. However, this principle appeared to be compromised when it was viewed by activists to jeopardize the social change purposes or strategies of their organisations. This ethical conflict within the LGBT community was often viewed by many LGBT activists as an unresolved issue embedded in every aspect of their activities. One of the LGBT activists who largely spoke about this ethical conflict at length was Paul:

The discourse on abusive language is like a dive from very high to very deep.... Namely there is an issue when a new member comes and discusses the dominant abusive language and shows no ability to depart from this, to move forward to the next step... and you say to him/her that the basic thing that we agreed before the meeting was that when one uses abusive language and someone else says that this language is abusive to him/her, then you must shut up and it is your responsibility to find out why this language is abusive to him/her. But this is not easy, it is impossible, at least speaking about two particular persons who were in a group, it was obvious that they could not be in the same group. And it is not only these two persons. Only those who are capable at having this particular perception and willingness and they are in this particular phase of their life, because in order to do this you must offer a lot of energy, only these persons will survive there, namely those who have the need for analysis and theory. But this group cannot function as a group of.... How can I say this... but both sides are necessary. This is why I don't like it when I see the one side turn against the other. Namely those who groom their language and the terms they use continuously are necessary and useful, but the others are also necessary... Namely I have friends who are a couple and they have never gone to the Pride, and when we go to a club and I start a theoretical discussion they get bored within 30 seconds. My boyfriends are also exactly like this and I have chosen them because I could not stand having a relationship with a person who theoretically analyses everything the way I do. I would have died! (Paul, 37-years old, gay man)

Paul's description sheds light on the power relations in questions of concerning "otherness". Paul initially argues that differences in the ways that members perceive abusive language make their co-existence in a group impossible if these are not resolved. The group to which Paul refers seemed to have already established a guiding rule, ethically based on the foundational unethical character of abusiveness that leaves no room for tolerance. At the same time, this rule created a space where, as Paul argues, members who are not willing to comply

with cannot survive. Paul goes on to name those who will finally survive in the group as those who have a need for analysis and theory. By contrast, the “others”, those who differ from this modality are doomed to be ostracized from the group. Yet, Paul embraces the particular trait that is otherwise estranged within the group in which he participates in his friendships. This suggests that the potential for political alliance is not foreclosed even if these different voices may indeed have to find a room for dialogue and negotiation outside the group.

Consistent with what Namaste (2011) and Taylor (2007) have argued, language appeared to cause a deeply political contest and simultaneously represented an important embodied aspect of class position. For most of the LGBT activists politicizing language was an act of caring and solidarity for the oppressed. Similarly, the introduction of new concepts, terms and ways of speaking were an integral part of the process of a radical re-visioning and construction of a socially just world. On the other hand, for John, the language used within the LGBT community was certainly a place where he felt alienated. For example, John was one of the few participants who were particularly angry with the excessive usage of English language. The assumption that everything written or verbalized in English is immediately more appropriate, sophisticated and accurate than the equivalent in Greek was also not accepted by him. In a way he appeared to feel forced to speak a language that was foreign and meaningless to him and reflected the devaluation of his identity as Greek. For example, he was opposed to a series of English words embedded in the everyday vocabulary of the LGBT activists such as “gay”, “pride”, and he was sarcastically laughing at words like “queer”. In one case he also correlated the commercialization of the Pride parade with its designation in English language. He particularly said:

I bought this [a little rainbow flag] 5 euros! Is it possible this little flag to cost 5 Euros at Pride? Get the fuck outa here! Ah! My friend! 5 Euros for a little flag? I could have sewn one myself! And I don't like “Athens Pride” my love, what the fuck does Athens Pride means? Highlight this! Am I wrong? “Ημέρα Ομοφυλόφιλης Υπερηφάνειας” [homosexual pride day] my love! Athens Pride and bullshits! They turn me off

Similarly, John also seemed to be critical towards the fact that words such as “fuck” were regarded as being outside the academic language:

[...] for example I will not fuck a 16 year old boy, I'm saying it as it is, because things are not only theories, sex is the issue, theories stem from acts, without acts there are no theories my love

I believe that the main reason that John was considerably concerned about his exclusion from the LGBT community was because he had no other supportive social network. John felt considerably alone and this was something that was repeatedly and explicitly articulated throughout our conversation. In addition, John has repeatedly experienced homophobic abuse and harassment as well as violations in his house. The below excerpt from his interview is very characteristic of how much this fear was constantly undercurrent affecting him on a daily basis:

I am scared...I am... I am scared, I have overcome fear but I am scared... namely... I am scared; I can't go outside and hear bullshits. With what right do you speak to me like this you son of the bitch? Do you want me to take your number and go.... Why should we get to that point? Look, I am all alone here Dimitra. If I start allowing every junky and every filthy person to enter my house you will find me dead. Is it necessarily to get killed out of my sexual lust? No, I am not going to get killed because of that. Let me tell you something, a guy called me before, he asked me "do you want company tonight?" what does he mean? How the fuck could I know who the hell is he?

In my discussion with John his main need was to share with me stories which were mainly about the ways he experiences homophobia within family and his neighborhood. When I asked him to focus on health issues and his experiences with health professionals he quickly made a statement that he is "clean" with a "proof", meaning that he had a recent negative result from an HIV screening. He said that he got tested for HIV in a public hospital under a rapid procedure which entailed nothing but a question about the reason he wanted this test by a doctor, whom he described as being indifferent and distant. John wanted this HIV test because he wanted to work again as a sex worker and the test was part of a small series of other tests in order to register to the municipal health department. He also decided not to reveal this information to the health professionals that provided the tests.

Overall, John did not have many experiences to share from being a receiver of health care services as beyond regular HIV screening tests he never had health checkups nor did he have ever a stable professional relationship with a doctor. In addition, as described in Section 3.8, his experience as a primer carer of his father when he was hospitalized was strongly impacted by the absence of social support and the consequent feelings of loneliness.

John argued that coming out to a doctor is irrelevant to the quality of health care received, but he interestingly implied that coming out to a person is about being respected for who you are. Nevertheless, for John a doctor-patient relationship did not necessarily require respect as this relationship was not that important. Therefore, coming out to a doctor was not that important either. In the quotation below, John described his experience with his doctor:

Don't think that this is necessary, why should doctors care if I fuck or if I get fucked? Because of my health? I don't care either if doctors know... I am interested in if you know, I am interested in if my friend Mary knows and respects me for who I am, but why the doctor? [...] the treatment was classic, the doctor was a very beautiful woman, I would lick her pleasantly if she was sitting in a dentist chair, very beautiful but she was like this [he stretched his body], but I didn't give a shit! "Why are you doing this test?", "I am going to work", what should I tell her, that I am a faggot? Can't she see it? Do I have to say it too? The next time I will tell her so as to shock her and make her calm down, this is the first thing, the other thing is that when I went to take the results they told me "we haven't brought the machine to test the blood", after one and a half month! Come one! Aren't they ashamed a little bit?

John's argument about the necessity of disclosing our sexual orientation to a doctor, as well as his perception of doctors' distant and strict behavior during medical interviewing resembled those described in Chapter 3. In comparison to others, however, John had never received preventive health care services such as heart disease prevention tests, PSA test for prostate cancer etc. Furthermore, during the interview with John, and despite him declaring that he had never dealt with any health problem, he appeared to have health concerns that he had never discussed with a doctor. For example, while we were speaking about his last two visits to the hospital for the HIV tests, which were prerequisites to be registered as a sex worker, John told me that he has been groping a small tumor in his

testicles for some years but he forgot to speak to a doctor despite him recently visiting an urologist in the hospital. John himself explained his tension to ignore medical issues as an expression of his fearlessness towards death:

I never had any other tests, for blood sugar and all that crap... the wine will show [he laughs], I am not scared. Why should I be scared? Not to die? One fag less! Right? One person less... you come and go anyway... I am saying this from this point of view, namely I don't care if I die

That John refused to care for his health issues could be encountered as a self-neglecting behavior, although the concept is itself quite complex. Most individuals engage in some behavior or activity that could, in broad sense, constitute self-neglect (O'Brien et al., 2000). Nevertheless, it has been argued that self-neglect may reflect an active expression of resentment or withdrawal from the community (O'Brien et al., 2000). This is particularly important, as throughout our conversation John was consistently referring to his sense of social isolation.

Moreover, both informal and formal social networks have health promoting qualities and are considered to be a key mechanism in the relationship between poverty and poor health. Nevertheless, as Cattell (2001) argues, the relationship between them remains under-researched. Many of the issues raised by John provide some clues on the ways that class, age and sexual orientation may be associated with the lack of social support. In addition, the positive role of the LGBT community in the health care needs of the participants have also been demonstrated in the previous sections. This suggests that interventions to increase social support and/or cohesion both within the LGBT community and generally in society are at least worthy of exploration as they have been proved to have positive impact on health outcomes.

Conclusions

The purpose of this chapter was to illuminate the effects of the historic pathologisation of being an LGBT person to the construction of systematic barriers in health care. The invisibility of lesbian sex and the pathologisation of non-penetrative sex appeared to make lesbians considerably uncomfortable to

seek Pap test and discuss issues around safe sex practices with their doctors. By the same token, the stigma around anal sex made rectal examination be a source of shame for gay men and it was often the root of denial of services. Trans participants reported to have been frequently experiencing discrimination when accessing health care; from disrespect and transphobic insults by health care providers to outright denial of service. All the above, combined with providers' ignorance about the health care needs of trans persons appeared to lead trans participants to complete exclusion from preventive health care as well as transition related medical care. Findings relevant to the treatment and prevention of HIV highlight the need for systematic intervention and anti-discrimination policies/practices against the denial of services to people who live with HIV. In addition, the battle against the HIV stigma should be of the core objectives of all domains in health care.

The data presented in this chapter demonstrate/dictate a compelling need to expand our understanding of the complex structural dynamics and social variables/factors that influence equal access to care for diverse groups, especially those who are on the margins of both the LGBT community and society in general. The multiple incidences of discrimination both within and outside health care services, the social isolation and the high risk for poor health outcomes of LGBT people suggest a need for special attention.

The LGBT community appeared to be an important source of support not only for trans participants but also for everybody being in the midst of the identity formation process or those experiencing social isolation. The insights provided by the participants' stories imply that there is always an important link between the identity struggles and people's health care needs. This suggests that if we want to improve service access and health outcomes for LGBT people, then, health care providers need to listen to communities and involve them in the formation of the health care processes. However, tensions within the LGBT community resulting from "within-group" complexity can obscure people and limit their access to community support (Monro and Richardson, 2010, McCall, 2005). Finally, the intra-categorical analysis was a useful means of illustrating how experiences of being gay are permeated by social class contributing to the marginalisation of an under-class gay man.

CHAPTER 5 INVISIBILITY AND PATHOLOGISATION IN MENTAL HEALTH CARE

Introduction

Issues related to mental health care emerged strongly among the participants. This was not a surprise given that, internationally, there is a growing awareness that LGBT people are more prone to psychological distress and mental health problems as a consequence of living in a world which constructs them as inferior (Fish, 2006). This by definition suggests that LGBT people as a group deal with important mental health inequalities stemming from their repeated exposure to a wide range of psychosocial stressors associated with anti-LGBT attitudes and behaviours, which include stigmatisation, discrimination and violence (Adams et al., 2013). This also may predict greater usage of mental health services (King et al., 2003, Fish, 2006) although LGBT people are often able to advance coping mechanisms and strategies to counteract minority stress and lead their lives to resilience without necessarily experiencing mental health problems (Wilton, 2000). In fact, it is often suggested that coping with a stigmatized identity may entail great opportunities for emotional and spiritual growth, affiliation with community and community development, critical stance toward dominant structures, development of alternative values and structures (Meyer, 2003, Menken, 2001). As Menken (2001) points out:

Spiritual or psychological rank is the only rank that has been available to those disavowed by society. Value and power are earned by the blood, sweat and tears of transforming incredibly oppressive circumstances (p.21)

Despite the attention that must be paid to the many ways that humans can advance strategies for resilience and community solidarity by reversing their oppressive experiences, minority stress should be dealt as a health inequality that limits LGBT people's potential to a healthy life.

In fact, the vast majority of LGBT participants of this study, in particular 31 out of the total number of 46 persons with whom I spoke during the individual and group

interviews, had at least one experience of receiving mental health services. The experiences of LGBT participants with a mental health professional were usually related to seeking support in order to deal with parental reactions and rejection after coming-out as LGBT, grief and bereavement issues, internalized homophobia/ transphobia and coming-out issues, panic attacks, psychosomatic disorders, bullying and post-traumatic stress. For three participants, the first experience with a mental health professional was in the hospital after a suicide attempt or a self-harm behavior (e.g. accident as a result of heavy drinking). In addition, some of the participants, mostly the lesbians, preserved long-term professional relationships with mental health professionals or homeopaths, whose prime educational credential was in psychiatry, by expanding their personal targets and claims to issues related to personal development and self-awareness.

In the two first sections of this chapter I discuss how LGBT participants perceived the impact of homophobia and transphobia on their mental health. The third section discusses doctors' perception of the same issue. In the following sections of this chapter the ways that homophobia and transphobia were manifest within mental health care services will be illuminated by focusing on seven strong issues that emerged among the participants.

5.1 LGB participants' perceptions of the impact of homophobia on their mental health

The majority of LGB participants reflected on many stories about the ways that homophobia negatively affect or had affected their everyday lives, the level of their life satisfaction, their psychological wellbeing or their personal relationships including the most significant ones (e.g. with parents, partners). However, making clear links between the occurrence of a mental health problem and their experiences related to homophobia was sometimes a difficult endeavor or an unpleasant topic to reflect upon.

Firstly, it appeared to be related to the difficulty understanding the meaning and the multiple facets of homophobia especially in their more subtle forms. Many participants argued that they had to spend a lot of time and energy on self-reflection, on reading or participating in the collective processes in the LGBT

community and re-evaluating past experiences in order to realize the meaning and the impacts of homophobia and transphobia on their lives. Yet, stepping back from what is already “institutionalized” in social contexts or realizing what is missing in terms of opportunities that are rejected to those who are subject to discriminating norms is not easy. This was expressed by Paul when I asked him to reflect on his experience in terms of homophobia when in hospital with his partner:

There are many levels of discrimination, and I cannot tell you how my life would be without them as I haven't lived this, it is that simple, we just didn't hear something blatant such as “you are faggots” or something like that (Paul, 37 years old, gay man)

As many theorists have argued, homophobia is not easily recognizable as it is an oppressive structure that is deep rooted cultural prejudice underpinned by historically dominant and taken-for-granted understanding of sexuality and gender (Sue, 2010, Hoffman et al., 2001, Wilton, 2000, Blumenfeld, 1992). Everyone is imbued with heterosexist culture's unexamined assumptions and, therefore, it is difficult to have an in-depth understanding of how these affect individuals and communities. For many LGBT participants, overcoming homophobia meant learning to be continuously skeptical about the societal values and norms which subject and traumatize their lives, but tragically this was often after they “had grown thick skins” from homophobic trauma. Furthermore, in a context where homophobia is a quite “permissible” and socially unrecognized form of oppression, LGBT people are prone to absorb homophobic attitudes (Hoffman et al., 2001). Context realities may also expand or minimize the trauma caused to LGBT people. By referring to the Greek context, Vassiliou, a psychotherapist practicing in Greece, argued that the trauma caused in the LGBT community in Greece was expanded by the collective response to homophobia. She summarized some of the points above in an interview she gave to an LGBT magazine:

One thing that I notice as I work with people is that in Greece we have managed to go to post-homophobic era, the era of “there is nothing wrong, everything is permissible” without passing first through the era

of the awareness of what homophobia is. Namely we found ourselves in the era of human rights without even dealing the meaning of homophobia and how much homophobic the Greek society is. How much traumatic this is for the LGBT community! In Greece you often meet people who are victims of homophobic experiences, but many times they don't even recognize it as homophobia. Namely, they are traumatized without even knowing why they have been hurt. And this is because homophobia is so much acceptable as a social stance that it is difficult to recognize and be able to name it. So, when you are not able to recognize homophobia in your environment you become vulnerable to internalizing it without even knowing that at this moment you are becoming very homophobic (Vassiliou, 2011)

Secondly, the difficulty in making causative links between homophobia and mental health was also related to the nature of mental health problems. For example, in the cases of panic attacks or psychosomatic disorders (such as chronic headaches, colitis etc.) finding the root cause of anxiety was not easy, and the majority of the participants with such experiences felt that they had never found the root cause of their anxiety although most of them had finally taken at least some control of the symptoms. As a result, the impact of the symptoms to the overall sense of psychological or social wellbeing was minimal. In addition, some participants argued that since their symptoms are persistent to later stages of their coming-out process and as they felt that they had overcome internalized homophobia it is impossible to continue relating their mental health problem with homophobia. In a way, the experience of a mental health problem and especially the persistence of a symptom was sometimes not only a reminder of old negative feelings about oneself and the traumatic experiences lived, but most importantly, a current invalidation of the accomplishments made during/through a long struggle to overcome external or internalized homophobia. This was in fact one of the most important things that I learned during my study. The LGBT participants of this study need to be affirmed in terms of their identities and the pains they have suffered as a result of structural or internalized homophobia/transphobia. However, they also needed to be acknowledged and affirmed in terms of their strengths, the coping mechanisms, the courage and the wisdom obtained during their personal battles with homophobia and transphobia.

Moreover, for some participants the experience of a mental health problem entailed the risk that their many aspects of personality will be once again invisibilized as they will be viewed by mental health professionals solely as members of a sexual minority rather than as full personalities. Referring to her personal experience with mental health professionals Helen explained her need to be viewed as a whole person:

When I speak with a psychologist or a psychiatrist I don't like everything to be colored by my sexuality or my gender identity, and I have a relevant experience with a professional. We discussed this issue, there were moments who mentioned this but he didn't interpret everything according to this and this is how I also feel about, not all my problems arise from this, besides I didn't go to solve this, not that I don't care but I didn't go to solve this, so I would be bothered if he was constantly mentioning this and he was trying to deal this as a problem. So, I had break downs and panic attacks recently and I started to visit a psychologist, to some extent, I think, my bisexuality was related, particularly in relation to my relationships, the anxiety that relationships caused me because of this, the way that people treat me because of this, so, yes, it played some role and especially my first psychiatrist dealt with this, within this little time he had, and I was satisfied with this, the other psychologist didn't bother much, he disregarded this, but I think they should take it into account, when you examine a person you must know the life conditions of this person (Helen, 23 years old, bisexual woman)

In the example above, although Helen seemed to recognize that she is somehow disempowered by biphobia and is therefore more vulnerable to the experience of mental health problems, she simultaneously resisted to another form of disempowerment which is related to one of the most important functions of stigma. As Herek et al. (2007) explain, once a person is known to be member of a stigmatized group, this fact is regarded by others as the most important piece of information they possess about her/him. This shadows and minimizes all other aspects of individuals' identities and uniqueness since stigma establishes these individuals to be primarily or solely members of an "outgroup" and colors all other information about them, even information totally irrelevant to their stigmatized status. This function of stigma also fosters the development of stereotypes which distort individuals' identities too (Herek et al., 2007). In fact, the fear of being stereotyped was sometimes intense when participants visited or thought of

visiting a mental health professional. For example, Nick who was a 19 year old bisexual man expressed his concern that a mental health professional whose clientele is comprised mainly by gay persons is prone to stereotype his/her service-users. The fact that this concern was expressed by a particularly young person is also not coincidental. In comparison to all other participants, my general feeling was that LGBT youth appeared to be particularly more concerned about the negative stereotypes ascribed to LGBT individuals and they were very conscious of the ways that stereotypes are reproduced. Nick explained why he was about to choosing a psychiatrist with no reputation at working with gay persons:

Maybe I would feel more comfortable to speak to a doctor who hasn't seen other gay persons and doesn't deal with these issues. These doctors probably feel that the issues are repeated and they provide the same solutions to everyone, but if I go to a doctor who is inexperienced he might say something different, something new, his own opinion on my issue. I am telling you, a doctor who constantly sees gay persons and has seen many cases, it is like he repeats himself and this doesn't help me

Another factor that appeared to problematize the causal link between the occurrence of mental health problems and the experience of homophobia was that some LGB participants acknowledged that the more they recognized oppression, the less satisfied they were with their lives. This sometimes involved negative feelings of despair and depression due to the realization of the heterosexual privilege that is lost. Also, this was experienced irrespectively of whether a person had proceeded in an unapologetic everyday experience of his/her sexuality or the active avoidance of homophobic trauma. Therefore, some LGB participants were reluctant to relate the emergence of a mental health problem with high levels of internalized homophobia or one's consequent exposure of extremely homophobic environments. The complexity of this reality was vividly described by Alex whose words made me relax from my worry to trace a causal link between homophobia and the emergence of mental health problems:

When I was 18 years old I was asking my grandma "grandma do you love grandpa?", and she said that I was too young to tell me, anyway, when I was more than twenty I continued asking her and at some point

she said “this is the man I married, this is the man they gave me, of course I love him”, and I asked her “does grandpa love you? Is he gentle with you?”, and she responded “he was taking off my pants, we were doing what we were doing, we made five children and that’s it”, but my grandma was not an unhappy person, you could see this, namely what you could see is that she was a very balanced person, a very grounded person, she was full of life, she enjoyed life, but to my eyes she could be seen as a woman who was experiencing all the oppression of the phallogocentric society through my grandpa, right? [...] I am not sure what is health, how science defines health, but if you are asking me I cannot answer this through a definition of health, what I can tell you is that I prefer to be in the way I am although I am suffering, because although I am out I still suffer as I live in an environment that is not friendly, so I prefer this instead of being unaware of But is it possible to be so reconciled in your closet that you do not have panic attacks or depression or whatever? I am not sure... because I have friends who are closeted and they take antidepressants, I am also on antidepressants but I am out of the closet... I don’t know Dimitra, this is a difficult one

Like Alex, for many other participants coming out of the closet and overcoming internalized homophobia meant becoming reconnected with a tremendous inner source of energy which in turn made resilience and recovery from social isolation, psychological and emotional repression possible. Yet, this was simply not enough for securing good mental health. In most cases the experience of the free expression of one’s true self was priceless. However, this often entailed costs including conflicts, emotional and actual distance with loving ones, strict boundaries with colleagues and old friends, a constant struggle to educate others about homophobia, the negotiation of acceptance or the emotional cost of being rejected, to name just a few. As Ritter and Terndrup (2002) argue, a deeper awareness of minority sexual orientation usually results in a deeper sense of loss. Overall, living a life in constant opposition to societal rules and cultural norms had its own potential risk factors in terms of psychological wellbeing of LGB people. As Menken (2001) points out:

I do not think we can develop in isolation from the external culture we are living in. Individuals cannot feel well until the culture as a whole develops (p.89)

Nonetheless, the view that LGB people who suffer from mental health problems are exclusively those who “don’t get along with themselves” prevailed among LGB participants and doctors. This resulted in a secondary victimization of LGB participants as they often feared that once their experiences would be scrutinized by mental health professionals they would be diagnosed as persons who “don’t get along with themselves” even if their sexualities would be affirmed.

Moreover, some participants felt that by exhibiting self-acceptance to others, they were relaxed and comfortable with their sexuality or gender and would advance their chances for social acceptance. However, being genuinely mentally healthy was seen as imperative in being able to participate confidently in awareness raising and education about LGBT status and experience among heterosexual peers and families. For example, Ariadne, a 42-year-old bisexual woman and a doctor said that she was accepted in her working and educational environment as she was able to perform her bisexuality unapologetically, just as heterosexuals live their sexuality, and because she presented her same-sex partner, just as heterosexuals present their opposite-sex partners.

I am a person who had a same-sex relationship in the university and never hidden it. Nobody said or did anything to me. In my work they knew I had a same-sex relationship and nobody had a problem with this and they dealt my relationship as a normal relationship. Namely I trust people, I trust them, and I think the way you present this to others is crucial. Namely if you are nervous and you are not getting along with yourself the others will also think that there is something wrong with you, they will think that what you do is not right. So in this way you give them a push to think whatever they want, but if you are alright with this and you present it like if you were presenting a boyfriend then you will have no problems

Ariadne’s experience is characteristic of how oppression operates against minority groups and the LGBT community in particular. As Fish (2006) argues, oppression operates through assumptions of a deficit and it demands that those deemed inferior approximate the characteristics of the superior. The price of acceptance then for minority groups is to become just like the dominant group which is often employed by a strategy to emphasize similarities and hiding differences. If Ariadne exhibited nervousness, fear, uncertainty or insecurity when presenting her partner, her sexuality would be perceived by her heterosexual

peers as a distinguishable trait and she would probably trigger their inferiority ideas about homosexuality/bisexuality. This, in turn, would possibly jeopardize her inclusion in her environment, which appeared to be another important reason why the majority of the participants who experienced mental health problems or homophobic/transphobic violence did not share this information with their families of origin or with their heterosexual peers. Unfortunately, for at least some of the participants this would also mean extended periods of suffering in isolation and deprivation of social support.

Despite the many ambiguities involved, the majority of the participants reflected on ample examples to link the emergence of mental health problems with the everyday experience of homophobia. One participant even linked the emergence of autoimmune diseases and congenital heart diseases to lesbians and gay men as a result of their exposure to excessive amounts of stress in their daily lives. Referring to her network of lesbian and gay friends, Sofia said:

I am not sure if it is a coincidence, although I speak with a lot of people, if it's just a coincidence. For example a lot of my friends have autoimmune diseases, I don't know if it is... for example one friend of mine has lupus, this is autoimmune, she had no history of lupus in her family, nothing, another friend of mine has congenital heart disease, again without any history in her family but she has a serious problem with her heart since she was very young, INCREDIBLY many psychiatric cases, namely I don't even believe this. Sometimes they say that I am very... but I see many psychiatrically problematic behaviors... You can see that some people are not well from the way they act, I mean psychologically they are not well, namely I see a lot of mental health issues to the point that I have told Eleni [her partner]... not in a racist way but I want to really know somebody before I make him/her a friend of mine (Sofia, 32 years old, lesbian)

In reference to the mental health issues of gay men, Paul, who was a seasoned gay activist, argued that many gay men are involved in self-destructive behavior which is often expressed through the way they do sex, including unprotected sex or sex which is unpleasant and an aspect of their self-destructive behavior. From my observations, gay men did not always relate unprotected sex with self-destructive behavior except if they detected untreated STDs in their sexual partners. In particular, during my field work I met several gay men who shared

their dating stories with me. I noticed that those who had detected untreated anal warts or other suspicious skin infection in their partners had immediately characterized them as being “mentally unstable” and they usually avoided dating them again.

Paul argued that unprotected sex is strictly connected with, and an outcome of, the homophobic context where gay adolescents develop their sexuality. In the following excerpt Paul exemplified his argument by referring to his ex-partners:

Three or four years ago I was totally freaked out when I realized that all my ex-boyfriends had similar characteristics, they were a bit younger, with higher levels of homophobia, who do not easily discuss openly some things etc., they were all diagnosed with HIV [...] I can see how much the self-destructive and obsessive- compulsive sex dominates the gay community. This is exactly because the first developmental steps of a gay adolescent or a preteenager are made in a totally unacceptable context, namely, if a 13-year-old gay adolescent [he refers to an ex-partner] could make his first steps normally like all other children he would experience sex completely differently but instead he experienced this intervention by a 28-year-old guy which was in fact abusive, so this was something that marked my ex. Two years after we broke up he told me that he was infected, but I knew how he used to do sex, and this was clarified when we were together that he basically asks to be abused and he continued this

Paul’s argument is consistent with a substantial body of literature which explains the causal link between homophobia and the self-harming behavior including risky sexual behavior (Aho et al., 2014, Hunter and Baer, 2007, Shernoff, 2006, Fisher and Akman, 2002). In particular, it has been argued that heterosexism, homophobia and transphobia distort the developmental processes of individuals from the early stages as children develop awareness of the ways in which members of their sex are supposed to act (Savin-Williams and Cohen, 2007). Children who have same-sex attractions realize that those feelings are likely to be viewed negatively by their society and they are prone to societal meanings of straight and gay life which are structured by the omission of homosexuality, the invisibility of LGBT positive role models and the domination of popular myths, e.g. that all gay persons are promiscuous and incapable of forming mutually loving relationships and companionship (Fisher and Akman, 2002, Ritter and Terndrup, 2002). Many may begin to fear humiliation or even physical violence if others

discover these attractions and as they are denied opportunities for peer dating and socialization they may turn to anonymous sexual encounters with adults. All of these factors also help to reinforce the power of internalized homophobia in an individual's psyche. Internalized homophobia may create an unconscious sense to the individual that s/he is unimportant, undervalued, and not worth very much, thus increasing his/her sense that s/he is expendable (Shernoff, 2006).

In my study unprotected sex was reported by two gay men, all lesbians and bisexual women but none of these participants related their behavior to internalized homophobia. However, many participants, and especially many of the youth, argued that their sexual wellbeing had been harmed during their early stages of their coming-out process due to internalized feelings of homophobia and transphobia or by their excessive fear of HIV/AIDS. As Fisher and Akman (2002) state, the early stages of the coming-out process can be extremely stressful for the LGBT youth and as adolescents attempt to understand themselves and how they fit into the society, various coping strategies are employed. Some of these strategies that LGB youth appeared to employ included: the avoidance of any sexual activity until adulthood or until they leave to a bigger city, a turn to religion and spirituality, dating opposite-sex partners, and extreme focusing on studying. In most cases, those coping strategies were experienced as a delayed social and sexual adolescence and often entailed isolation, depressive symptoms and despair. The following two examples are characteristic of the mental health consequences of homophobia during the early stages of the coming out of LGB youth. In the first quotation, Panos, a 19-year-old gay man, argued that much of his psychological functioning had been "switched off" before he eventually decided to come out to his friends and connect with the LGBT community. He said:

During the first year [of studies in university] I remember I was far behind in this respect, I had no sex drive at all, namely I had no horns at all, I was very much in denial, obviously my impulses were suppressed, it was when I tried not to think that I am gay and I was trying to do something with a girl... I was trying to get the fact that I was gay out of my head, I couldn't even flirt, somehow I could flirt with a girl spiritually but without sex, and later with all this pressure I had, my body was also in pain, I had no energy, zero efficiency, sleeping all

the time, sleeping was my basic need more than anything else, I was in a complete weak state until I started to come out to my friends and suddenly I felt like my organism switched on [...] I moved on and I said that's enough, there is no way to lose another school year crying, I have to live it!

Similarly, Aris, a 20-year-old gay man, felt that during his early stage of coming out he imposed himself into a "pause" although this was limited to sexual life. Targeting high grades in school that would secure a place in the university and a life in a big city was part of Aris's resilience strategy. Fortunately for Aris, his strategy succeeded as he wished. At the time of the interview, Aris was already a medical student in a big city and a member of an LGBT organization.

I think I was retrogressed in a way, developmentally let's say, it wasn't bad, but I was attached to my toys, my comics, I was in a more childish phase because I had imposed to myself a limit that I will do whatever I want once I finish school and leave from the village to go in a big city, I wanted to go to Athens, so I imposed myself into a pause, a completely asexual phase, nothing, nothing

Moving to a bigger city from rural areas, coming out to friends and connecting with the LGBT community appeared to be the three main resilience strategies that the two young men above used in order to deal with the psychological perils they encountered. Particularly those who had the chance to connect with the LGBT community had also the opportunity to develop their self-concepts through the collective meanings that were developed in LGBT groups. Furthermore, they also seemed to have advanced a sense of belonging to a community which is found to be associated with fewer depressive symptoms (McLaren et al., 2008).

LGB participants who had experienced depression, suicidal ideation, self-harming behavior or even a suicide attempt, all linked their experiences with homophobia, parental rejection, the fear of homophobic violence, post-traumatic stress due to actual incidences of being victimized by homophobic violence/bullying, and to some extent with internalized homophobia. Availability of support and alliances in the environment where each participant lived was the major factor that determined the severity of the effects of a homophobic trauma as well its long-term consequences on participants' mental health. By contrast, those who lacked

supportive resources were extremely vulnerable in homophobic violence exhausting their energy in a continuous battle with hostility and struggle to stand on their feet.

One of the most characteristic illustrations is Apostolos whom I interviewed in a period when he was still recovering after a long struggle with depression and post-traumatic stress. We decided to meet in his small apartment in order to ensure privacy. As soon as he started to share his story with me, Apostolos closed the windows as he was harassed in the past by his neighbors who were calling him names in the middle of the night. Similar to many others' stories, Apostolos was one of those who had targeted entrance to university primarily because of his desperate need to leave his village and move to a bigger city. Apostolos said that his entrance to the university was experienced as a prize for surviving long-term homophobic bullying and harassment from schoolmates, teachers and his family. Apostolos remembered that bullying against him started when he was just 8 or 9 years old while in primary school, which was continually increasing throughout high school years reaching the point of being victimized by three boys who immobilized him and pretended that they were raping him in front of all his classmates who were joyfully laughing at the scene. Apostolos described:

I was beaten up and nobody ever protected me, even the boys who were friendlier never got involved, maybe they were afraid that they could come into my position... they were afraid that they would be targeted like I was... they were crawling me over the gravel but the worst experience in high school was.... one day, two boys pushed me in a corner and a third boy was behind me and he was moving like he was fucking me... it was so humiliating....also because we were in the classroom and all children had raised their hands up and they were laughing, and they were laughing, I don't remember what they were saying, but at this moment I really felt that I will be a laughingstock for the rest of my life

Despite the brutality of the assault, Apostolos argued that none of the adults in his school ever learned about it. Students also kept silent and no-one ever mentioned this to an adult. His family was not aware of this either, as Apostolos had decided to keep silent on the incident too due to a change of "*policy in the home*". Before

this incident Apostolos' mother had repeatedly visited other children's parents to make their children stop bullying her son, albeit unsuccessfully. Apostolos described his mothers' last complaint to the headmaster of the school who excused bullies on the basis that Apostolos was provoking their attitude with his "feminine" behavior. Apostolos' parents then decided to change their protective strategy to their son by teaching him "how to be a man".

One day my mother went there [to the headmaster of the school] to make a complaint and he said, he was a teacher, right? "Madam, what is the fault of other children who laugh at your son since he is provoking them?", and I am wondering, what exactly was provoking? What is provoking to a child's attitude when he is in high school age? Was I going to school too bendy? And I remember as they had called me bendy once, I was afraid that maybe I moved in feminine way so I used to attach my hands to my waist and legs so as not walk like... to not walk like... this... but the more they saw me trying, because they could see I was nipped-up the more they did all these, so my mother changed completely her policy after she talked to the headmaster, and she told me that I had to harden myself, she was saying that there must be something in my attitude that everybody wants to hurt me, "if someone beats you, you must beat him back and if you cannot do this you must suffer it until....", until you become a man, so there was a period I was being terrified in my own house because every time I was beaten up in school I went home but I couldn't talk to anyone as I was repeatedly threatened by my mother that she knows all my teachers and they had asked them to check if I had cried or laughed, and if I did I would be beaten up by her in home, so when I went home I didn't say anything, I went through this alone

What is clear from the quotation above is that Apostolos' parents had finally surrendered to the abusive strategy of the bullies and acted upon the homophobic ideas that structured their son's abuse. Apostolos left his village to study in a university in one of the largest cities of Greece. As soon as he started to meet other gay men, he realized that the public image of gay men was completely distorted as a result of the homophobia reproduced via the mainstream media in Greece. By meeting other gay men, Apostolos also realized that one may have a love life and started to de-pause his sexual impulses similar to others participants' stories. His confidence then started to recover and as a result Apostolos decided to come-out to his mother. The news was devastating for her and Apostolos found himself in a new round of homophobic reactions and insults,

this time mainly from his close but also extended family. Soon after his coming out to his mother, Apostolos started to experience depressive symptoms which were gradually developed to suicidal ideation. After a bad experience with a mental health professional who defined homosexuality as a mental illness in front of his mother, Apostolos finally found support from a gay friend who helped him find the outlet from both depression and homophobia. The following excerpt from Apostolos' interview provides important insights for those who are interested in an in-depth understanding of the link between the experience of homophobia and the gradual development of a mental illness and how those two feed one another.

Depression is gradual, it is not a sudden desire to die, in the beginning you say that "ok, it is a sadness", and there are other things that make you happy as well, you can laugh, when I was suicidal I remember I called my mother and told her "mum I called you to say goodbye you", and she said "you are a coward", so at this moment.... I didn't feel any hate or something, I just said that I am lost case, that I am a lost case, if your own mother says that you are a coward no one can and there are many people who say that those who suicide are cowards, but in reality they are not cowards, it is an exclamation of dismay, a cry for help which is not heard, this is what it is [...] so I began to go deep, deep, and deep and deep, I didn't even enjoy eating, I didn't have taste or smells, I was bored to get out of the bed, it was difficult to sleep at nights, I was bored to wash myself, I stayed unwashed for days, in the beginning I was saying that it is just a phase, I will get over this, maybe something nice was happening at the same time, I was saying to myself that I am not depressed, but I was going deep, more and more deep, I also had panic attacks and all these things, I saw things completely wrong, completely illogically, so I started to get used with the idea of death, namely "what's the point? We will never be accepted", "people will always make fun of us", I thought that whatever we do, no one will say anything, nothing, things that you don't say when you are psychologically well, when you are ok you say "I don't give a crap!", "do as you wish, I am carving my own path" [...] my buddy Nick, I have no words about Nick! He is an angel! He is a man of God, if there is a God.... I had friends that I was talking to, they were supportive and they were listening to me because they could see that I needed it, but they didn't know how to support me because straights haven't suffered common things with us, so Nick had similar experiences, and he told me the right things to do, he said that I had to

set boundaries to my relationship with my mother or whoever hurts me, and indeed there is nothing healthier than setting boundaries with people, to set your limits, “that’s it, this is what I like, this is what I don’t like”, do you understand? He later told me that I have to stand on my own feet, and here I am, now I can see... I can see that we don’t see the world as it is, but as we see it through our inner condition at a particular moment

This section discusses the way that participants perceived the impact of homophobia on their mental health. I highlighted some of the factors that make it difficult to outline the causal link between the occurrence of a mental health problem with homophobic trauma including the difficulty identifying homophobia and its individualistic understanding which results in a secondary stigmatisation of LGB people. Other factors were relevant to the experience of a mental health illness which sometimes signals the devaluation of the accomplishments made by those who struggled with internalized homophobia and the difficulty in knowing the root cause of a mental health illness. In the following section my focus is on transphobia and the ways that participants felt its impact on their mental health.

5.2 Trans participants’ perceptions of the impact of transphobia on their mental health

Many of the mental health concerns of LGB people overlap with those of trans people as gender variance is the phenomenon that unites all these communities (Lawrence, 2007). However, LGB persons are gender variant mostly in their sexual partner preference although some of them may also identify as trans or cross-dressers. By contrast, trans people are those who live outside normative sex/gender relations as their gender identities, often including their gender expression, vary significantly from what is traditionally associated with or typical for members of their biological sex (WPATH, 2012, Namaste, 2000). Therefore, trans persons are mainly targeted because they transgress the binary gender model usually, but not necessarily, by aligning their biological sex with their gender through hormones and/or sex-reassignment surgery, by changing gender expressions and mannerisms, dressing etc. In fact, one participant defined

transphobia as the societal punishment of those who modify and disturb the “nature” of the body, particularly the sex-related body parts that are socially valued as sacred.

[...] I am oppressed by an extra form of oppression, you can understand it but you haven't experienced it, it is the transphobia within a society which is against changing your gender. That's it. But I don't even like this term because it implies that you change something when in fact you just change a body, you don't even have to do this, you may not even take hormones but you can still be trans, you may have socially transitioned, you say “Hi! My name is not Mitsi anymore, my name is Kostas”, whoever doesn't speak to you by using male pronouns denies your gender. It is oppressive when people do not accept your gender and expect you to do something first, an effort or something... people expect to see first.... In order to be Kostas you must have hair on your chin, people expect you to appear and behave as man, people expect things from you, and namely they are throwing the ball to you. “I will call you Kostas but only if you do...”, “No! you must call me Kostas and I am doing nothing about it”.... cis persons do not understand why we do all these things, and sometimes they are even more aggressive “how did you dare? Why did you change the body that God gave you? Why did you change the body that nature gave you? Am I stupid that I remained a woman?” (Fanie, 34 years old, trans woman)

Despite the many differences among the trans participants, all of them had at some point of their life experienced or were still experiencing discomfort with their bodies as a result of the discrepancy felt between their gender identity and the sex that they were assigned at birth or the associated with sex gender roles and/or primary and secondary sex characteristics. In other words, what is typically defined as gender dysphoria, (WPATH, 2012) although some participants did not prefer the term as it reflects the psychiatrisation of gender identity and they used the term “body dysphoria” instead. The emotional result of body dysphoria for participants was often depression, anxiety, distress and an often restless urge to change body and gender expression. For example, Melina, a 29-year-old trans woman said:

[being trans] is not something you choose, you just experience it, and since for some reason it happens to you there is no reason to hide; to hide it from whom? It is meaningless anyway, because a trans person is choked by his own body, do you understand? It is not all these

fucking stereotypes that people believe that a man who wants to be a prostitute dresses up and all this shit, it is not that, it is not that, your soul is different than the body with which you are born, this is what trans is. And of course this has a great impact on mental health too, heavy depression, suicidal ideation, despair because many trans persons do not have the money to “correct” their body, that’s the reason, and of course many trans persons have no support from their families

Body dysphoria and the consequent impacts on mental health appeared to be at least exacerbated by the many manifestations of transphobia and the rigid norms of masculinity/femininity which oppress human diversity. This was reflected by Jason’s argument:

society makes trans condition very difficult, despite that we do want transitioning to be as quick as possible, I believe that society presses us, society is nasty with us if we don’t reach its standards, this is why we press ourselves and we keep saying to ourselves “am I masculine enough? Am I feminine enough?”, “ah! my nose, my ribs, I have a cock, I have breasts, ah! Help me, I don’t like these” and all these things, so, I believe that if we lived in a different society we would not be like this, I believe that this body dysphoria including the body dysphoria which cis persons or other queer persons experience would be lesser

Jason was an 18-year-old trans man who had just finished school. In a context like in Greece where there is a complete lack of public understanding and acceptance for trans persons, Jason at the age of 11 developed depressive symptoms as he already felt that his body was somehow “destined” to correspond to social roles that were not aligned with how he experienced his gender. Jason in his own words said:

It was when I was 11 or 12 years old, I had just entered puberty and I already had something like depression, I was in a mess, and it was also the trans issue involved that I didn’t know exactly what was happening to me, I was trying to accept my social role and my body in the way that this body was being interpreted through this social role, this was not possible, I had incredible dysphoria with my body and my parents could see in what mess I was, and because they are a bit overprotective they took me to a psychologist who however was

completely inappropriate, she was a completely inappropriate person for these things, I don't think she helped me, maybe her approach was not that good, she was interpreting things Through the unconscious I think, she was interpreting all things through this, I mean everything! Everything! She used to tell me not to wear my father's clothes, that there is the Oedipus complex which does all these things... ok, maybe there is such a complex but it doesn't mean that we must reduce everything according to this theory, namely.... All these things are theories, you cannot generalize everything, this is unbearable, so at some point I came out to her (Jason, 18 years old, trans man)

In the quotation above Jason described that his first experience with a mental health professional, which was also the first person to whom Jason came out as transgender, was unable to support him as the psychoanalytic model that the professional used to interpret Jason's experience inadequately corresponded to Jason's need for affirmation of his gender identity. Furthermore, the counsellor, instead of assisting Jason to explore different options for expression of his identity, used the Freudian concept of Oedipus complex to pathologise and invalidate Jason's experience and expression of his gender. To make things worse, Jason described that after he self-identified as a man, his counsellor explicitly started to deny Jason's identity by even asking Jason to provide some short of evidence for being a man. In fact, this is exactly what has been described as one of the most prominent forms of transphobia; an authoritarian denial of someone's identity based on preconceived and limited notions of sex and gender roles (Namaste, 2000). This form of transphobia may entail body-shaming and, most importantly, may reach the point of denying trans persons' right of agency and self-determination. The restriction of trans persons' right to self-determine themselves was actually a predetermined response of the mental health system which appeared to be underpinned with the transphobic idea that trans persons are mentally ill therefore limiting their ability to decide what is best for them. In the quotation below, Jason describes how his counsellor's transphobic denial of his self-identification was extended to the point of being denied his right and capacity to determine what is truly therapeutic for him or not. In the quotation below Jason describes his counsellor's reaction to his coming out:

She [the counsellor] reacted very badly, she said that I am a girl but I just don't know it, she said that there are many masculine girls and that I should adjust with this, that it is not necessary all girls be very feminine, back then I was much more masculine because I was trying to prove the unproved, [he laughs] anyway.... Because she insisted on this and I also insisted on who I am, she started to ask me about my physical characteristics like "where is your thing?", she asked me this, of course she asked it with her own way as a psychologist, but she literally asked this and I said to her "No! no! I can't stand this anymore, what things are you asking me?", after a while I managed to forcefully escape because she wanted to keep me. I told her that I am going to visit a psychiatrist and she got happy with this as she thought that I would be helped more by a psychiatrist, so I also told my mother that I am going to stop visiting her

After two other similar bad experiences with mental health professionals, Jason finally found an appropriately trained psychiatrist to support his transition. Meanwhile, Jason had accomplished to educate himself on trans issues, feminist and queer theory and had therefore managed to advance his capacity to resist against the blatant forms of transphobia by the mental health professionals he met as well as educate his parents who gradually became really supportive towards him.

At the time of the interview, Jason was awaiting a written diagnosis of gender dysphoria which was a prerequisite in order to have a mastectomy and hormonal treatment. After all these years of being subject to societal pressure to prove his gender identity to his counsellors, parents and friends, Jason said that only after getting this letter would he finally be free to experiment with his gender expression in the way he wished. As Jason argued, there appeared to be a shared understanding between his psychiatrist and himself. During their last session the psychiatrist appeared to witness that all these years Jason was constrained to "wear a suit of armor" so as to conform to the psychiatrist's expectations and perceptions about gender. Similarly, all other participants appeared to be in a constant struggle to prove their gender identity to others or to themselves. The impacts of this pressure on the mental health of trans participants were immense. For example, for trans youth the development of secondary characteristics of their birth sex was sometimes emotionally devastating as they felt that their bodies betrayed them and verified societal

denial of their gender identification. For example, breast development and menstruation of trans teenage boys, chin hair and body development of trans teenage girls were all body changes that sometimes caused enormous distress and body discomfort. For two trans youngsters body discomfort had an immediate negative impact on sex satisfaction and imposed a “pausing” phase of sexuality development on them similarly to that experienced by gay adolescents. For trans youth, however, this “pausing” phase appeared to be prolonged as a result of the many barriers that delayed their gender transition. As many trans persons felt mismatched with their bodies or with the gender-specific parts of their bodies, their comfort to get sexual pleasure was restricted. In the extract below, Andreas, a 20-year-old trans man, described the impact of body discomfort on his sexual life:

I had only some glimpses when I was in a party... but I generally never had [sexual mood] to be honest, it is different to do something to your partner and it is different to allow him/her do something on you, this is very important, I never allowed anyone clearly because of my body, I believe that once my transition is complete, I mean the surgery and all these things I will be more “cool” with myself, more liberated

However, sex satisfaction and body dysphoria both appeared to be strictly connected with how transphobic the environment was perceived and experienced by trans participants. This was clearly exemplified by Lena, a 22-year-old trans woman who reflected on her experience from her recent travel in The Netherlands. When I asked Lena to compare her experience of living in Greece to The Netherlands in terms of transphobia, she replied:

My God! What can I say? I will just say it was a huge difference indeed! Quite contradictory! Where can I start from? I will just tell you that I could go out in a bar and find anyone to have sex with, without any worry, nothing, I didn't have any anxiety about my genitals, about how he will react, about nothing, it was just that simple

Furthermore, the dominant conception of gender as being grounded in a person's physical anatomy and biological characteristics such as sex chromosomes and sex hormones made two trans youngsters try to confirm their internal sense of

gender by hormonal tests. For example, Angelo, 18 years old, during our interview said:

Now I am thinking of having a hormonal test, to check if I have more female hormones. What do you think? Do you think it is certain that I have more female hormones? I don't know, what do you think? Namely do you think that there is a possibility for the test result to indicate that the male hormones dominate? [How do you think this test will help you?], I will say to myself that this is who I am and that's it. But even if the test show that I have more male hormones I am still certain, but there is also this possibility

At the time of our interview, Angelo had already started to experiment with his gender as more female by wearing make-up, dressing privately with female clothes, adopting female mannerisms. Yet, his gender expression had always been treated with hostility by his environment and he had been traumatized by awful assaults. His parents had beaten him because they saw him wearing women clothes at home, schoolmates, friends and teachers had repeatedly humiliated him in school, his safety was threatened by his peers, he had lost friends when he disclosed that he deep/inside feels being a woman and he already felt that strangers mock him in public spaces. Despite the abuse Angelo had suffered, my impression during our talk was that Angelo remained emotionally detached from his experiences which were probably one of his coping mechanisms so as to bear the emotional pain. However, his need for positive affirmation of his gender identity was apparent and expressed in many ways. As indicated in the excerpt from Angelo's interview, his need for a hormonal test was part of his need to find verifications and affirmation of the fact that he inherently felt like a woman. Other ways in which this need was expressed were his efforts to "prove" during our interview that he was never attracted to women, as heterosexuality is socially one of the primary identifiers of being a man or a woman. Angelo also expressed being happy when he was assumed to be a woman in public spaces and was persistent at asking me if I can actually see that his physical characteristics are female.

One of the most important challenges on the mental health of trans participants appeared to be the everyday stress which was associated with "passing" and its

interplay with the prominence of societal negativity and violence towards trans and gender non-conforming persons. This stress appeared to be exacerbated by the fact that most of the participants had identity documents that did not accurately reflect their current name, gender identity and gender expression.

In Greece, like in most countries of the world, documentation of identity uses the biological concept of two distinct and mutually exclusive sexes, females and males, which become the primary marker for identification (Tauches, 2011). Furthermore, the law in Greece does not allow people to reassign their gender on official documents without first having sex-reassignment surgery. In the quotation below, Fanie, a 34-year old-trans woman, exemplified the detrimental interplay between societal transphobia and statutory denial of gender identity which enforces trans persons to negotiate their access in public services on an everyday basis if they are in the process of getting psychiatric approval for surgery as many trans persons do not want or cannot afford the surgery.

For two years I lived as a woman but I had a male ID. Do you know how shitty situation this is? I was going to a bank and they were telling me that I am lying about who I am. I remember I went to a post office once to collect something I was sent. I went like I am now but my ID had a male name, inevitably, you can't even change a photograph, and you can't change the name. So I went there but no one from the staff could understand my claim so they called their manager. I explained him very clearly that I am a trans woman and this is my ID and "what can I do?" So, he started to say "come on girl, you are so beautiful, what are we going to do now?" and "you are kidding me" and "I don't know if you are kidding me" and I said "are you serious?" and then he got upset but he also started to make jokes, and I said "do you want me to lift my skirt to check if I have a penis or not?" and he said "dude ...eh... young lady we are not making jokes with these things", ok! All this time he was making jokes with my gender but this was not a problem! Anyway... he gave me the letter and he said "I am giving it to you but I hope I will not get any trouble", fuck off you idiot!

Crucially, Fanie's story is revealing of how differently stigma is experienced by trans persons in contrast with the LGB people who are impinged by what Herek et al. (2007) define as sexual stigma. In particular, contextual realities such as the statutory and bureaucratic regulations that significantly constrain trans persons' right for self-identification and as a consequence their right to manage issues of

visibility/invisibility, require a careful application of theories on stigma/stigma management. For example, what is clear from Fanie's story is that her ability to control information of herself was considerably constrained by the fact that she was exposed to enforced discrepancy to appear publicly as female holding a male ID. This suggests that Fanie was enforced to make her stigmatized status visible by revealing personal information that often relationships with strangers are not really needed. She was also forced to disclose this information without first being able to secure safety from possible transphobic reactions. Her vulnerability then relied on her limited ability to apply what for other stigmatized minorities would be at least partially available, that is to "pass" herself as a member of a non-stigmatized social group which has also been defined as a major stigma management strategy (Herek et al., 2007, Goffman, 1963).

Moreover, trans persons who failed to pass as cis-men or cis-women either because of mixed female and masculine characteristics or because of the discrepancy between appearance and IDs were often socially punished as they very often experienced extreme forms of public humiliation and abuse for this "failure". Therefore, the need of trans persons to pass themselves as cis persons was not only part of the internalization of societal gender norms but crucially it was often a cognitive protective strategy from transphobic violence. Overall, the trans participants whose ideas were informed by queer theory appeared to be more liberated to express their gender, more comfortable with their bodies and more self-accepting. However, they were equally prone to transphobic violence and public shaming. An example of the transphobic punishment of trans persons was provided by Fanie:

Non-trans people do not understand the oppression of trans although it is an everyday experience. I went once to get paid [from the company she was working as freelancer] and although I faced the same difficulty like every time I was there, this time was the worst. In the entrance of the building there were two guards and one of them said "hey girl what's up? Did you come to get paid? Ah! Good! Just give me your ID please", I tried to avoid it, I said that they are waiting for me upstairs but he insisted, so I gave him my ID and his attitude immediately changed completely, he got really strict and when I returned they were laughing with my ID, they were holding my ID and they were laughing, I said "give me my ID" and I just left. It is difficult not to be understood, ok, this denial is very common, the denial of parents with gay children is also very common, one comes out as gay to his parents and after

two years they say to him “you never said to us that you are gay! Why are you doing this to us today?” “but you know this two years now!”, to trans persons they often say “but you don’t look like a woman... you are lying, you are saying bullshit, we don’t believe you, we don’t accept you, if you looked like a woman we would accept you but you don’t, so fuck you, it is just a caprice”

Because of negative experiences like these described by Fanie, three of the participants appeared to actively avoid situations that necessitated presenting an identification paper to any authority or services as they found the whole experience to be humiliating. This appeared to be exacerbated by the prominence of societal transphobia and violence that participants lived on a daily basis. For example, by the time I was interviewing Lena, a 23-year-old trans woman, the Greek elections were approaching and we were drinking our coffee in Exarcheia region which is a well-known quarter for Greek anarchists, leftists and a safe area for ethnic/racial and sexual minorities. Lena had chosen this place as the appropriate context for the interview to be held although she would later reflect on several violent transphobic attacks that were held in Exarcheia Square, one of those published also in the social media, the feminist/leftists and LGBT blogs (Queertrans, 2015). Lena herself had become a victim of transphobic bullying and verbal attacks several times in several public spaces including in Exarcheia region. In one incidence the perpetrator of the attack was a police officer who was surrounded by his colleagues who were laughing with the transphobic insult. In the quotation below is Lena’s own description of the attack in an otherwise safe region of Exarcheia:

Two years ago I was walking near a police squad in Exarcheia, there were many cops, and suddenly one yelled at me “And the father was handing 5,000 drachma notes [ie highest denomination] and was bragging it’s a boy! It’s a boy!”, and the others were laughing

Not surprisingly, when Lena described that she had also become the victim of continuous and long-lasting transphobic bullying in her own house from her neighbors she did not consider police intervention could ensure her safety:

I don't have problems in this area, like I used to have two years ago when I was renting a house there Should I declare their nationality? Is it necessary? Anyway... they were Georgians, they were renting a house in the same block with me, I had a problem with them, they called me names, of course in their own language, but they yelled at me every time they saw me in the corridor of the block, and sometimes they called their friends and they all sat in the ledge of the entrance of the block and every time I passed they started again [...] I only told this to my mother and she said that there is nothing we can do... of course there was nothing we could do, what could we do? Call the police and say about this transphobic attack? That they are calling me names? What would police do since I am attacked by police? How could police help me?

Overall, homophobic and transphobic harassment by police officers and squads was not uncommon. Other participants also reported being harassed or having a friend that was harassed by police officers and squads. These cases mostly involved the victimization of gay men and many trans women. As already discussed in section 1.3, during 2012-2013 a systematic prosecution and police harassment of trans women was held under the pretext of ID verifications and the health provision 39A that allowed enforced HIV screenings in police departments (Mavroudi, 2013, Galanou, 2013). Against this background the State and its institutions played a significant role in the increase of societal hostility and they were also directly involved in the increase of violence. Particularly the transgender participants expressed their distrust and detachment from the upcoming electoral process. The interlink between the societal transphobia and the absence of legal recognition of gender identity that forces transgender persons to change their official documents only when they have a sex-reassignment surgery is exemplified through Lena's words:

I am not going to vote.... First of all, I am afraid of going to vote, namely at the time of the elections my appearance will have already been changed.... Meaning, I will have to show my ID to a random person and say that I want to vote? They are going to stare at me from top to bottom; I don't want to go through this, besides I don't care if I vote or not, so why should I go through this since I am not interested in voting?

Overall, the interplay between transphobia and citizens' rights concerning the impact of mental health was crucial for trans persons. The emotional result of body dysphoria that all the participants had experienced or were still experiencing appeared to be at least exacerbated by the institutionalized rigidity of norms of masculinity/femininity imprinted on the mental health care system and the legal conditions for changing gender identity in documentation papers. Physical and verbal attacks in public spaces were strong issues among the trans participants which had an immediate and recurring impact on their overall psychological and social wellbeing. In the following section I discuss the ways that doctors perceived the impact of both homophobia and transphobia on the mental health of LGBT people.

5.3. Doctors' views on LGBT mental health vulnerability

Doctors who participated in my study never used the terms homophobia, transphobia or prejudice to express societal negativity towards LGBT people. When they used these words it was usually after I had used them first in our discussion. In reference to the discussion regarding LGBT people's mental health, doctors usually used the concept of stigma or societal hostility to link the emergence of mental health problems with the LGBT status of their patients. In particular, 6 out of 10 doctors stressed that LGBT people are generally more prone to stress-related health problems, particularly those related to mental health such as anxiety disorders, panic-attacks and depression. Nevertheless, when doctors exemplified this argument their examples referred to gay men rather than any other category of the acronym LGBT.

In addition, although some of these doctors perceived that the stigma experienced by LGBT people is somehow "irrational" or exacerbated (see also section 3.4), they believed that societal negativity or the stigma attached to LGBT identities are important stress factors that are at least negatively replicated to the mental health of LGBT people. Stelios' response is representative:

Societal rejection is a stress stimulus, an important stress stimulus which may precipitate a mental disorder or exacerbate the symptoms of a mental health disorder. Besides, the model of psychiatry is the

model of predisposition and of stress, namely stress can activate a predisposition which may not be activated if this stress stimulus was not involved. I think homosexual people or those who are different in terms of their sexual behavior are exposed to more stressful conditions at least during some periods of their life, so, within this context, a mental health disorder is possible to be manifested (Stelios, 44 years old, psychiatrist)

By referring particularly to gay men, two doctors related the emergence of anxiety disorders and depression specifically to those who are closeted or those who have not reached the later stages of the coming-out process of their identity formation. For example, Leonidas, a 56-year-old psychiatrist said:

I haven't dealt with such cases a lot, but I think that particularly those who want to hide it develop panic attacks or anxiety disorders, this is certain, at least speaking about the cases I had. Namely because of the effort they made in order to hide it, at least to some degree and in particular phases of their lives they experienced a lot of stress which could be developed into panic, which may later develop into depression or addictions

Similarly, Dimitris, a 46-year-old GP by reflecting on his experience with gay men with HIV, related the positive identity development of gay men with better mental health which in turn produces better adjustment in treatment of the HIV. He said:

Those who self-identify and are compromised with this have no problems, they also take care of their health and they are very trustful in what they say

In some cases the acknowledgment that stigma negatively affects the mental health of LGBT people coexisted with homophobic and transphobic ideas that were infused in my discussion with doctors about the mental health of their LGBT patients. For example, Lucas, a 56-year-old pathologist, argued that through his clinical experience he has noticed that gay men and trans women usually suffer from stress-related heart problems. Yet, his view might be somehow problematic as his personal statistics were based solely on his assumptions based on the physical appearance or mannerisms of his patients. Lucas believed that he had no reason to ask the sexual orientation or the gender identity of his patients as this was easily distinguishable by appearance. For Lucas, all gay men had the

“feminine element” and similarly trans women were easily identifiable by the mixture of feminine and masculine body traits. When I asked if he is also able to identify lesbians and bisexuals he said that this is difficult for him to identify as lesbians hide their sexuality and he said no word about bisexuals. In the quotation below, Lucas referred to his clinical experience and particularly to the patients he had assumed to be gay men or trans women and argued that many of these patients had psychological issues. He particularly said:

Many had psychological issues that were expressed also clinically, namely you could see these through cardiology ...yes, very often tachycardia, insomnia, dizziness episodes, heart rhythms disorders, but I am not going deep in these issues, only in cases of young men with hearth attacks, young ages, between 28 and 35, I check if drugs caused this, ask about drugs, this is something that I do need to know, because if he takes drugs, especially if he takes cocaine which may cause pulmonary edema, or stroke, right? In these cases I do ask, but in the other cases I am not going deep

As Lucas believed that my study was about exploring the discrimination of LGBT patients in health care by doctors' attitudes, he was eager to declare that he provides the same quality of services to all of his patients despite his personal opinions about the differential traits of his patients. This is why right after his argument about his clinical experience with gay and trans patients, he made the statement below, in which he explicitly describes homosexuality as a psychological problem:

But even if I believe something for this person I will keep it to myself, I am not going to say anything, I am not going to revenge this person just because he has a problem... because it is a problem, right? Homosexuality is a problem [what kind of problem?] eh... it is a psycho.... This person has split personality, right? Namely, if you visit a psychiatric clinic you will see many of these persons there

Lucas' belief that gay men have split personalities as a result of their homosexuality was unavoidably infused in his practice. When I asked Lucas if he referred such cases to psychiatrists since he believes that homosexuality is a mental illness, he suddenly changed his words and argued that he had never

treated a gay or a trans patient himself. Yet, he stressed that if he would treat one in the future, he would refer the case to a psychiatrist. He particularly said:

I never had such a case, but if I had one I would call the psychiatrist, because I believe that these people must take some medicines too. [What kind of medicines?] Antidepressants, antianxiety medicines for reasons.... They know why... homosexuality may force you to take these medicines [but why?] maybe because they feel.... They have two worlds inside them, so they must make the one sleep/hibernate and exhilarate the other

Lucas also believed that homosexuality can be prevented only through early intervention during childhood or during puberty. According to his view, sexual orientation in adulthood is stable and therefore gay men would never return to heterosexuality. I believe that this view, in conjunction with the view of homosexuality as a mental illness, is an important implication for medical practice and the way that mental health problems of LGBT people are dealt. The belief that homosexuality is an untreatable mental health illness, at least in reference to adults, can possibly make doctors consider referrals to be pointless. As a consequence, mental health conditions such as depression or excessive stress may remain untreatable or out of the therapeutic plans of patients if these are assumed to be aspects of their “untreatable” homosexuality or transgenderism. Furthermore, since homosexuality was an unspoken issue in health care, homophobic ideas not only remained unchallenged but also left doctors uncertain on how to deal with LGBT patients, who had pathological issues that were somehow reflected on their mental health. This is another factor that may lead doctors to ignore the mental health issues of their LGBT patients as the process of a referral presupposes to provide them with a rationalized and verbalized explanation for the referral to psychiatry.

Dimitris, a 46-year-old GP, also correlated societal hostility against gay men with their excessive appearance concerns which he clearly identified as being facets of a mild mental illness defined as “narcissism”. He also argued that depression and anxiety were common to gay men who live with HIV as their life are influenced by a double stigma as well as the psychological distress which is

correlated with the realities of living with a chronic illness. Dimitris particularly said:

If a homosexual by choice lives in a hostile environment it is certain that he will develop a mental illness at some point of his life, this might be some form of narcissism... narcissism, these people are very narcissistic, namely you can see this, they are very well dressed, their bodies, their cloths, if you pay them a compliment you immediately see that they.... this is a mental illness, a mild one, yet it is an illness. Disorders such as depression and anxiety are common, but it is also the [HIV] disease which causes these, when you know that you have this thing and you must take all these medicines, that you have to deal with society which is hostile towards you, your environment which rejects you... now things are somewhat different... their families accept them more... they accept them... they accept them better than before, few years ago when you were diagnosed with HIV it was like in Spinalonga, namely nobody wanted to know them anymore, they were all alone even if they were husbands, parents, they were not even invited in their house for dinner

As Ritter and Terndrup (2002) argue, since Freud's era, homosexuality and narcissism have been correlated in psychological literature. However, this has been often done in a way that pathologised homosexuality. Atkins (1998) argues that this was because of the lack of any recognition about gay culture and theoretical discussion that could produce some sort of explanations in early studies. In particular, although gay culture places an elevated importance on all aspects of a man's physical appearance this is often ignored resulting in an indirect pathologisation of gay identity (Ritter and Terndrup, 2002, Atkins, 1998). Therefore, appearance concerns of gay men may be more related to the process of integrating a gay identity into self-concepts and their need to conform to the norms and expectations of the gay community rather with their experience of societal hostility or any kind of psychological distress. Nevertheless, body dissatisfaction and appearance concerns may indeed be correlated with narcissistic injury as a result of the parental rejection of the homosexually orientated child and affirmative mirroring by the broader society. As Ritter and Terndrup (2002) argue, having internalized many of the heterosexist and homophobic attitudes of their early surroundings, sexual minority individuals have

elevated needs for validation and affirmation, and, thus, are highly prone to develop narcissistic defences that are often expressed through needs for admiration, grandiosity, fantasy, arrogance etc. However, as Ritter and Terndrup (2002) argue, misreading psychoanalytical theories about the narcissistic injury of minority groups may lead to misdiagnosis by incorrectly correlating the narcissistic personality disorder with the above mentioned behaviours and the ways that gay men experience and value appearance in their sense of self.

In this section, doctors' perceptions on the impact of stigma and societal negativity on LGBT people's mental health were discussed. The focus was specifically on gay men as all of the examples doctors referred to were relevant to this group. Overall, doctors believed that LGBT people are more prone to stress-related health problems although this perception was often infused with homophobic ideas. Such implications are worthy of attention especially if mental health problems such as panic attacks, or anxiety are assumed to be comorbid disorders of the assumed primary disease of homosexuality. In the following sections, seven strong topics that emerged among participants will be presented representing the ways that homophobia and transphobia were manifest in mental health services.

5.4 Sexual orientation and trans 'blindness' in mental health services

One of the most astounding issues that emerged during my interviews with the LGB participants, who were in psychotherapy, was that their homophobic traumas were rarely, if not at all, "an issue" to work on in therapeutic sessions. The erasure of homophobic and transphobic trauma in psychotherapy appeared to be an immediate consequence of what is referred in literature as counsellors' "sexual orientation blindness" (Sue, 2010). This is a concept similar to "cultural blindness" which has been more broadly used to describe ignorance of certain cultural areas and the inability to be aware of our ignorance. Cultural sensitivity counterweighs cultural blindness and its negative effects, and is the prerequisite for the development of cultural competence (Sue, 2010, Tseng, 2001).

Sexual orientation blindness often appeared to be part of counsellors' efforts to express their acceptance of LGBT identities and same-sex relationships. In fact, some participants argued that when their direct or indirect (e.g. mentioning a same-sex partner) disclosure as LGBT was ignored or was treated as information that would not intervene in therapy, it was a signal of positivity from the part of the counsellor. This was clearly expressed by Evie, a 44-year-old lesbian, who maintained a long-term professional relationship with a psychotherapist and part of their discussions were her relationship issues. By referring to her current counsellors' response towards her sexuality, Evie said that he gives the impression that "there are no genders" and that he does not make any differentiation between heterosexual and same-sex couples. Evie felt that this was a clear indication of his positivity towards homosexuality and she was overall satisfied at least in contrast with her previous counsellor who was encouraging her to experiment sexually with men. However, when she reflected on an emotionally difficult period she had in the past as a result of conflict with an ex-partner, she argued that she initially could not realize homophobia in the dynamics of her relationship. So I asked her whether homophobia was this time brought up as an issue in her psychotherapy and she replied negatively:

No, we haven't discussed this, I mean we haven't discussed this particular thing, to be honest it took me a lot of time to realize some behaviors, namely her [her partner's] homophobic behavior was a bit covered, namely when a person says to you that "I am a person with strict principles and I don't want to publicize my personal life", so, she was trying to present this with another way, to be honest it was this last year when I realized that... when I reflected on all these incidences and I realized that all these things were the result of homophobia [...] we [she and her counsellor] never discussed about homophobia and things like that...look, I was always speaking about my relationships in psychotherapy but we didn't.... there was no focus on the gender of my partners, there was no particular focus on gender

The example above is a clear illustration of how culturally blind therapists discourage their service users from bringing issues relevant to their minority status into the discussion or interaction. However, denying acknowledgement or even refusing to see race, gender or sexual orientation is a denial of differences (Sue, 2010). In the case of psychotherapy for LGBT people, this results in the

therapists' denial to take the responsibility of helping their service users to explore and raise their awareness of the ways that homophobia hurts them and their relationships. In fact, Kort (2008) argues that ignoring the invalidating impact of homophobia to same-sex couples by adopting a stance that "a couple is a couple" is a covert form of homophobia and heterosexism because it diminishes or disregards the unique issues that gay and lesbian couples face. Although there are common issues and factors that may harm *all* couples, homophobia poses unique challenges for gay and lesbian couples especially if partners are not supported at acknowledging the way that homophobia (internalized or external) is manifest in their relationship. For example, the relational coming-out of partners which may be a challenge especially if partners are in different stages of the coming out process is a common issue among many gay and lesbian couples, also indicated through Evie's story above. Affirmative practice, then, is much more than acknowledging a lesbian or gay couple as a couple. It should involve counsellor's competence at facilitating an educational process so that partners can understand and stop allowing homophobia to disrupt their intimacy and the growth of their relationship (Kort, 2008).

Similarly, counsellors appeared to erase homophobic trauma originating from families of origin. In the example below, Chloe described how both she and her counsellor missed defining homophobia as the root cause of Chloe's mother's negative reaction to her coming out:

I was going to a psychologist some time ago when I had a lot of problems with my mother who had reacted very negatively with my coming out, I was very troubled with this, so I was trying to deal with my mother's homophobia, yet, I didn't see this as homophobia, I perceived this as a reaction of a parent to its child, namely now that I am thinking of this and after three years, I see it as homophobia, but back then... she [the psychologist] also saw it as a problem of a mother-child relationship (Chloe, 22 years old, lesbian)

Coming out to parents usually involved a series of often, long-standing stressful and hurtful events including verbal and physical aggressions between the LGBT participants and their parents, sudden, extreme and uncontrollable emotional

outbursts of parents, grief, feelings of loss and anxieties regarding the social stigma and the fear of HIV/AIDS. Getting advice on how to deal with these was often one of the major concerns of LGBT participants when they firstly sought a mental health professional. However, in most cases, participants argued that their counsellors' effort was exclusively focused on setting boundaries for intrusive parents or facilitating their developmental task of individualization from their families of origin albeit without connecting these issues to homophobia. These basic therapeutic targets of counsellors were truly helpful to participants as they were relevant to the ways that they learned to protect themselves from traumatic behaviors. However, reducing a mother's homophobic reaction to an attachment issue or a normal or common parental behavior rooted in their inability to accept their children's adulthood, appeared to be another expression of counsellors' blindness to homophobia. Expanding this further, by encouraging LGBT persons to accept their parents' homophobia as normal or as a developmental process where both parts (parents and children) must learn to accept each other's diverse "opinions", fuels the internalized homophobia of LGBT persons and exposes them unwittingly to homophobia (Kort, 2008, Greene, 2007).

The pattern of sexual orientation blindness appeared to be strengthened by LGBT participants' fear that their counsellors would attempt to change their sexual orientation or define it as a sign of pathology. Because of the many bad experiences with counsellors who, in a more or less explicit way, defined homosexuality as a form of pathology, LGBT participants preferred sexual orientation-blindness or "professional neutrality". One of the most representative examples is the way that Natassa presented her claim and herself during her first session with a psychologist:

I told her that there is something I needed to tell her so we could speak honestly, I told her that I am homosexual and if she had a problem with this she should tell this immediately so as not to discuss anything with her, I told her that I would pay her but I will just go to search for another therapist, so her answer was "you didn't come here so that I judge you, you came here for a reason and it is good if you want to discuss it with me, it is none of my business what you are doing or don't, I am not going to judge you even if you take drugs or even if you have killed somebody, my opinion is irrelevant and you are not here to be judged" (Natassa, 26 years old, lesbian)

In the majority of participants' experiences, mental health professionals appeared to endorse a "neutral" stance towards homosexuality by avoiding defining it as either normal or abnormal sexual behavior or a choice. Even when participants appeared to challenge their counsellor's belief about homosexuality they often responded with phrases such as "you are not here to be judged" or "it is your choice". The sexual orientation blindness was an effective way to maintain this neutrality stance. Not surprisingly, some participants expressed their concerns for the ineffectiveness of psychotherapy to LGBT people:

I had a relationship with a guy who lives in a rural town, and he is in psychotherapy for 8 years now, or maybe 10? And during all these 10 years he hasn't understood that he has earned nothing from psychotherapy, because I watch him all these years, right? And he is at the same level of self-incrimination, that his gay identity is a problematic one, and he constantly searches the problems that are related with this problematic.... namely he hasn't worked on the homophobic incidences that he was subject all these years since he was a child, and how the context, how society and his family are involved, so as to stand on his own feet, he hasn't stood up on his feet, and it is absolutely certain that such persons have instant explosions of sexual liberation and then they return to the closet of homophobia and during the phases they are activated they are totally self-destructive and extreme (Paul, 36 years old, gay man)

Similarly, by reflecting on his first experience of panic attack at the age of 18, Alex argued:

The first panic attack I had, I mean the panic attack as defined by psychiatry, namely this sudden panic which is accompanied with a fear of impending death, with body symptoms such as increased heart beats, blood pressure, sweating, loss of control, I had all this for the first time when I was 18, I was in a taxi, the driver said nothing, I also said nothing to the taxi driver, nothing had happened to explain the cause, a trigger point or something... after many years I started to realize that these panic attacks had to do with my homosexuality although my psychotherapist believed that this was irrelevant, when I say with my homosexuality I mean the issue of acceptance, the rejection of my homosexuality (Alex, 51 years old, gay man)

Trans blindness appeared to be expressed by the undifferentiated application of psychological theories even under the alleged acknowledgment of the trans status of service users. Therefore, theories that might otherwise have been

employed to facilitate goal achievements proved to be traumatic for trans participants. In the example below, Fanie's experience is characteristic of an inappropriate application of the theory of bereavement:

I used to see a psychologist who was very persistent that I should feel love about my testicles and my cock so as to grief once I lose them, because this was supposed to be the normal. I told her that I didn't feel hate nor love about my cock so why should she force me to love it so that I to mourn it? Why can't we just skip one step and remove it from my body? She told me that in this way I would not do a proper processing of my feelings and all these craps. These are totally nonsense! Nonsense! I never felt grief (Fanie, 34 year-old, trans woman)

In one case, trans-blindness appeared to considerably impede counsellors' ability to empathize with a trans participant who was required by her psychiatrist to have regular sessions with a psychologist in order to be provided with a letter of diagnosis for gender dysphoria. This is particularly important as empathy is considered as one of the foundational dispositions in counselling and an important factor that determines effectiveness in therapy. The excerpt below from Fanie's story is an illustration of how cultural insensitivity can decidedly limit the empathetic ability of a counsellor. Nevertheless, the cruel way that the counsellor appeared to dismiss Fanie's experience raises doubts on whether the concept of trans-blindness alone is sufficient to explain this attitude.

The psychoanalyst who made me cry every time I saw her asked me "how was your week?" and I said, this was a good week because nobody addressed me with a male pronoun so at least this had been a good week for me, and she would reply that this was not important, "is it important not to be addressed with male pronouns? Other things are important", I don't remember anything in particular but she asked me what was important during the week and then she told me that what I found as important is not, so, this kind of intrusive things psychologists do to trans people, because they think that the cunt and the balls are more important than a nose which you can go and cut off whenever you want

In total contrast with the examples above, in two participants' stories their LGB status, issues and needs were placed in the fore ground of counsellors' interest. These counsellors appeared to transcend the myth of neutrality as a form of good professionalism and the heterosexual norm which assimilates LGBT issues and marginalizes LGBT people. For this reason I consider these stories as examples of affirmative practice which really enhanced the resiliency possibilities of the participants. Unfortunately, however, there was not a single similar example described by trans participants.

Orestis, a 30-year-old gay man, visited a psychologist with a claim to get support at dealing with his procrastination which made him postpone important issues relevant mostly to his education and career. Orestis believed that his gay identity would not be an issue to be discussed in therapy as he didn't see any relevance of his sexuality to his claim. Besides, Orestis was feeling very confident with his sexual identity, he was very active within the LGBT community and very conscious of the ways that homophobia, including internalized form, homophobia impedes LGBT lives. However, he was prompted by his counsellor to reflect more on his gay identity. In this way, Orestis had the chance to work on his experiences of homophobic traumas and losses which were relevant to the fall from the grace of heterosexual privileges to the stigma of queerness (Brown, 2003). Orestis in his own words:

I went there because I had a terrible problem with procrastination, so we started to discuss and through our discussions I realized that this was a symptom of other problems, right? So, if there is something helpful in psychotherapy it is that it helps you to see some things that were in front of your nose but you denied dealing with, this is something I realized through psychotherapy, like I told you before I had never mourned that I had never shared with my family things that are related to my sexuality, like that at 18 I was verbally abused, nor that I could not share with them fact for which I am happy [...] I began by asking her opinion on homosexuality, and I told her that I asked her because I am homosexual and a member of an LGBT group, and sometimes there are some members who search for a counsellor, so I could refer her name to them, and she later asked questions about my history, and I spoke generally about my parents, about their relationship, about my relationship with my parents, but I didn't mention anything about my sexuality, and then she told me that she was curious about the reason I wasn't speaking at all about this, so we ended up on dedicating many sessions, on this issue, right? Because it never occurred to me that.... the whole process was revealing and

liberating experience... I saw myself in a complete different way, right? And I really saw, let's say, my internalized homophobia, ok, it is not solely the internalized homophobia because it is a very stressful process to admit the pain and cost of homophobia

Valerie sought mental health support after being rejected by a woman whom she dearly loved and they were friends some years before Valerie realized and admitted her attraction to her. As this was the first attempt of Valerie to have a same-sex relationship with a woman, she was emotionally overwhelmed because the rejection also triggered the fears and the confusion related to the early stages of the coming-out process. Valerie described being relieved as her counsellor responded actively to her fears and questions that were relevant to stereotypes about lesbianism, same-sex attractiveness, and gender issues. The affirmative practice appeared to support Valerie to handle the coming-out process more easily and advanced her possibilities of a healthy and happy lesbian life. Not surprisingly, Valerie spoke with a very positive fervor about her counsellor and the counselling process:

I think this process was one of the best experiences I have ever had, because the first time I went there I was collapsed by the rejection, it was the first time I felt such an infatuation for a woman and I had collapsed by the rejection... the girl was straight, right? She was straight... I am not sure how I would handle this now but back then it was... I was It was this whole situation and I was totally rejected, so it cost me a lot and it was also this whole thing which blew up, so I went there [what exactly blew up?] eh....this whole thing I felt, let's say the first acceptance that I was a lesbian, because it wasn't the first time I felt this way for a woman but it was the first time I had such an infatuation, and the first time I confessed it to myself [...] when I went there I was a person with a huge load on my shoulders and within 55 minutes she relieved me from this, I never had felt this again, at this moment she was a little God to me [...] I was a person paralyzed by fear, worries, doubts and within the first 15' she started to analyze things and she eradicated one by one all of my fears, and I suddenly felt completely lighthearted, she took all the load out of my shoulders, it was a very delightful process

Valerie had chosen a counsellor whom she knew was a lesbian. This played a significant role in the counselling process as Valerie was relieved that not only

she would survive the rejection of the woman she loved but the fact that Valerie's counsellor was a lesbian reassured her that she would also survive as a lesbian. As LGBT people are generally deprived of positive LGBT role models, the identification with an LGBT therapist can strengthen tremendously the formation of a positive LGBT identity (Rochlin, 1982). The familiarity of the counsellor with the LGBT community and its resources was also supportive to Valerie as part of her fears was relevant to the culture of the LGBT community which till then was unknown and foreign to her. As (Meeks, 2011) stresses:

Coming out is intensely emotional, not only because it is personal, but because individuals who come out are participating in a drama that transcends them and that binds them to a community and that community's values (pp.60)

As indicated earlier, professional blindness on the LGBT status of participants was the most common response to the mental health care needs of participants especially for those who did not actively seek to find an LGBT counsellor or a counsellor that was known to have experience working with LGBT people. Cultural blindness could also be described as a form of a prejudice by omission as it does not explicitly speak to the pathologisation of LGBT identities. Nevertheless, examples where homosexuality and transgenderism were explicitly pathologised within mental health services were not uncommon either and will be discussed in following sections.

5.5 Homosexuality as mental illness

Apostolos was in his twenties when he came out as gay to his mother. His homosexuality was experienced as a family crisis; as his mother had reacted in an extremely negative way, she was devastated by the news of her son's homosexuality and she appeared to desperately seek the support of her relatives in order to "save" her son. As Apostolos was imposed to continuously apologize for his sexuality both to his mother and to his extended family, he decided to accept to visit a psychiatrist with his mother so as to get support. The choice of the particular mental health professional was made by Apostolos' relatives who

had chosen one who was both an Orthodox priest and a psychiatrist in private practice. Although Apostolos initially feared that the religiosity of the psychiatrist would be a negative influence to his judgments, he finally compromised with the idea on the basis that “professionalism” and “scientism” would prevail over “religiosity” and the psychiatrist would be finally supportive and affirming to homosexuality. He also hoped that his religious mother would be more open to trust hearing a religious psychiatrist condemning the pathologisation of homosexuality or anti-LGBT attitudes. However, the psychiatrist was explicit in defining homosexuality as being a severe mental illness and he even prescribed anti-psychotic medicines to Apostolos. In the below quotation, Apostolos describes his experience with the psychiatrist:

I was with my mother in his office, and my mother started to say “I am a mother-father, I was born to be a mother, this is my role as a woman, I don’t care about professionals and all these things, I can throw myself into the fire to save my children”, and you know, every time I hear a woman saying “I am a mother” I believe she has a problem! Really! Because she castrates her children, she doesn’t want her children to go away from her, to move on, this is something I really believe, so, she was saying “my son was not like that, in the kindergarten he had a relationship with Mary, we had bought her a pink bag, and he wanted to buy her a pink jacket, and they were dancing”, and she was saying all these tragic things, her dream as a mother was falling apart in front of her own eyes, “my child was not like that”, and then I told her that she doesn’t accept me, although I was totally upset I could still say logical things, that I didn’t choose to suffer all these things, I didn’t choose it, nobody chooses it, and then my mother intervened and said to him “if I didn’t accept him I would have thrown him out of my house”, and then this priest turns to me and says “listen to me, my child, there is no doubt that your mother loves you, there is no mother who doesn’t love her children, many homosexuals have come here and all of them were psychopathological cases, there is not even one case of a balanced person”, so, obviously this person though psychiatrist he was projecting his religious belief, namely this man should not have a license, this person is not a human being, he is an animal, he was destroying me, he took 100 euros for the session and then I told my mother that never would I visit him again, and my uncle who was waiting outside asked me the same thing and I said there is no way to come back again to him. He had given me a small phial with a liquid in it, I haven’t kept it, he told me that you will drink three drops

in a glass of water, it was a dark red liquid [...] he said that it was for the nerves, but he gave this to me not to my mother

Given the explicit homophobic stance of the Orthodox Church in Greece it is easily assumed that Apostolos' psychiatrist enacted on his religious beliefs and prioritized his religious values over LGBT affirmation. The fact that Apostolos' mother addressed the psychiatrist as "father" is indicative of the psychiatrist's power, which was not solely based on his assumed scientific expertise on human behavior but also on the fact that he was viewed as an authority figure of a dominant religious tradition. It is also possible, although not clarified during the interview with Apostolos, that the psychiatrist-priest was wearing his cassock while in medical interviewing as the Orthodox Church does not allow priests not to wear their cassocks, with the exception of surgeons or military doctors who are obligated to wear their military uniform. However, the psychiatrist did not appear to justify his homophobic ideas on religious or moral grounds, but contrarily, to his clinical experience as psychiatrist and his medical expertise to suggest specific medicines to "treat" Apostolos' homosexuality. Given that Apostolos did not reflect on any efforts of the psychiatrist-priest to clarify his identities in their session or to refer to his religious world views, it remains unclear whether the psychiatrist's homophobia was religious-based.

However, historically it is not uncommon the manipulative misuse of scientism in order to disguise and justify blatant prejudices, the denial of human rights, religious or political beliefs. One of the most prominent and extreme example is Nazi racial science which was used to justify massive murders via human experimentation and tortures, massive sterilizations and euthanasia deaths of the "scientifically" assumed "genetically diseased" persons, and the manipulation of Darwinian concepts to evidence the inferiority of human beings on racial grounds. As Greene (2007) argues, beliefs about sexual orientation do not occur in a historical or professional vacuum, but in a much broader social context in which some groups are privileged and others are socially disadvantaged. In this context then, science or scientific evidence can be selectively used to support behaviors, policies or institutions that maintain social hierarchies. In fact, Paul who was a

seasoned gay activist argued that the scientification of moral beliefs mainly by church and far-right agents is endemic in Greece. In particular Paul said:

It is very common in hate speech of the church agents or of the far-right to try to medicalize or biologise... how can I say... I am not sure about the appropriate term of this issue, they distort Freud's or whatever scientific theory or forensics manuals, this is something that the Bishop of Piraeus has done it extensively, and now in the reaction against the Pride parade of Cyprus, an association went publicly and used psychiatry and terms of psychopathology in a completely unacceptable and unscientific way, so this is a speech that can be found in the speech of many public figures, in academia, and in many.... in many psychiatrists, and through internet in the way that they consult people (Paul, 37 years old, gay man)

Apostolos' story was unique in terms of how explicitly his psychiatrist defined homosexuality as a mental health illness but not unusual in terms of the rapid prescription of psychotropic medicines that were often accompanied with a poor diagnosis, usually within the first session with a psychiatrist and without any consultation on alternative consultative or psychotherapeutic available treatments. Paradoxically, in one case, the prescription of anti-depressant medicines was accompanied with a reassurance that there is nothing to be treated. In particular, Argyris, a 33-year-old intersex gay man said that the first time he visited a psychiatrist was at the age of 17 and during his early stages of his coming-out process where he was feeling different from other boys of his age and confused with his gender. Argyris argued that his psychiatrist reassured him that his fears and worries were common to all adolescences of his age but he prescribed him an antidepressant medicine anyway. Not surprisingly, Argyris was dissatisfied with the provided services by the psychiatrist. The antidepressant medicines did not support Argyris to process and overcome his confusion and fears but his emotional state was negatively impacted. By trusting the opinion of an expert both Argyris and his parents decided to take the medicines for "his own good". After taking the antidepressant medicines for more than one year, Argyris decided to stop taking them as he was feeling completely detached from what was going on in his life and as he was feeling "out of space". In fact, Argyris argued that because of being medicated during his last year of high school his

school performance was negatively affected and he was able to enter in the university one year after having stopped the medicines.

Furthermore, the fact that Argyris' psychiatrist made a clear and reassuring statement which normalized Argyris' feelings is an important trait of the affirmative stance of a therapist. However, such statements remain insufficient if LGBT people are not provided with time and support to process their feelings so as to understand what they are going through, manage those feelings and move through the stages of identity development in ways that are empowering (Kort, 2008, Matthews, 2007). This was also a form of professional blindness that was discussed in previous section (5.4).

One of the three psychiatrists who participated in the study appeared to be unsure whether homosexuality is defined as a mental health illness in the ICD10. In particular, Leonidas initially made an explicit statement that homosexuality is not a mental health illness but while he was developing his argument he took in his hands the ICD10 from his bookcase and he was searching the classification of homosexuality in it so as to be assured. He also interestingly referred to homosexuality as a choice of a sexual identity while his views appeared to be informed by the way that homosexuality was classified in the earliest edition of the DSM III. This was reflected in the fact that Leonidas referred to the psychiatric diagnosis of ego-dystonic homosexuality, though in a slightly different and more descriptive way. Leonidas in particular said:

Homosexuality has been removed as a mental illness, this was long time ago, it is not perceived as pathology, it is a choice, it is a choice of a sexual identity... the problem is when homosexuality is not in tune with the ego, namely when someone has homosexual experiences or impulses and this causes him dysphoria because he feels guilt, when he is not well with this and he is troubled, so he has a problem, a psychological problem, so this is when this choice is not in tune with his ego, when it is in tune with one's ego it means that he has accepted oneself as homosexual, that he has these kind of relationships, that he has taken this route in life, he has no problem to declare it publicly or at least in his small world or in a wider social or working environment and not be afraid that he would have a problem if he declares it, if he has anxiety whether he will be or not accepted, if he thinks that he is doing something wrong, morally or whatever, all these are within the psychological sphere [...] but since we discuss categorical taxonomy I just want to mention as I have this latest edition

of the ICD10 in front of me that homosexuality is not even mentioned there

The psychiatric diagnosis of ego-dystonic homosexuality that Leonidas mentioned appeared for the first time in the DSM-III in 1980 and in practice meant the re-pathologisation of homosexuality after the first removal of homosexuality from DSM II in 1973. This is because the diagnosis of ego-dystonic homosexuality suggested inappropriately reclassified struggles with homophobia as a mental disorder (Ritter and Terndrup, 2002). In the revised version of DSM III-R in 1987 ego-dystonic homosexuality was finally eliminated on the basis of insufficient empirical data that support the diagnosis, on the inappropriateness of labeling culturally induced homophobia as a mental disorder, and on the basis that the diagnosis was rarely used.

5.6 Homosexuality as a hormonal disorder

In another example, the view of homosexuality as a hormonal disorder was the absolute factor that eliminated any possibility of establishing a trustful professional relationship between a lesbian and a psychologist. This was unfortunately at a time when Valerie, a 32-year-old lesbian, urgently needed to find psychological support in order to deal with difficult emotions as a result of a broken same-sex relationship. In particular, Valerie was communicating with a woman who she had met in a lesbian dating chat-room. Although they were speaking for many hours every day for almost a year, they had never met each other, as this woman continuously postponed their meeting for various reasons each time. As they lived in different cities many of these excuses were reasonable to believe and Valerie continued to invest emotionally in her. At some point, however, Valerie started to see that her expectations of her were completely unrealistic, their communication became more and more unpleasant and Valerie experienced incredible amounts of disappointment and started to feel depressed.

At a time when her emotional pain was difficult to control, she took an instant decision to find a psychologist to talk with. She firstly called a psychologist with whom she had a positive experience during her early stages of her coming out

but as this was many years ago her previous therapist could no longer see her because she had retired. She then quickly found a psychologist who was practicing near her home and booked an appointment. During the first minutes of their session and while Valerie was describing some of the details of her relationship, the psychologist interrupted her to question if Valerie had tested her hormones, probably, in order to check whether her lesbianism is treatable or not.

And at some point she asks me “have you ever been tested?” And I thought, here we go again with the stereotype that all gays and lesbians have HIV. I told her “what kind of test should I do?”, and she said “a hormonal test”, and I had my first shock! I said “What? Why should I do a hormonal test?”, I don’t even remember if she responded somehow, I don’t remember at all, but what I told her is “I guess you know that there are many masculine men who are gays and many feminine women who are lesbians, right?”, and she said that she knew that there are such cases but she believed that men who are feminine and women who are masculine must test their hormones, the woman was insane, right? Namely I should have denounced her for the sake of society... and she also mentioned a case she had of a boy, who was a student, I am not sure if he had visited her with his parents... I don’t remember... but I remember she told me that he had a hormonal test and by taking the appropriate hormones... and I said, wait a minute, do you mean that this boy was gay and after a hormonal therapy he became straight? And she said yes, and then I started to laugh and I said it is impossible for you to believe such a thing, we said a lot of things that I don’t remember, and then she said ok, I am open-minded, my best friend is gay, so after this I had enough and I just wanted the time to pass and leave because there was no chance to analyze my personal story to her

Although Valerie’s concern was not about questioning her sexual orientation, she found herself in a position defending her lesbianism as a healthy aspect of herself rather than an aspect of an assumed hormonal disorder as her psychologist had suggested. As the psychologist reflected nothing more than societal heterosexist views and ignorance about homosexuality, the counselling was inappropriately directed towards the possibility of changing Valerie’s sexual orientation. Although Valerie appeared to be able to resist both the authority and “expertise” of her psychologist and her arguments that devaluated Valerie’s sexual orientation, she

was compelled to do so by trying to educate her psychologist about homosexuality. In fact, educating a doctor or a mental health professional was one of the most prevailing and ongoing outcome when LGBT participants decided to disclose their sexual orientation in medical interviewing or counselling. Yet, although it is good for “experts” to acknowledge that their patients or the people they serve may know more about some issues, LGBT people are often overburdened with the responsibility to educate the wider society about their experiences and issues about homosexuality or gender and dispel cultural myths and stereotypes about LGBT identities.

Moreover, the psychologist appeared to inappropriately respond to Valerie’s anger and annoyance by stating that she has a gay friend and that she is open-minded. These statements aimed to deny possible biases from the part of the psychologist and therefore to unfound Valerie’s anger and annoyance. Not surprisingly these statements were completely inappropriate to restore any possibility that would make Valerie trust the psychologist. In fact, as Kort (2008) argues, although therapists may have genuine positive feelings towards their LGBT service users they may also deny that they are equally imprinted to be heterosexist from childhood and this is a form of covert homophobia.

The idea that homosexuality is the result of a hormonal imbalance was not uncommon. In another story, Manos, a 25-year-old gay man, reflected on his experience of being twice admitted to an endocrinologist during his adolescence by his parents so as to get a hormonal test as they believed that Manos’ homosexuality was due to hormonal imbalance that could be cured. Manos believed that his parents never disclosed to the doctor the reason they wanted their son to have a detailed hormonal test as they were psychologically in denial and they would never discuss publicly their son’s coming out as gay, which would positioned it in a realistic level. Manos said that once his parents were reassured from the test results that his hormones were normal they stopped the efforts to cure his homosexuality but their attitude towards Manos became harsher as they lost hope on curing medically their son’s homosexuality. Manos described:

I remember my parents took me there [in a medical clinic] to have a hormonal test because they believed that my homosexuality is because of my hormones, in fact they asked for a detailed analysis,

they asked a lot of tests, I remember they were forcing me to have this test and I was resisting, they treated me like if I was demonized and I got crazy because I was experiencing this as a rape... I couldn't understand at this point why they were so persistent in having this detailed test [...] after this they changed their attitude, it didn't get better, it got worse, it was like you are not guilty, so based on these data we cannot do anything to you, it was like if they had lost their weapons out of their hands, so they tried to attack me in other ways, they started a psychological war

Manos' story is indicative of how crucial the role of all doctors is, not only that of mental health professionals in educating and supporting the family of adolescents or LGBT individuals as they struggle with popular myths about what homosexuality is and is not. Manos' parents turned to an endocrinologist due to their preconception that gay men are hormonally imbalanced and therefore they hoped that their son's homosexuality could be cured through medicine. As Fish (2006) argues this myth is rooted in the early twentieth century when homosexuals were believed to comprise the "third sex". Homosexuality was an intermediate sex and homosexuals were said to be stuck at a primitive stage of evolutionary development. This idea was reinforced by the subsequent discovery of sex hormones (testosterone and oestrogen) that were believed to be imbalanced in lesbian and gay men.

Actually, the idea that homosexuality is the result of a hormonal imbalance was also expressed by the only endocrinologist who participated in the study. In particular, Thanos believed that gay men have less androgenic activity and as a result they produce less testosterone which is known to be important in male development. During the interview Thanos insisted that testing such a hypothesis through research does not necessarily aim to construct homosexuality as inferior, but on the contrary, homosexuality could emerge as a developmentally evolved characteristic of human beings through scientific evidence.

If I want to search why these people became gay and some others didn't, they [gay people] are not going to let me search and prove this. They are not going to allow the scientific community to say that the gay community statistically has less androgenic activity, namely their androgen receptors work less, so what if I am going to say this? Will this bother them? They are just scared because they are on the fence from earliest times, and generally they are a closed community, trans

are fewer and more vulnerable, truth be told, but gays... they are unionized! Internationally they are ... they are exactly like Jews, we try to avoid them, we are not touching them, so I cannot tell them, with all my good intention, let's see why! I am curious! I have a son, will he become gay? Why shouldn't I do this? I am not going to say anything bad if he becomes gay. I just want to predict it, and one can ask why I want to predict this, so to see if my son will be more evolved

Thanos appeared to believe that scientific inquiry is threatened and limited by gay activists who try to secure their place in society as they still feel being “on the fence”. He implied that gay and Jewish communities are unreasonably overprotected by society as they have attained great amounts of power internationally and therefore it is not just fair to be protected on racial or sexual orientation grounds. As Thanos had a personal experience of working with trans individuals during their transition, he was able to have an insight on their vulnerabilities and this, at least partially, made him differentiate the trans community from the gay and the Jewish communities. However, this comparison was possibly aimed at strengthening his principal argument of the powerful gay community. In addition, making the comparison between the gay, the trans and the Jewish community and not between the gay and the heterosexual community was to maintain unrecognized the fact that heterosexuality remains dominant over homosexuality since their very construction (Brickell, 2001).

Thanos argument is also an illustration of the dominating perception that scientific inquiry, its research questions, data and analysis can be value-free and motivated by a pure curiosity to understand the world. Based on this assumption, Thanos defended the good intention of his research hypothesis and even argued that the long history of the pathologisation of homosexuality could be overcome by research evidence that could prove that homosexuals are actually better-“more evolved”-species in contrast to heterosexuals. Nevertheless, as Thanos developed his arguments about the gay community he uncovered his heterosexist assumptions and negative judgments about the gay community. Thanos particularly said:

Let me tell you something else; are you in favor of breastfeeding? [yes], how can a gay couple breastfeed? [obviously they can't but there

are many straight women who also cannot breastfeed their children], we are not talking about this, we are talking about the ideal, not about what is possible, pediatricians say that children should be breastfed for many reasons, for their mothers' antibodies and all these, right? I am discussing this because they [gay men] want to adopt children, do you understand? Namely if they take this, what will they demand next? Will be satisfied with this? Wouldn't they demand to take political posts? Authority? All of us, as a society, we are racists and we are underestimating them because we are not allowing them to become members of the parliament and ministers like in UK, right? Shouldn't we allow this as well? But what would they like to do next? I mean, we should maintain a balance I believe... do you think people like the Jews? They are socially demonized, the Germans did all these things to them, but they are a very closed caste, do you understand? A caste which is full of agendas, this is the whole point, I am not sure if you understand me, I am talking about my personal opinion, and I have gay friends, who are from those who are very provocative, and I love them very much because I believe they are very smart doctors, so I love them very much and they are very good friends of mine and in fact they were friends of mine before they changed and realise they were gays, and I understand how much they were strained, and their internal revolution in order to do what they did, so, they agree with what I am saying, namely we have some people now.... Like in the field of fashion, do you think that a straight guy can become couturier?

Thanos appeared to feel threatened by the gay community as he felt that equality between heterosexuals and homosexuals has been already achieved, and therefore, any further demand on the part of the gay community would mean that they seek special privileges that could be ensured at the cost of the fracture of important social values and the assumed established egalitarian order - what Brickell (2001) names as the myth of egalitarian society. In the excerpt preceding, the invocation of the nutritional and immunologic benefits of breastfeeding to children is crucial in Thanos' argument that gays have gone too far in terms of their demands on civil rights. According to his view, gay rights on adoption would mean an unnecessary deprivation of children from the best possible nutrition for their development. To make matters worse, Thanos applauded Greek civil society for banning gays from political positions and political power as a proactive strategy to delimit the terrain of their demands on predetermined by the "broader

society” limits and terms. Thanos also appeared to perceive the strong boundaries and ties of closed minority communities and their collective identities empowering minority groups as conspiratorially threatening the powerful hegemonic cultural ideals and only protecting their own values.. Furthermore, his claim that heterosexual couturiers are excluded from the field of fashion was a means of discounting heterosexism. As Fish (2006) claims, reverse discrimination is one of the many processes by which heterosexism is perpetuated in society.

5.7 Homosexuality as a choice

Sofia, a 32-year-old lesbian, had sought the support of a mental health professional after graduating from school and during the early stages of her coming out process. She described having an intense need to leave her home as a result of feeling alienated from her environment. She had an abstract sense that the fact of her attraction to women was somehow related to her alienation but when she revealed her same-sex attraction to the mental health professional his response was to define same-sex attraction as a choice implying that Sofia could simply choose to stop being attracted in women. In fact, this is a typical heterosexist view of sexuality and a fundamental assertion of reparative therapists who believe that homosexuality can be prevented or cured (Kort, 2008). This view of sexuality could collude with Sofia’s internalized homophobia and lead her to suppress her innate sexuality but fortunately Sofia resisted her therapists’ views and decided to stop consulting with him. In the following excerpt Sofia described her mental health care experience with this particular therapist:

I didn’t have any experience with a woman but I knew I was attracted to women, in fact at some point I mentioned that I was attracted to a woman, and he replied “ok, this is a choice, it is something you either choose or not”, and instinctively, without having any knowledge I told him “do you really believe that it is a choice? It is not a choice, if it was a choice why wouldn’t I choose the easiest one? Why would I choose the difficult choice?”, and he generally appeared to believe that it is like a fashion trend... I don’t remember if he was a psychologist or a psychiatrist because I used to go to a free program in a public mental

health center, it was public so I was going there without giving any money [...] it was a period when I wanted to escape reality, I wanted to leave my home, there was nothing to keep me there, my parents knew nothing about it, but it was in a period when I realized what was happening to me, I was feeling that I was just not fitting in the environment, namely I wanted to just leave and I wanted to be independent to the point I didn't care about anything, so I went to this psychologist and I explained some things to him, the way I was feeling and when he said this I said to myself "fuck it" and I just didn't go again... I think I had two sessions, I think it was during the second session when he told me this, during our first session he was just listening to me and he wasn't speaking, the second time he was doing a dialogue with me and I said this, I told him how I felt, I told him that I didn't know if it plays some role but this is how I feel about women, and he responded in the way I told you, so I said ok I am not going to... I think he was not a psychologist, he was a psychiatrist

Sofia characterized her counsellor as being "not appropriate" for her. Her consequent decision to stop seeing him was clearly related to the fact that he viewed same-sex attractiveness as a choice and an ephemeral one similar to a fashion trend. When Sofia found another mental health professional she decided not to disclose her same-sex attraction to him and she focused on discussing the way she feels about her family and her need to keep distance from them. Sofia's account of her second mental health experience was that she was encouraged her to do whatever she wants and enjoy whatever she already has as "there is no perfection to anything". Sofia described being overall very satisfied with this experience as she was supported to maintain some emotional balance.

The view of same-sex attraction as a choice was not always perceived by LGBT participants as devaluing or homophobic, especially if the mental health professional did not attempt to change their clients. For example, Chloe, a 22-year-old lesbian, asked for a counsellor's advice on how to deal with her mothers' negative reactions with her coming out. She described being happy with the fact that her lesbianism was not challenged and was perceived as "granted". Chloe said:

My psychologist never asked me why I am a lesbian or why I never had sex with a man, her only comments on this were a bit

psychoanalytic when I discussed my relationship with my father, namely she interpreted some things and she said “ah, this is why you chose to be a lesbian”, I was very happy with the fact that she took it for granted, but I was engrossed a lot when she told me that it was my choice... I am stuck with it, and as I am prepared to deal this, to hear from mental health professionals that this is a choice I asked her “are you saying that it is a choice that I need to change?” and she said no and that it is simply a choice, she just believes that it is a choice, and I haven’t concluded if I agree with her interpretation, but I am satisfied with the fact that she doesn’t suggest to do something in order to change this, but when I told this story to a friend she perceived this as homophobia and she told me a similar experience she had with a psychologist whom she stopped visiting because of this, she felt that she was criticizing her sexuality, I didn’t understand it like that

The definition of same-sex attraction as a choice within psychotherapeutic sessions was often problematic as the wording of “choice” implies a cognitive process in which a person consciously decides upon possible options. In the example above, although Chloe’s psychologist defined lesbianism as a choice she did not suggest that Chloe could have possible control over her lesbianism. Nevertheless, she appeared to also believe that Chloe could have turned on the “heterosexual choice” if she had built a better relationship with her father.

In the following sections the focus is on transphobia and the way it was manifest within the mental health system and counselling.

5.8 Denying trans identities

Typically all trans participants during their early stages of coming out had at least one experience with a mental health professional to discuss issues that were related to their gender identity. In some instances, a visit to a mental health professional was to some extent involuntary and involved parental pressure to seek the support of an “expert” within the mental health system framework. Participants had also their own worries, some of them being relevant to feelings of ambivalence or uncertainty about their gender, questions about transitioning or they just wanted an “expert’s” view on what is happening to them. Overwhelmingly, all participants argued that the usual response of mental health professionals to these worries was that they could not possibly exist outside the

gender binary and they could not possibly identify otherwise than their assigned gender at birth.

For example, Angelo came out as transgender for the first time to a psychiatrist as he wanted to get information and resources on “practical issues” about gender transition. Apart from the videos he was watching on YouTube with stories of other trans persons, he had never met an openly trans person. In addition, as he assumed that all psychiatrists would be knowledgeable on trans issues and he did not have money, he chose to visit a public community mental health center. At the time of the interview, Angelo was 18 years old and at his early stages of realizing that he was trans. He visited a psychiatrist to seek assistance in the form of a counselling context that would be supportive of his transgender status. In the below quotation Angelo describes the multiple ways in which his psychiatrist repeatedly and actively ignored Angelo’s self-identification while at the same time he was interpreting Angelo’s behavior and feelings in a way that eliminated one’s possibility of being trans. In particular, the psychiatrist appeared to verify that Angelo is mentally healthy as long as he accepted that he is a narcissist, a person with extreme ideas, irascible and gay.

I went to a psychiatrist and he told me that I didn’t have a mental health illness and that my thoughts were just extreme, “Do you have to wear makeup?” he said, and also that I have ended up being very irascible. He said that with all this pressure and anger I got irritated very easily, I think he said narcissism, something like this [narcissism because you get angry easily?], because I get angry easily and because I want to be the center of attention, but I don’t want to be the center of attention, others made me feel that I am the center of attention.. he told me that I ended up being this kind of person with all the pressure that I have suffered, that’s it [...] I told him that I wasn’t gay and I was... but he didn’t discuss it with me, I used to go in a public mental health center, we discussed other things, how I would come out to my parents, he was asking me instead of asking him.... namely he didn’t ask me if I know these issues, what I could do, where I should go, what steps I should take... it was like if I hadn’t told him, although I told him I am not gay, I am transgender

Rejecting the possibility of trans identities was often, if not always, accompanied by explicit negative comments towards gender expressions which challenge the binary gender system. For example, in the excerpt above the psychiatrist deplores Angelos' practice of wearing make-up. The more participants pressured their mental health counsellors to focus, discuss and acknowledge the possibility of transgender identification, the more the mental health professionals pressured participants to comply with appearance that they considered "normal" for gender expression. In several cases, the mental health professionals appeared to clearly reject participants' gender self-identification while they were trying to convince participants to suppress, stop thinking, "get over", "settle" with their assigned at birth gender. The following participant's experience in which a psychiatrist appears to encourage Melina to suppress her female soul is representative.

Doctors are uninformed, a few years ago I went to a psychiatrist and she told me that I should leave my female soul where it is, I was 24 years old, when I was ambivalent, I wasn't sure if I should move forward or not, so I visited a simple psychiatrist who didn't know the trans condition and she said that I should leave my female soul back as it is, and she said that I should at least not change my body, but this is not possible when you are cerebrally and mentally the opposite of what your body is, namely you are constantly in a conflict no matter how much you fight against it, it is not possible, so I went there for two or three times, I didn't stay long but she didn't help me, psychiatrists do not know about transgenderism (Melina, 29 years old, trans woman)

Similarly, Jason was visiting a psychiatrist who had a clear pathologising stance on trans identities by trying to convince Jason not to alter his body through surgery, by defining transgenderism as sickness owing to his parents and blaming them for causing it to their child. Jason in his own words said:

I told him [to the psychiatrist] everything and I was honest with him, he told me that I should accept my body as it is and I replied him that there is no way to do this, I told him that I needed a surgery, that I couldn't stand this anymore and that he would never convince me that it would be ok if I stayed as I was, he was driving me backwards, it wasn't right, he convinced my parents that I am sick and that it is somehow their fault, that they did something wrong during my childhood. Yeah, all these bizarre things, so we left after a year, we had a very nasty fight (Jason, 18 years old, trans man)

Choosing a mental health professional randomly either in private practice or in public sector was in most cases a devastating experience for trans participants. This is because the view of gender as a binary category of two mutually exclusive genders -feminine and masculine- and believing that each person fits into one and only one gender constituted the absolute norms. As a result, trans participants were never encouraged by mental health professionals to be who they are and pursue what they want. In some cases, mental health professionals appeared willing to view masculinity and femininity as being more flexible than what societal norms suggest. However, this was sometimes in order to convince their patients not to alter their bodies. Furthermore, counsellors who denied trans identities never provided any information on available support networks within the trans community or resources on trans issues. Instead they often encouraged them to view their urge to alter their bodies as a form of pathology. For example, Andreas, a 23-year-old trans man, visited a psychologist for the first time during his last year in high school which was also a period when his coming out as trans was experienced as an “explosion” in his family. As the relationships with the family became harsh, his mother encouraged him to visit a psychologist along with her. Andreas had weekly sessions for a period of about 3 months. According to Andreas’ accounts, during the first month of sessions the psychologist was keeping a non-intrusive attitude and her purpose was focused on getting to know each other. However, during their second month of sessions, the psychologist was clearly rejecting the possibility of Andreas’ trans identity and she encouraged him to love his body as it is by implementing a technique to move around his home naked. Andreas particularly said:

My mother and I had decided to visit a psychologist, she didn’t intend to ask her to ‘fix’ me, we just wanted to see what is happening, but the psychologist said that I should love my body, that it is impossible to be what I want to be, and she recommended that I should move around my home naked for at least two hours a day, and we said “What?”, and then I was really mad at her. I wanted to kill her and I just left [...] My mother had found this woman, I am not sure how, I don’t give a shit, this woman doesn’t exist for me anymore, she should just leave... anyway, this was a very nasty experience for me [...] first of all, she completely rejected the existence of trans people, they were invisible! And basically, the first experience is the one that counts. Now I am negative with everyone in the mental health profession.

After this negative experience, Andreas did not seek support from a mental health professional again, until he met a psychiatrist in a hospital where he was hospitalized to be cured for a broken arm. When Andreas was admitted in hospital he was heavily drunk and probably the psychiatrist was called in order to assess Andreas for self-destructive behavior. The psychiatrist in the hospital affirmed his trans identity and she made herself available to support Andreas' transitioning. Andreas also appreciated the fact that his psychiatrist was actively searching trans patients to support by providing her services. Andreas, in his own words, said:

I hate all doctors except my psychiatrist whom I love because she is very nice, but even she didn't gain my trust immediately and only after six months I started to tell her important things [...] she came to see me on the first day I was in hospital, she understood that it was this issue [the trans issue] involved, I continued going to the hospital mainly because of my arm and later we started working together so as to take the letter from her. I liked her very much not only because she was very open-minded on this issue but also because she had never worked with a trans patient and she was actively searching to find such cases to help, so she is very nice, that thing is very important to me, I don't think other doctors do this

Overall, the affirmative stance on trans identities, the caring behavior and the genuine interest in supporting trans individuals or the trans community at large, made participants trust their counsellors even when they knew that they are inexperienced on trans issues or even completely uninformed. Nevertheless, in most cases trans participants actually educated their mental health professionals (e.g. by challenging distorted ideas about gender), and this proved to be a burden especially when they depended on their counsellor's diagnosis letter or when mental health professionals completely rejected the very existence of trans people. In fact, other studies from a range of countries, have reported similar issues regarding the experience and knowledge of health and mental health practitioners in relation to trans issues (Ellis et al., 2014, Adams et al., 2013, Sanchez et al., 2009). Melina's response is representative:

I just think that they [the mental health professionals] are ignorant which means that we are the ones that must find what is going on and train them, and this is a bad thing, do you understand? In other words, a genetically wrong thing, a peculiarity of nature is perceived as a

taboo or remain unspoken... this is wrong because there are many people who suffer, they don't even have a family, and they don't have money

As I argued in section 3.7, connection with the trans community and the web forum of Queer-trans in particular, appeared to be clearly related to the location of trans-friendly and well informed mental health professionals, endocrinologists, and with useful information on trans issues like the avoidance of professionals that were reputed to be transphobic and to have harmed trans persons.

5.9 The psychiatric policing of gender identity and gender transition

Consistent with what Bockting et al. (2006) have argued, all trans participants felt being disempowered by the fact that mental health professionals and psychiatrists in particular were positioned as gatekeepers to gender transition. Trans participants felt dependent on their psychiatrist's authority to let them have access to hormone therapy, sex-reassignment surgery or breast removal. Therefore, they were continuously expected to conform to their psychiatrist's understanding of gender, healthy mood and behavior, and readiness for transitioning so as to finally obtain "the letter". One of the most important implications of this appeared to be their distrust of sharing with them the actual problems they faced. This issue is consistent with the study by Ellis et al. (2014), who found that 30.9% of their respondents felt that they could not be truthful to their health providers in Gender Identity Clinics (GIC) on grounds that honesty on several issues (e.g. disclosure of non-heterosexual orientation) could negatively affect their access to treatment. As a result, visiting a psychiatrist or another mental health professional while in the process of obtaining this letter was not viewed as a place to address life challenges for the trans participants of my study. This is why two of them chose different mental health professionals to discuss issues that were not related to their gender transition and others were so negative towards mental health professionals that they totally avoided them.

The categorization of trans people within the framework of mental disorders and the consequent psychiatric control over gender identity and transition was

devastating for all participants especially if the practitioners were perceived to have narrow definitions of gender and forced participants to conform to these. For example, Theano was 55 years old and she identified as a trans person. She considered herself suffering from gender dysphoria since her early 30s as she never accomplished to do much in terms of her gender transition. Her gender dysphoria was initially experienced as depression which progressively developed after she gave birth to her first child. Theano recalled that back then she perceived her depression as stemming from her suppressed attraction to women. After many years of being in a heterosexual marriage, Theano finally came out as a lesbian to her family and divorced her husband. She started dating women and she became strongly connected and active within the LGBT community. Theano was in a long term lesbian relationship when she started to realize that her depression was a result of gender dysphoria and irrelevant to her sexual orientation. During the last years Theano and her partner consulted many mental health professionals who were known in the LGBT community for being affirmative therapists. However, as their support was mainly focused on helping the couple deal with the life challenges of a lesbian couple who are raising children in a heterosexist social environment, Theano felt that she was never appropriately supported for her gender dysphoria. Theano was currently seeing a gay psychiatrist who was helping her deal with her depression but she felt disappointed as her psychiatrist interpreted her gender dysphoria as a symptom of her depression. As she was also involved in the LGBT community and kept strong ties with the trans community she was aware of and concerned about the many negative experiences of trans individuals by the mental health care system. The individualistic understanding of gender dysphoria and the pathologisation of trans persons within the mental health care system were clearly identified by Theano as two important factors that constrained her transitioning. She particularly said:

I would like to go in a public hospital and ask to have a mastectomy and remove my ovaries and be prescribed a hormone therapy according to my health because I have diabetes and high blood pressure. But I don't want to go to a psychiatrist to have a letter from him because I can't stand this, I can't stand this thing, namely even Lavrentis, who is gay and an educated person, believes that those who

have gender dysphoria have a problem and they cause problems to their children, this is what he has studied

The dissatisfaction and despair of trans participants for the mental health care system was not only relevant to the very need of psychiatric control over their gender identities but crucially because this control was often exercised with cruelty and involved disrespectful and humiliating practices against trans participants too. The two following examples are clear illustrations of this.

Jason was one of the three participants who had experienced the gender dysphoria assessment in the most reputable department of gender and sexuality disorders in a public mental health hospital in Greece. He felt his assessment was a cruel interrogation and he felt traumatized not only by the verbal transphobic comments, questions and interpretations of the practitioners but also by the process as a whole. He described being in a room with four mental health professionals, two of them asking him questions and the other two observing him, keeping notes and occasionally speaking to each other secretly. For Jason this process lasted three sessions (with one session every three months), while for the other participants the process was prolonged. Jason described being bombarded with intrusive and rude questions most of them reflecting stereotypical ideas about gender such as if he wanted to have long hair or body hair. He also argued that the questions were not only inappropriate but also asked in an insensitive way. In the following example, Jason described being asked if he was a virgin by an arrogant psychiatrist who persistently and deliberately addressed Jason with a female pronoun:

Mr. Sklapanis asked me if I was a virgin, all others were speaking to me with a male pronoun and Mr. Sklapanis asked me “are you a virgin?” And I said “WHAT? WHAT DO YOU MEAN?” and he didn’t understand that I was freaked out with the question and he asked me again like if I haven’t heard the question, anyway, I never went to him again, I didn’t have to see him again

Deliberate mis-gendering by psychiatrists, invasive and insensitive questioning were not uncommon and participants experienced this as an aggressive and

transphobic rejection of their self-identification and as disrespect. In fact, as Namaste (2011) points out, one of the most virulent forms of institutionalized forms of transphobia is that trans persons are required to give their autobiography on demand and answer questions that cis persons are never asked due to cultural taboos regarding speaking openly about sexuality and genitalia. Similarly in Ellis et al. (2014) study, which was specifically focused on the experiences of trans people by the GIC, the participants reported feeling their experiences in GICs quite traumatic, and the clinical sessions undermined their dignity and their human rights.

When trans participants resisted their psychiatrists' understandings of gender or transphobic views and comments, they felt that they were being punished by waiting prolonged periods before getting the psychiatric diagnosis which was often accompanied with even more extensive scrutiny and testing of their gender identification often with brutal methods. For example, Fanie, a 34-year-old trans woman argued that when she was assessed for gender dysphoria her psychiatrist considered her identification as a lesbian to be incompatible with her identification as a transgender woman. Despite Fanie's efforts to support that this idea is based on an inappropriate conflation of gender identity and sexuality, her psychiatrist insisted that in order to finally conclude with his diagnosis Fanie should be hospitalized in a men's room of a psychiatric clinic for two months. Although Fanie felt that this testing was totally humiliating and torturing, she was prone to comply with her psychiatrist's suggestion so as to finally get the diagnosis for gender dysphoria after two years of sessions. However, she finally decided not to subject herself to this testing and instead she pressed her psychiatrist just to confirm that she had regular sessions for two years with him. Fanie was planning to have a sex reassignment surgery in London and she was told by her surgeon that in order to proceed into surgery he required approval letters from two psychiatrists. She travelled to London being uncertain if her surgeon would agree to proceed given that she only had one letter from her psychiatrist who expressed his doubts on whether Fanie is a trans woman or not. The surgeon referred her to the psychologist of the gender clinic and within one session Fannie was finally provided with a letter approving that she could proceed to sex reassignment surgery. Fannie described this experience:

I went to the surgeon and he told me that I should see a psychologist who was very experienced on trans issues, so I saw him for a half an hour and he said that I am a very mature young trans woman, “Bravo! Bravo! Bravo!”, and he gave me the letter within half an hour, I went to the surgeon and I gave him the letter of the psychologist and the letter of my psychiatrist, he took the letter of my psychiatrist and put it aside, he looked at the other and said “Ah! Good! Wonderful!, he didn’t care about the doubts of my psychiatrist written in his letter, this is a simple example of how many unnecessary barriers we must overcome

Fannie returned to Greece empowered because she finally had the sex-reassignment surgery she had been pursuing for years. She was also empowered because her surgeon and the psychologist who provided her with the letter in London disqualified her psychiatrist. This was experienced as a testimony to her unnecessary oppression and torture by the mental health care system in Greece. In addition, her experience was shared within the trans community therefore helping other trans persons, including two of the participants, to protect themselves from their psychiatrists’ heteronormative views by being more cautious when discussing issues around their sexuality.

Despite Fanie’s satisfaction with the quality of services provided in the GIC in London, she remained a great opponent to the institutionalized authority of psychiatry to manage gender transition of trans persons. Fanie aspired to a world where all trans persons could change their gender in their identification papers without any compulsory medical treatment as well as without the involvement of psychiatry whenever trans persons wish a surgery or hormonal treatment to alter their bodies. Fanie believed that trans persons are subject to the cultural norms and the bioethical rules regarding the human genitalia which are seen as sacred in comparison with other body parts. She perceived this as one of the root causes of the discrimination against trans people who are institutionally indicted for being mentally disordered while cis persons enjoy their right to autonomy to alter their bodies in whatever way they want. Fanie also believed that psychiatrists themselves are often afraid of taking the responsibility to affirm the trans status of their patients especially if trans persons are not confident enough to be self-determined. In the quotation below Fanie explains how disastrous it is for trans

persons when their own internalized transphobia becomes the ground for psychiatrist to act upon their transphobic views on gender transition:

Many trans persons with high levels of internalized transphobia and ... I don't know, unprocessed gender identity visit psychiatrists and expect from them to determine if they are trans or not, and since doctors are scared to take this responsibility they say inappropriate things such as "since you are not sure you are probably not a trans person", "you are not suitable to become a woman so you should better not attempt doing it", they say dangerous things such as "if you have a surgery on your dick you will never have an orgasm again", so they say dangerous things which blackmail trans people

Other participants were less absolute in relation to the involvement of psychiatry to gender transition. For example, Lena, a 22-year-old trans woman distinguished sex-reassignment surgery from hormonal therapy on the basis that the outcomes of the first are irreversible. She particularly said:

I believe that the hormonal therapy should be prescribed without a letter of psychiatrist because our bodies belong to us and we should have the right to do whatever we want on them. But the sex-reassignment surgery is a huge issue which may influence your whole psychological and social life to a great extent. So, it is good to have a specialist's opinion, basically not simply an opinion, it is good to start a whole program so as to be able to see if you actually need this surgery because this is irreversible

In fact, Lena had decided to start hormone therapy by visiting an endocrinologist in private practice who prescribed treatment without requesting a letter of recommendation from a psychiatrist. Although the opinions about the particular endocrinologist varied within the trans community and one trans participant argued that she puts profit over the health safety of her trans patients, Lena felt compelled to visit her. This was due to the prolonged waiting time in order to even book an appointment with a specialist psychiatrist that could provide her with a letter of recommendation. Lena reported that she had called for an appointment numerous times but she was suggested to call back again after two or more months to just check again if there is any change in terms of the availability of services.

5.10 The illusive boundaries of psychiatric diagnosis

Overall, trans participants were particularly frustrated with the fact that their gender identification as trans was easily conflated with mental health disorders both within their families and within the (mental) health care system. This has also been highlighted by Galanou (2014) who argued that psychiatrists in Greece diagnose trans persons in an offensive and stigmatizing way which also limits their legal capacity.

Three of the trans participants reported being misdiagnosed and medicated with antipsychotic medicines or lithium during their early adulthood or puberty as a result of misrelating trans identification or gender dysphoria with severe mental health illnesses. For one of the young trans participants the experience of being misdiagnosed with bipolar disorder and medicated with a lithium was so traumatic that he refused to elaborate much on the topic. Fanie who shared her story recalled being assessed by a professor of psychiatry who appeared to view Fanie's identification as a woman to be a symptomatology of schizophrenia. Fanie described this experience:

When I told my parents I was trans they admitted me to a professor of psychiatry and he prescribed me anti-psychotics, the voices in my head saying that I am a woman never stopped... but he never admitted this, so he said that he had to give up, I don't know, he said, and if anti-psychotics didn't help, then he didn't know what I had, while he could simply say that I am a trans woman, but he said "I give up", he said that I had something so rare that he could not solve. So, because I had taken anti-psychotics my mother told this to Sklapanis and he talked to her behind my back, I guess my mother went to him, without me knowing, and she asked him to make me a man, that was not appropriate of them. He believed that I had schizophrenia this is why he couldn't speak about trans issues for which he was unfamiliar anyway

The fear of mental health stigma prevailed among the trans participants particularly because they had to adhere into a process through which they were actually categorized according to psychiatric classification manuals of mental health disorders. The fear expressed by Jason who was waiting the

recommendation letter from a psychiatrist to start hormonal therapy is characteristic:

Now I have been waiting the letter which will be from Dafni and I asked them what it will say because I am afraid that I could be damaged... I am afraid that it may say that I am a psychopath and then I must deal an additional form of racism” (Jason, 18 years old, trans man)

Jason’s reference to the name of the institution “Dafni” rather the name of his psychiatrist is worthy of attention. Dafni is the name of the oldest and bigger psychiatric hospital of Greece which has historically taken all the weight of mental health care in Greece. However, its name simultaneously reflects the failure of the psychiatric reform in Greece, the chronic institutionalization of patients, the function of outmoded asylums, the physical restraint of patients, and only recently the three deaths of physically restrained patients. Not surprisingly, Dafni is imprinted in Greek people’s consciousness as representing the institutional management of “madness” in Greece. In fact the word “Dafni” is a commonly used word in the everyday language and integrated into the everyday expressions where people use it as a synecdoche for madness or when characterizing someone as insane. This contextual understanding is particularly important in order to fully comprehend the emotional load of an 18-year-old trans person getting a letter which bears not only his classification as disordered but also by an institution which is widely known as a synonym for madness.

Jason also referred to the name of the clinic in Eginitio hospital which is considered as the specialist center for the assessment and treatment of trans persons in Greece. He argued that its name as “department of sexuality disorders” reproduces the conflation between sexuality and gender which results in the distortion of the meaning of trans identification. Like other trans participants, Jason felt uncomfortable sitting in a waiting room of a department signed as being for disordered persons. This was in a total contrast to the non-pathological sense that Jason as well as other trans participants had for their gender identities. Jason also implied that the stigma of pathologisation ascribed to trans persons is exacerbated when they are subsumed with disorders that are

not only irrelevant to them but also socially condemned such as pedophilia. He argued:

In Eginitio Hospital you go to the department of sexuality disorders, this is the sign posted in the waiting room, so you may find pedophiles in the room or whoever, whoever, they don't care, so you wait a while and then you go in and they take your record

Insights of how easily trans identity is conflated with mental health illnesses were provided also by one psychiatrist who participated in the study. Panagiotis, a 47-year-old psychiatrist, was regularly appointed as a member of the committees of KEPA (Disability Certification Center) which is the official body in Greece for providing disability certifications and determining specific disability rates according to statutory regulations prescribed in the Disability Severity Assessment (KEVA). Panagiotis reflected on a case where a trans woman applied to be assessed and certified with a 67% disability rate as this would allow her to have dependent coverage from her father's health insurance. This would be possible only if the committee would certify a psychosis such as schizophrenia. Panagiotis argued that her medical history did not justify such a diagnosis and he was reluctant to provide a certification on schizophrenia particularly because he did not want to participate in a stigmatizing process of misrelating gender dysphoria with psychosis. However, he was inclined to do so as the woman was claiming that unless she had a health insurance she would be unable to have a sex-reassignment surgery. Panagiotis described being frustrated as the other members of the committee appeared to unproblematically relate gender dysphoria with schizophrenia and they were willing to provide this certification without any hesitation.

The institutional reproduction of transphobia described in Panagiotis' story is also clearly reflected in the official manual of KEVA. Following ICD-10 taxonomy system, KEVA provides a general definition of Personality Disorders in which Gender Identity Disorder (GID) is mentioned as an example. KEVA classifies personality disorders into ten categories: the paranoid, schizoid, dissocial, borderline, impulsive, histrionic, anankastic, anxious, dependent and mixed. Although none of these categories apply to what GID is supposed to represent,

the final classification of all trans persons who apply for a disability certification is to be found among these 10 categories. Therefore, trans persons are provided with a disability certification in which GID is not even mentioned and is replaced with other terminology, which is completely irrelevant to gender transition.

Conclusions

In this chapter my attention was on the ways that LGBT participants experienced and identified the impact of homophobia and transphobia on their mental health. I then outlined the range of ways in which homophobia and transphobia were manifest within mental health services. The findings of this study reveal particularly problematic experiences in terms of how the LGBT status of participants was treated in mental health services. Many of the participants' experiences showed that professionals appeared to respond in the similar oppressive way, that most of societies respond to minorities that is by ignoring their very existence. Sexual orientation and trans blindness can be viewed as tantamount to eliminating or erasing LGBTs experiences. As Ritter and Terndrup (2002) argue, in a world where LGBT identities are culturally stigmatized, anything less than an affirmative approach in mental health services is problematic and insufficient for LGBT people regardless of the treatment focus. Nevertheless, the meaning of affirmative practice appeared to be often reduced into simple declarations like "I have gay friends", "I have no problem with gay people", "homosexuality is normal". Although all these declarations are well-intended, affirmative practice should be viewed as an approach that necessitates specific knowledge on how to meaningfully integrate and expand clinicians' affirmative mirroring into traditional paradigms of psychotherapy or consultation.

Furthermore, the idea that homosexuality and gender-variance are forms of pathology was also often explicitly communicated to LGBT participants indicating that the long history of pathologisation of LGBT identities by the mental health system is still alive. This was particularly evident in the case of trans participants who remain the target of psychiatric treatment due to the diagnostic classification of Gender Dysphoria and the consequent definition of gender transition as a form of a treatment that should be managed and controlled within a mental health

framework. Findings demonstrated that both sexuality and gender identity intersect with mental-health diagnosis/status as normative conceptualizations of healthy sexuality and the gender binary affected the mental health care experiences of LGBT participants. However, trans participants appeared to be further disempowered as they were subjected to the narrow (and binary) definition of gender adopted by mental health services. As a result, all trans participants had quite traumatic mental health care experiences and their eligibility for treatment (e.g hormonal treatment) required their voluntary positioning within a framework of pathology. These findings also support the decision to develop an intra-categorical analysis and the separate analysis among LGB and T people because uncovering power relations that decisively inscribe the mental health experiences of people are central to intersectionality (Monro and Richardson, 2010).

Minority stress -that is the mental health consequences of stigmatisation and marginalisation- can lead directly to poorer (mental) health outcomes among the LGBT population, while institutionalized discrimination and heterosexist/transphobic bias may impede LGBT people's access to appropriate mental health care, further exacerbating ill-health (Herek et al., 2007, Meyer, 2003). In addition, sexual orientation and gender identity may influence more general mental health concerns (Matthews, 2007). The findings of this study clearly illustrate that the need for cultural competency training for all mental health professionals is intense and urgent. This necessitates a specific intervention at an institutional level such as curriculum changes in educational settings, affirmative services development, policy/legal protection from malpractice and a clear commitment of mental health policies to meet the needs of LGBT people.

CHAPTER 6

SUMMARY AND CONCLUSIONS

Introduction

In this final chapter, I return to the research questions in order to achieve an in depth understanding of the ways that homophobia and transphobia are manifest in the health care of LGBT people. The relevant findings discussed in Section 6.1 address the following research questions:

1. How is homophobia/transphobia experienced by LGBT people in health care settings in Greece?
2. How do homophobia/transphobia and the fear of homophobia/transphobia impact the health and health care experienced by LGBT people?
3. How do doctors perceive the impact of homophobia/transphobia on LGBT people's health and health care?

Following this section, I review the limitations of this study and provide my recommendations for future research. In the conclusion I also present my recommendations for policy and practice to improve accessibility and quality of health care services for LGBT people.

6.1 Overview of the research findings

The health inequalities of LGBT people in Greece which this research sought to explore can be founded upon Phoenix's couplet "normalized absence, pathologised presence" (Phoenix, 1987). The phrase can be broadly interpreted as the social exclusion of a particular group or groups based on negative stereotypes and assumptions. In chapter 3, I focused primarily on the ideas, assumptions and practices which together worked to invisibilize the LGBT participants and their health care needs within health-care settings. One of the most prevailing ideas among participants was that sexual identities are irrelevant to health care markers of patients' identities thus constituting such a focus of a questionnaire by health care providers or disclosure by patients themselves unreasonable. However, this idea was underpinned by the heterosexual

assumption which established heterosexuality as an invisible marker of identity within health care settings. Specifically, all LGBT participants reported being routinely assumed to be heterosexuals and by extension their health care needs were assumed to be identical to those of heterosexuals. Clearly, heterosexism was the major mechanism that normalized the absence of sexuality as a critical aspect of life that matters in the delivery and quality of health care.

Furthermore, sexual identities were usually assumed to be strictly related to sex, therefore their visibility was deemed necessary only when a sexual history was considered to be by a health provider. Overall, the domination of the biomedical approach of health and disease appeared to reinforce the invisibility of LGBT people in health care by depersonalizing the provided services. The immediate negative impacts of the domination of the biomedical approach on the quality of health care were: a) the reduction of the role of the doctor-patient relationship for an appropriate diagnosis and treatment, b) the disconnection of people's health care issues/problems from their social realities and experiences, c) the structural ignorance of the social dimensions of sexuality.

Participants' narratives also revealed the crucial role of stigma in the invisibilization of LGBT people. Specifically, LGBT participants appeared to be very uncomfortable and scared to disclose any information on their LGBT status to health care professionals. When they noticed a complete absence of signals of positivity towards LGBT identities in health care settings, LGBT participants felt obliged to present themselves as heterosexual, which was part of their proactive strategy to prevent the enactment of explicit homophobic attitudes. Although the very heterosexist assumption was experienced as an early indicator of unsafety, it was often a source of embarrassment and intensified their stress and need for self-surveillance. However, the doctors who participated in the study appeared completely disengaged from any effort to respond to the notions of safety that would be relevant to LGBT people. The individualistic understanding of stigma, which was fueled by heterosexist/cissexist ideas and ignorance of LGBT people's everyday realities and struggles, appeared to determine a context of structural indifference towards LGBT people. The findings highlight some of the negative consequences of LGBT invisibility within health care as:

- a) Misinformation on important health issues/needs
- b) Misdiagnosis (e.g. unnecessary pregnancy test, lack of acknowledgment of important information on sexual history, undetected mental health care needs)
- c) Exclusion of trans people from preventive health care
- d) Exclusion of LGBT people from sexual health information
- e) Misreading of lesbianism as virginity
- f) Exposure to inappropriate/ unsafe environments for disclosure
- g) Exposure to offensive comments/jokes/ derogatory opinions on LGBT identities
- h) Exposure to inappropriate questioning/ heterosexist assumptions (e.g. “are you married?”, “do you fuck?”)
- i) Invalidation of same-sex couples within health care
- j) Lack of any acknowledgment of the challenges that LGBT carers face.

In the mental health sector, the invisibility of LGBT participants, discussed in Section 5.4, appeared to be reproduced primarily by counsellor’s sexual orientation and/or trans identity blindness which, similar to the broader concept of cultural blindness, denoted their denial of acknowledgment or pretense of not seeing the sexual orientation and/or trans identity of LGBT service users. Drawing on Sue’s theory of micro-aggressions (Sue, 2010), sexual orientation and trans identity blindness serve to negate the gender and sexual identities of people, ignore and invalidate their realities, prevent topics of gender and sexual orientation from being freely and openly discussed, enforce assumptions of “sameness”, suggest that differences are bad and divisive and deny the heterosexual and cissexual privilege. According to Sue (2010), the power of micro-aggressions such as sexual orientation and trans identity blindness lie in their invisibility to the perpetrator, who are unaware that they have engaged in a behavior that threatens and demeans the recipient in a communication. It is also argued that micro-aggressions cause greater harm to LGBT people than overt forms of homophobia and transphobia, as their subtle, nebulous and unnamed nature makes them difficult to identify and rectify (Sue, 2010).

In this research, out of the 46 LGBT individuals who participated in the individual or group interviews, 31 had at least one mental health care experience and many of them were in long-term psychotherapy. In contrast with a generalized tension to not disclose their sexual orientation to health care providers such as GPs and other specialties, all of them had come out to their counsellors. In addition, all of them believed that homophobia and transphobia negatively affected, or had affected, their everyday lives, the level of their life satisfaction, their psychological wellbeing or their personal relationships including the most significant ones (e.g. with parents, partners). These findings are consistent with the international literature according to which LGBT people's vulnerability has been linked to increased risk for the development of mental health problems (Dentato, 2012, Meads et al., 2012, King et al., 2008, Herek et al., 2007, Meyer, 2003). Some participants even made explicit reference to suicide attempts, suicidal ideation and self-harm behaviors while navigating their developing identity.

Nevertheless, homophobic and transphobic traumas were rarely, if at all, "an issue" to work on in therapeutic sessions. This blind spot appeared to be the norm within therapeutic sessions developed by the sexual orientation and trans blindness perspective of therapists. The analysis of LGBT participants' mental health care experiences highlights some of the most significant expressions of sexual orientation and trans identity blindness as:

- a) The tension of counsellors to endorse a "neutral" stance towards homosexuality by avoiding defining it as either normal or abnormal, or defining it as a choice that should not be judged in therapy,
- b) The counsellors' message that "a couple is a couple", or the pretence that they do not see the gender of their clients' partners,
- c) The reframing of parental homophobia and transphobia to attachment issues and/or as normal parental behavior,
- d) The reframing of homophobia/transphobia as aspects of human diversity or a matter of people's different opinions towards homosexuality/transgenderism that should be accepted as such,

- e) The message that psychological theories such as psychoanalysis are not/should not be concerned with the gender or the sexual orientation of clients,
- f) The reframing of body dysphoria as a symptom of depression,
- g) The undifferentiated and inappropriate application of psychological theories to trans persons,
- h) The inability of therapists to empathize with trans participants' needs to "pass".

The psychological consequences of these blind spots can be enormous for LGBT users of mental health care services. As Kort (2008) argues, counsellors with a sexual orientation blind perspective are completely unable to help LGBT service users to the depth needed in therapy sessions and may even damage their clients. This is because counsellors with a sexual orientation or trans blind perspective are not aware how their own heterosexist and cissexist ideas may affect their clients' life-long struggles to form a positive LGBT identity which is defined as "the coming-out process". Moreover, they often collude with their clients' internalized homophobia/transphobia which blocks rather than facilitates the coming-out process. Even those well-intended counsellors who maintain a "gay-friendly" attitude may be blind to their clients' coming-out process and the particular stage where their clients are. In this study many LGBT participants reported being urged, in their counsellors' statements, to live their lives as they want, to liberate themselves, to disregard what others say and so on. All these statements were often the counsellors' first response to the participants' disclosure of their sexuality or an early comment on participants' worry that their sexual orientation may have an impact on their problems. In addition, such statements often signalled the end of any further discussion on sexual orientation or gender identity issues. Though well-intended, such attitudes may also be damaging to LGBT people as they disregard the coming-out process (despite its liberating characteristics) as a very difficult and traumatic process as it is radically affected by the painful impingement with societal, familial and internalized homophobic/transphobic ideas and attitudes. As Kort

(2008) argues, counsellors who are not aware of the particular stage of their clients in terms of their coming-out process may push their clients too quickly which sometimes results in overwhelming trauma responses, exacerbated Post Traumatic Stress Disorder (PTSD) symptoms that damage LGBT clients rather than help them. Furthermore, the sexual orientation and gender identity blind perspective leave mental health professionals completely unequipped to educate their clients to acknowledge and dismantle homophobia and transphobia from their life. This questions the basis of the therapeutic alliance between therapists and LGBT clients.

The pattern of sexual orientation blindness appeared to be strengthened also by LGBT participants' overwhelming fear that their counsellors would attempt to change their sexual orientation or define it as a sign of pathology. Indeed, their fears were not unfounded. Crucially, five of the participants (one gay man, three trans women and one intersex person) reported having been misdiagnosed and medicated with antipsychotic medicines or lithium during their early adulthood or puberty. Many others had numerous experiences of mental health professionals who had clearly defined homosexuality as a mental illness, a hormonal disorder, or a choice within one's cognitive control or a choice traced to attachment problems with a father/mother. Equally, trans identities were assumed to be impossible and gender variance a mental illness. These assumptions were communicated to trans participants in part because trans persons' need for medical transition care is still classed as such in diagnostic manuals. Not surprisingly, all trans participants expressed their despair of being subject to psychiatric policing and enforced to comply with psychiatrists' interpretations of gender. The practice of this power over trans participants was experienced most acutely during the psychiatric assessment for gender dysphoria and was described as a cruel, disrespectful and humiliating process. In particular trans participants reported deliberate misgendering, persistent denial of their gender identification, invasive and insensitive questioning as common transphobic responses by psychiatrists. This, along with the generalized shortage and poor quality of available transition related medical care (e.g. HRT) in public or private health settings created a framework making trans persons feel very vulnerable, completely unsupported and punished by the health care system.

All the domains of health care were affected by the same ideas and structures that historically pathologise LGBT people. As indicated earlier, these ideas were fostered within a culture of silence and invisibility of LGBT people and their health concerns. The stories of the participants revealed that within health care environments gender nonconformity, same-sex attraction and same-sex sexual behavior are still not understood and accepted as part of the normal spectrum of the human condition.

Penis-in-vagina intercourse appeared to be the absolute norm of what is perceived as healthy sex and the one type of sex that does not contravene gender and its “natural” expressions of femininity and masculinity. As a result, those who depart from this norm are doomed to be perceived as abnormal, not understood, inferior, lesser “women” or lesser “men”. Yet, findings discussed in Chapter 4 suggest that this is also an important barrier for LGBT people to accessing appropriate health care. The findings highlight some of the negative impacts of the pathologisation of LGBT people within health care to be:

- a) LGBT participants appeared to be considerably uncomfortable to discuss or other health professionals issues around their sex life or their health concerns/needs that were related to their sexuality and/or their trans identity with their doctors.
- b) LGBT participants reported avoiding, postponing, opting-out from medical care due to experiences of homophobia and transphobia during physical examinations
- c) LGBT participants reported feeling embarrassed by genital examination as they feared that they would trigger homophobic/transphobic responses or because they feared that their sexuality would be revealed.
- d) The majority of LGBT participants perceived their health care providers as ignorant on important health care issues relevant to their LGBT status. The trans participants especially felt they were the resource from whom their health care providers learned about gender identity, transition and the health needs of trans persons.
- e) LGBT participants reported having never seen health information related to LGBT people promoted to them or in official health websites of the NHS.

- f) Trans participants were left unsure whether they were entitled to gender-specific examinations
- g) LGBT participants reported being never informed or asked to be informed about STDs or about safe sex practices.

Furthermore, the intersectional analysis enabled the revelation of important barriers in health care that require particular attention for some sub-populations among the LGBT community. Firstly, findings in relation to HIV suggest that people who live with HIV are denied services in health settings on the basis that they may infect health professionals. In addition, a gay youngster reported having been treated in a public health setting as a possible infection threat to health staff just because he asked for an HIV test. Other LGBT participants stated that they would never ask for an HIV test in a public hospital because of their fear of being stigmatized. A story from an openly gay health professional working in an infectious diseases clinic indicated the prevalence of HIV stigma within health care settings as well as the vulnerability of LGBT health staff to discrimination at work. Secondly, worries about confidentiality may be exacerbated for people who live with HIV and those who live in rural areas, but also for LGBT youth and LGBT immigrants/refugees because of the presence of parents or interpreters during medical interviews. Lastly, the interview with one intersex person demonstrated the inadequacy of the biomedical approach to respond to the needs of people in sexual and gender minorities to label their difference- find a social identity- to connect them with a community.

Overall, research findings indicated that the “in-group” complexity that intra-categorical analysis addresses is relevant to discussions on how health inequalities are formed for minorities, marginalised social groups as well as for each of the sub-groups that the LGBT acronym represents. In fact, one of the objectives of my analysis was to highlight important issues that add extra layers of complexity particularly for bisexuals, non-binary and trans participants. This was with a view to making visible the processes of differentiation that are often invisible when treating the LGBT population as homogeneous (Monro and Richardson, 2010, Fish, 2008). For example, the research findings indicated that the medical and statutory denial of trans identities impeded the health care

access of trans participants in considerably different ways to those of LGB participants (e.g. the isolation of trans persons in hospitals).

In the lack of explicit education on LGBT issues to health professionals, it is reasonable to believe that health care environments could reflect nothing but the level of homophobia and transphobia of society at large (Rutherford et al., 2012). However, the role of the LGBT community appeared to be important for the alleviation of barriers in health care. For example, those who were affiliated with LGBT organisations or other informal networks had more access to sexual health information and transition related information. Support networks from within the LGBT community were also important in ensuring safety for trans persons when hospitalized. Community involvement was also reported to have been important for personal growth and sustaining good mental health by many of the participants.

6.2 Study limitations

One major limitation of this study is related to the lack of diversity of the sample, which although it was enough to yield manageable and meaningful results, it restricted the possibility of exploring in more depth variations in terms of class, age, disability issues and so forth. Therefore, generalizing the findings to the LGBT community as a whole is not possible and should not be attempted. Although I consider this study to have provided an opportunity to previously unheard voices, there are many voices that remained unheard. For example, trans individuals who are involved in sex work and older trans individuals are vividly absent from this study. Although I stopped my data collection when no further new themes appeared to emerge, I believe that the themes discussed in my study were also determined by the absence of important voices that should be included as well. This is particularly important as the most vulnerable groups from the LGBT community, such as trans sex workers, should be offered better access to health care and have a say on how these services could be transformed in order to meet their health care needs.

There were various reasons for not being able to negotiate successfully better access to participants from the trans community. One was that members of one portion of the organized trans community refused to participate until I spoke first with their president. However, despite my repeated invitations to their president she never contacted me to schedule a meeting. Therefore, I did not push members of this particular group to participate as I respected their sense of internal hierarchy that was crucial in order to foster participants' sense of safety when speaking to me. Other reasons were related to time limitations and limited resources. More specifically, some interviews during my short trips in the rural and provincial areas were cancelled by prospective participants and I could not afford to wait for rescheduling.

6.3 Recommendations for further research

The qualitative orientation of this study and its broad research questions bring new areas for exploration for future researchers. To my knowledge, this is the first study of its kind in Greece and my analysis was dedicated to providing an extended outline of the ways in which homophobia and transphobia appeared to act as barriers in accessing quality health care services for the LGBT participants. This was a conscious choice as I wanted to open a debate on LGBT health inequalities which is undoubtedly needed especially by those who are interested in dismantling the "virulent" social forces of homophobia and transphobia from society in a targeted and contextually meaningful way. Therefore, all the topics arising in previous chapters need to be further explored, enriched and expanded in their scope. Firstly, given the invisibility of the LGBT community, future research should focus on revealing and mapping the health care needs of the LGBT population including mental health care. To this end, the voices of mental health care providers and other health care professionals, who are knowledgeable, experienced and dedicated to providing appropriate services to LGBT people are also important since their insights can be a changing force in the quality of health care and mental health care services. I refer specifically to the need for research to report the Practice Wisdom, which, as a form of knowledge, is sensitive to situated contexts and therefore embodies local

knowledge of professional practice, formulated by service users themselves and the experiences they share with professionals. It is the product of the intersection of theory and practice, which is a valuable source of expertise development but often remains neglected and unarticulated (Chu and Tsui, 2008).

Furthermore, future researchers who aim to map the health care needs or experiences of LGBT people should also consider the need for a separate analysis for each group that the LGBT acronym denotes. This is because combining the LGBT populations as a single group may defy differences within the population. There is of course an empowering potential to affirm the collective identities used by LGBT communities in order to stand against common oppressive structures. However, it is equally important that we enhance mutual understanding of these groups by bringing to light differences that can potentially harm them in the long run if they are systematically minimized.

My study was restricted to the particular health issues that the participants raised themselves. As a result, some important health concerns that affect the LGBT community may have been obscured or overlooked but should be part of the focus for future researchers. For example, during the period of my fieldwork I met a lesbian art therapist who worked in a rehabilitation program for substance abuse. She spoke in an informal way, but in detail, about the ways that she experienced LGBT people quitting rehabilitation programs as a result of unwelcoming environments for LGBT identities, or being provided with poor services as a result of professionals' lack of awareness of their sexual orientation blindness. However, since none of the participants reflected on issues related to substance abuse, I did not follow up this particular matter. Substance abuse is a problem that affects every segment of our society. However, there is a substantial body of international literature suggesting that substance abuse is an important health concern within the LGBT community given the high rates reported for LGBT people in epidemiological studies (Buffin et al., 2012, Institute of Medicine, 2011, Cochran, 2001). Similarly, this study did not focus specifically on HIV issues although gay and bisexual men are still considered to be among those at higher risk for infection (Institute of Medicine, 2011, Eliason et al., 2009). The accounts of some doctors who participated in this study suggest important barriers in health care that need research attention.

I also recommend that future research should unfold, affirm and empower LGBT groups to foster resilience and resistance against barriers that negatively affect them in health care. Findings of this study suggest that there is a need and a potential for LGBT groups and networks to counteract the negative impact of homophobia and transphobia within health care settings. To this end, further research could serve to bring elements of learning, research and action together into a meaningful approach that can articulate and systematize specific tools to promote good health and health care outcomes for oppressed populations. This study aimed to provide a knowledge base for the recognition and acknowledgment of health inequalities within the LGBT community. Yet, this knowledge must be expanded by the active participation of the members of LGBT community holding the true potential for change. Therefore, future researchers could adopt participatory action research and community resilience approaches that actively link theories with emancipatory practices.

6.4 Recommendations for policy and practice to improve accessibility and quality of health care services for LGBT people

The findings are relevant to LGBT communities, those who are involved in public health promotion, health researchers and all health care professionals in education and clinical care settings. My hope is that the research findings may increase their commitment to LGBT health and health inequalities. The research has clearly demonstrated that there is a long way to go in order to promote accessible and quality health care that LGBT people deserve. With the recommendations following, I offer some guidance on what is needed.

Development of inclusive environments in health care for LGBT people

The experiences of LGBT people documented in chapter 3 and 4 as well as doctors' views on homosexuality and transgenderism provide evidence that homophobia and transphobia are still in place and continue to shape the health care services leading to LGBT people's pathologization and the marginalisation of their health concerns. The assumption that health care settings are "neutral" spaces was refuted through the many reported experiences of LGBT participants being exposed to homophobic and transphobic language and attitudes by health

professionals. These experiences, as well as the negative consequences, (e.g. opt-out from needed health care), demonstrate an urgent need to transform health care settings so as to ensure healing, safe and accessible clinical spaces for both LGBT patients and health professionals. This presupposes:

a) Mandatory and ongoing training for all health care professionals and staff on LGBT relevant information (e.g. the distinctions between sexual orientation and gender identity) and LGBT health issues. As with all patient populations, providing appropriate health care services to LGBT patients requires that health care professionals should be able to understand the cultural context of their patients' life, the issues around sexual and gender diversity and familiarity with the LGBT health needs. In addition, health professionals need to develop their ability to reflect upon personal attitudes that might prevent them from providing the kind of affirmative care that LGBT people need.

b) All involved in health policy and health care should start to utilize, adapt (if appropriate) and widely disseminate international literature and LGBT-focused clinical guidelines which have been developed to address cultural competence and promote good professional practice. There is a growing body of literature which enables health professionals to address important issues such as: the clinical rationale for monitoring sexual orientation, how to ask these questions in an appropriate way, trans-affirmative hospital policies/practices etc.

c) Specific protections, anti-discrimination policies for LGBT people and targeted initiatives to tackle homophobic and transphobic language and treatment within health care settings. Transparent policies are also required to allow patients to decide for themselves who may visit them or make medical decisions on their behalf, regardless of sexual orientation or gender identity.

d) Transcendence of the dominant "neutral doctrine" and acknowledgement that within a heterosexist and cissexist world, which is there is a need for health care settings and health providers to convey affirming messages for LGBT populations. Visible signs may include posters with LGBT affirming messages, LGBT magazines, rainbow pins/flags/stickers etc. It should be acknowledged by all involved in health care that the ideas that are conveyed through language determine spaces of inclusion and exclusion.

e) All patients should have private and confidential time to talk with health providers. Findings of this study suggest that this should be particularly helpful for LGBT youth.

f) The use of forms that include patients' preferred names and pronouns, and the tension of health information materials to be inclusive of the LGBT diversity. Restrooms in inclusive health care environments should include a gender neutral option.

g) Ongoing assessment of how health care is delivered. This could be achieved with the contribution of the LGBT community which should be encouraged to be actively involved in the design, delivery and evaluation of health services and health education.

Advancing the quality of mental health care for LGBT people

The fact that five of the participants reported experiences of being medicated with antipsychotics to treat their sexuality and/or gender identification is alarming and raises questions of whether the health care system in Greece can adequately respond and address such cases of medical malpractice. Furthermore, the conservative ideology that leads to the suppression of debate of sexual orientation and gender identity appeared to prevail, decisively affecting the therapy and counseling approach of mental health practitioners. In order to address this, we must provide more (research and clinical) analytical attention to this ideology as well as the way it evolves and can be employed within counseling settings. We must also begin applying what is already known in order to develop effective mental health care services for LGBT people. Internationally, affirmative practice has emerged to offer a culturally sensitive model for working with LGBT people. To meet this standard:

a) Training on affirmative practice should be included in the mandatory training of mental health care providers from a range of disciplines including psychiatrists, psychotherapists, psychologists and social workers. It is also crucial to achieve widespread curricular integration of the affirmative approach at both undergraduate and postgraduate level of professional training courses.

Affirmative practice challenges the notion of homosexuality and gender variance as pathological. Therefore, it mainly establishes the vital component of “therapy” in the relationship between LGBT persons and mental health providers.

b) Organizational support is needed in order to establish a culture of positivity towards LGBT people, advance LGBT –specific services and ongoing training for mental health professionals.

c) The possibilities of LGBT people to seek competent and affirmative mental health professionals in both the private and public mental health domain should be advanced. To that end, mental health professionals should indicate their expertise in their CVs, websites etc. There is also a need to develop LGBT equality provider directories.

Expanding the discussion on LGBT health within the LGBT movement

Findings discussed in section 4.4 show that the LGBT community is an important source of support particularly for trans participants and for those in the identity-formation process or those experiencing social isolation. The insights provided by participants suggest an important link between the identity struggles and health care needs of people. However, the discussion of some issues remains suppressed within activist groups (e.g. lesbians’ experiences of Pap test) or is framed as a strictly medical issue (e.g. Klinefelter syndrome). Overall, the meaning of LGBT health issues and inequalities appeared to be framed strictly together with HIV issues further limiting the demands of the LGBT community for recognition of their health rights.

Historically, health social movements have profoundly influenced health care systems and public awareness of health issues, and played a significant role in pressing for social change. For example, women’s health activists internationally challenged medical stereotypes of women, broadened reproductive rights and pressed for changes in traditional standards of clinical care (Brown et al., 2011). It is clear from this study that the formal and informal networks of the LGBT community in Greece have had a strong impact on access to health care and the good health of their members. The findings of this study affirm this contribution

and will hopefully strengthen the basis of the advocacy work of the LGBT movement. However, there is much to be done to change the ways that LGBT health and health inequalities are currently understood both within the LGBT community and generally in society. For the LGBT movement, going forward would mean expanding the discussion on LGBT health inequalities beyond HIV issues, which though still crucial for the wellbeing of the LGBT community, is not identical with the notion of LGBT health issues and inequalities.

Advocacy work on LGBT health inequalities may also entail forging partnerships, network and building coalitions with other human rights activists, health policy makers, health care providers and researchers who are committed to the changing processes that advance the quality and access of health care for LGBT people. The LGBT community can also consider the possibility of partnership with the Social Solidarity Clinics that have been recently developed in response to the catastrophic [recession that led to] health crisis in Greece. These clinics are managed and sustained collectively by health workers, activists and patients and are often characterized as being the backbone of a growing movement for the right to health. Although these clinics were primarily designed to protect those who were excluded from health insurance coverage, their premise is also to incorporate a new vision and ethos regarding the organisation and delivery of healthcare services. These clinics can constitute a fertile ground for the LGBT health activists to stimulate discussions and interventions about the development of a new paradigm for inclusive health care services to LGBT people.

6.5 Original contribution to knowledge

This study has offered an analysis and testament of the ways that homophobia and transphobia are perpetuated in the health care sector of Greece by drawing on insights from the lived experiences of the LGBT participants. This is particularly important since the health care experiences of LGBT people in Greece have not been assessed before. Thus, these first empirical data can provide a platform for a much needed dialogue on concrete and effective interventions that will strategically aim to eliminate discrimination against LGBT people in the health care regime.


The Greek authorities do not compile full statistics about the extent of racist, homophobic or transphobic violence and discrimination because there is no full-scale system for the appropriate reporting of such cases (ECRI, 2015). In addition, public authorities have shown little interest in researching health inequalities (Economou, 2012, Tountas et al., 2004). The limited number of research projects on health inequalities has been carried out by the departments of Social Medicine of the Universities of Athens and Crete. Research has focused on examining the relationship between specific socioeconomic groups and particular diseases (Tountas et al., 2004). As Economou (2010) notes, there are no national research programs, independent reports recommending policy action, and reports by government advisory committees or government policy documents that focus on reducing health inequalities in Greece. This is a severe gap given that a situation analysis is a prerequisite for concrete action to battle inequalities and discrimination. Therefore, the contribution of this study can be also considered in terms of the Greek context and the much needed generation of knowledge in the field of health inequalities.

I believe that the findings of this study also advance the potential for demonstrating homophobia and transphobia in Greece. This is important because Greece does not have an effective policy for LGBT persons' protection against discrimination, or a national program to raise public awareness and combat negative stereotypes and prejudices (ECRI, 2015). As a result, the meanings of homophobia and transphobia are not yet sufficiently discussed and publicly well-known concepts. Furthermore, homophobia and transphobia are often understood in narrow ways, usually linked exclusively to hate speech or homo/transphobic violence in public spaces. My analysis was dedicated to providing an extended outline of the ways in which these social structures appeared to act as barriers in accessing quality health care services for the LGBT participants. Furthermore, my focus on exploring homophobia and transphobia in the context of health care which is widely assumed to be associated with non-violence, political neutrality and orientated to the humanitarian treatment of all, uncovers the "virulent" and traumatic character of LGBT invisibility. Drawing on what Ward and Winstanley (2003) metaphorically called "the absent present" to characterize the oppressive power of silencing, I offer these findings to uncover

the invisible aspects of homophobia and transphobia and prove that they are powerfully “present” through the many “absences”, silences and invisibilities of LGBT identities in the health care regime.

Appendices

Appendix 1: Ethical approval letter from Durham University

Postgraduate Students Research Ethics and Risk Assessment Form	
<p>Name – Dimitra Giannou</p> <p>Student ID – 000232151</p> <p>Supervisors - Vasilios Ioakimidis & Mark Cresswell</p>	
<p>The above named students' Research Ethics and Risk Assessment Form has been reviewed by the Director of Postgraduate Research. Where appropriate the student has been given guidance to amend the form and the final version (attached) is now deemed suitable for submission for approval by the Ethics Committee.</p>	
<p>Signed –</p>  <p>Helen Charnley, Director PGR</p> <p>Date - 29 May 2014.</p>	<p>Note: Ethical approval for all aspects of the research except accessing doctors in Athens. Approval for that part of the study will be granted following receipt of a letter or email providing permission.</p>
<p>Passed to Ethics Committee - (Date) 30/05/2014</p>	

Appendix 2: E-mail communication with Panhellenic Medical Association (translated)

Subject: request relevant to the participation of doctors to a social study
Sent: 3 June 2014
To: pisinfo@pis.gr

Dear Sir/Madame,

My name is Dimitra Giannou, I am a social worker and a Phd student in Durham University. I conduct a qualitative study on the health care experiences of non-heterosexual people in Greece. As part of this study I will also interview private practice doctors whom I intent to approach in their private clinics.

As I am in the process of getting the ethical approval from the ethical committee of my university, I was asked to contact you so as to ensure that approval from the Association is not a prerequisite so as to interview doctors. Of course, the participation of doctors is voluntary and each doctor will be asked to sign a consent form. However, the university needs to ensure that the Association does not demand from its members prior approval for their participation to a study.

I would appreciate if you respond on my request either through e-mail or by post.

Many thanks,

Dimitra Giannou

RE: request relevant to the participation of doctors to a social study
Antigoni Tsagla (Panhellenic Medical Association) [pisinfo@pis.gr]
Sent: 4 June 2014
To: GIANNOU D.

Good morning! I inform you that you don't need an approval from PIS for your interviews with doctors.

Appendix 3: Information sheet for participants



Dimitra Giannou

Social worker

Phd student

School of Applied Social Sciences

Durham University

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DH1 3HN

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Research Participant Information Sheet/ Invitation for participation in a study with subject:

“Understanding homophobia/ transphobia in context: A qualitative study on health inequalities of Lesbian, Gay, Bisexual, and Transgender (LGBT) people in Greece”

Dear Sir/Madam,

With this letter you are invited to participate in a study investigating the role of homophobia/ transphobia in the reproduction of health inequalities for LGBT people in Greece. This study is being conducted to fulfill the requirements of my Phd in Durham University. The study has received an ethical approval by the ethical committee of the School of Applied Sciences in Durham University.

The purpose of this study is to raise social awareness about the role of homophobia/ transphobia and their function as social structures in the reproduction of health inequalities for LGBT people. The data of this study can be useful to the LGBT organizations and support their efforts to combat social inequalities for the LGBT community, as well as to the health professionals who are interested at enhancing the quality of their services and the accessibility of their services to all citizens.

Your participation is entirely voluntary. If you decide to participate you will be asked to provide 1 to 1.5 hour of your time to participate in an audio-taped semi-structured interview. Written consent will also be obtained. The interview time and location will be scheduled at your convenience. All participants and information shared will remain confidential. You are also free to withdraw your participation at any time.

The outcomes of this research will be available after the presentation and reporting of the research, which will probably be soon after June 2016. Any publication of these research outcomes will be with the protection of your personal or organization's details.

If you have any question about your participation terms, about this informative letter or about the subject of the research, please do not hesitate to contact with me or to my supervisor.

Yours sincerely,
Dimitra Giannou

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Appendix 4: Consent Form

Consent Form

Please tick the appropriate box

	YES	NO
Have you read the Research Participant Information Sheet?		
Have you had an opportunity to ask questions and discuss this study?		
Have you received satisfactory answers to all your questions?		
Who have you spoken to?		
Do you consent to be tape-recorded by the researcher?		
Do you understand that you will not be referred to by name in any report concerning the study?		
Do you understand that you are free to withdraw from the study:		
- At any time		
- Without having to give a reason for withdrawing?		
Do you agree to take part in this study?		
Signature of Research Participant:		
Date:		
Name in Capitals:		

Appendix 5: Draft individual interview guide (LGBT persons)

1. Can you please remember the last time you went to a health practitioner and describe me this experience?
2. Can you remember the last time you had to discuss with a health practitioner an issue that had to do with your sexuality or gender identity?
3. Have you ever experienced any incident of discrimination due to your sexual orientation or gender identity when seeking or obtaining health care?
4. Were there other things that could have influenced the way you were treated?
5. When do you think is necessary for a doctor to know details about your gender identity and/or sexual orientation?
6. Do you feel that your access in health care is limited due to homophobia/transphobia or any other reason?
7. Have you ever sought mental health treatment?
8. Are you currently receiving mental health treatment?
9. Do you think homophobia/transphobia have somehow affected your health?
10. What do you think will help to improve the quality of health care of LGBT people? (In terms of policy and practice)

Appendix 6: Draft group interview guide (LGBT activists)

1. What motivated you to participate in this group?
2. What are your current expectations from your participation in this group?
3. Do you think that the health needs of LGBT people are appropriately met in the health system? What issues arise?
4. How LGBT community manages these issues?
5. What do you think are the future issues and challenges for the LGBT community in terms of health rights?
6. Have you ever experienced any incident of discrimination due to your sexual orientation or gender identity when seeking or obtaining health care?
7. When do you think is necessary for a doctor to know details about your gender identity and/or sexual orientation?
8. Do you feel that your access in health care is limited due to homophobia/transphobia or any other reason?
9. Do you think homophobia/transphobia have somehow affected your health?
10. What do you think will help to improve the quality of health care of LGBT people? (In terms of policy and practice)

Appendix 7: Draft individual interview guide (doctors)

1. Have you ever experienced any incident of discrimination of a patient due to his/her sexual orientation or gender identity when seeking or obtaining health care?
2. Do you think LGBT patients are discriminated somehow in health care settings? (prompt for examples)
3. Do you think the health status of an LGBT person is somehow affected by homophobia/transphobia or stigma?
4. Do you think health care settings are safe environments for LGBTs?
5. Do you think knowing the sexual orientation/gender identity of your patients is important to your practice? (prompt for examples)
6. Which is the most appropriate and effective practice for working with LGBT patients?

BIBLIOGRAPHY

- ADAMS, J., DICKINSON, P. & ASIASIGA, L. 2013. Mental health issues for lesbian, gay, bisexual and transgender people: a qualitative study. *International Journal of Mental Health Promotion*, 15, 105-120.
- AHO, J., HAKIM, A., VUYLSTEKE, B., SEMDE, G., GBAIS, H. G., DIARRASSOUBA, M., THIAM, M. & LAGA, M. 2014. Exploring Risk Behaviors and Vulnerability for HIV among Men Who Have Sex with Men in Abidjan, Cote d'Ivoire: Poor Knowledge, Homophobia and Sexual Violence. *PLoS ONE*, 9, e99591.
- ALLEYN, C. & JONES, R., L. 2010. Queering care: Dissident Trans identities in health and social care settings. In: JONES, R., L & WARD, R. (eds.) *LGBT Issues: Looking beyond categories. Policy and Practice in Health and Social Care*. Edinburgh: Dunedin Academic Press.
- ANDROULAKIS, G. 2012. AIDS: Contamination and Protection. *Vima*, 2 Dec. 2012.
- APPLEBY, G. A. & ANASTAS, J. W. 1998. *Not just a passing phase : social work with gay, lesbian, and bisexual people*, New York ; Chichester, Columbia University Press.
- ATKINS, D. 1998. Introduction: Looking Queer. In: ATKINS, D. (ed.) *Looking Queer: Body Image and Identity in Lesbian, Bisexual, Gay and Transgender Communities*. USA: The Haworth Press.
- BAILEY, C., A. 2007. *A Guide to Qualitative Field Research*, SAGE Publications Inc.
- BALLAS, A. & TSOUKAS, H. 2004. Measuring Nothing: The Case of the Greek National Health System. *Human Relations*, 57, 661-690.
- BARBARA, A. M., QUANDT, S. A. & ANDERSON, R. T. 2001. Experiences of Lesbians in the Health Care Environment. *Women & Health*, 34, 45-62.
- BAUER, G. R., HAMMOND R FAU - TRAVERS, R., TRAVERS R FAU - KAAAY, M., KAAAY M FAU - HOHENADEL, K. M., HOHENADEL KM FAU - BOYCE, M. & BOYCE, M. 2009. "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in Aids Care*, 20, 348-361.
- BLASIUS, M. 1994. *Gay and Lesbian Politics, Sexuality and the Emergence of a New Ethic*, Temple University Press.
- BLUMENFELD, W. J. (ed.) 1992. *Homophobia : How we all pay the price*, Boston: Beacon Press.
- BOCKTING, W. O., KNUDSON, G. & GOLDBERG, J. M. 2006. Counseling and Mental Health Care for Transgender Adults and Loved Ones. *International Journal of Transgenderism*, 9, 35-82.
- BOWLEG, L. 2008. When Black + Lesbian + Woman ≠ Black Lesbian Woman: The Methodological Challenges of Qualitative and Quantitative Intersectionality Research. *Sex Roles*, 59, 312-325.
- BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- BRICKELL, C. 2001. Whose 'Special Treatment'? Heterosexism and the Problems with Liberalism. *Sexualities*, 4, 211-235.

- BROTMAN, S., RYAN, B. & CORMIER, R. 2003. The health and social service needs of gay and lesbian elders and their families in Canada. *The Gerontologist*, 43, 192-202.
- BROWN, L., S. 2003. Sexuality, Lies and Loss: Lesbian, Gay and Bisexual Perspectives on Trauma. *Journal of Trauma Practice* 2, 55-68.
- BROWN, P., MORELLO-FROSCH, R., ZAVESTOSKI, S., SENIER, L., GASIOR ALTMAN, R., HOOVER, E., MCCORMICK, S., MAYER, B. & ADAMS, C. 2011. Health Social Movements: Advancing Traditional Medical Sociology Concepts. In: PESCOSOLIDO, B. A., MARTIN, J. K., MCLEOD, J. D. & ROGERS, A. (eds.) *Handbook of the Sociology of Health, Illness, and Healing*. London: Springer.
- BROWNE, K., BAKSHI, L. & VOSS, G. 2014. It's a gap, not an overlap: queering bi health *Queering Health*. UK PCCS BOOKS.
- BUFFIN, J., ALASTAIR, R., WILLIAMS, H. & WINTER, A. 2012. Part of the Picture: lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011). Manchester: LGF.
- BUTLER, R., A.,. 2010. *An Assessment of Lesbian, Gay, Bisexual, and Transgender Curriculum Infusion in U.S. Medical Schools*. SPEA Honors Thesis, Indiana University.
- CARASTATHIS, A. 2013. Identity Categories as Potential Coalitions. *Signs*, 38.
- CATTELL, V. 2001. Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social Science & Medicine*, 52, 1501-1516.
- CHARALAMPAKIS, M. 2015. Ambrosios' delirium against gays. *Ta Nea*, 09 December 2015.
- CHATZITRIFON, N. 2014. Providing informal learning: The case of a gay-lesbian-bisexual-transsexual film festival. In: PHELLAS, C., N., KAPSOU, M. & EPAMINONDA, E. (eds.) *Sexualities: Opinions, Studies and Experiences in Cyprus and Greece*. Athens: Polichromos Planitis.
- CHU, W. C. K. & TSUI, M.-S. 2008. The nature of practice wisdom in social work revisited. *International Social Work*, 51, 47-54.
- COCHRAN, S. D. 2001. Emerging issues in research on lesbians' and gay men's mental health: does sexual orientation really matter? *Am Psychol*, 56, 931-47.
- COLPITTS, E. & GAHAGAN, J. 2016. The utility of resilience as a conceptual framework for understanding and measuring LGBTQ health. *International Journal for Equity in Health*, 15.
- CONNOLLY, C. M. 2004. Clinical Issues with Same-Sex Couples. *Journal of Couple & Relationship Therapy*, 3, 3-12.
- CONNOLLY, L. 1996. Long -Term Care and Hospice: The Special Needs of Older Gay Men and Lesbians. In: PETERSON, J., K. (ed.) *Health care for lesbians and gay men: Confronting homophobia and heterosexism*. New York: Harrington Park Press.
- COREIL, J. 1995. Group Interview Methods in Community Health Research. *Medical Anthropology*, 16, 193-210.
- CRENSHAW, K. 1991. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43, 1241-1299.

- CROWLEY, J. E. 2007. Friend or Foe?: Self-Expansion, Stigmatized Groups, and the Researcher-Participant Relationship. *Journal of Contemporary Ethnography*, 36, 603-630.
- CRUZ, T. M. 2014. Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination. *Social Science & Medicine*, 110, 65-73.
- CSDH 2008. Closing the gap in a generation: health equity through action on the social determinants of health. *Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organisation.
- D'EXAERDE, C. D. K. 2001. "*Dedoublement*": *The Negotiation of Gender in Transvestism*. Phd, Durham University.
- DASKALAKIS, D., C., LANDOVITZ, R. & CESPEDES, M. 2008. Sexual Health. *Fenway Guide to lesbian, gay, bisexual and transgender health*. US: American College of Physicians.
- DAVIS, K. 2014. Intersectionality as Critical Methodology. In: LYKKE, N. (ed.) *Writing Academic Texts Differently: Intersectional Feminist Methodologies and the Playful Art of Writing* Routledge.
- DENDRINOS, P. 2008. *Contemporary Greek male Homosexualities: Greek gay men's experiences of the family, the military, and the LGBT movement*. Phd, University of Glasgow.
- DENTATO, M., P.,. 2012. The minority stress perspective. Available: <http://www.apa.org/pi/aids/resources/exchange/2012/04/minority-stress.aspx> [Accessed 5/12/13].
- DEUTSCH, C. P. 1981. The Behavioral Scientist: Insider and Outsider. *Journal of Social Issues*, 37, 172-191.
- DICK, S. 2008. Homophobic hate crime, The Gay British Crime Survey 2008. UK: Stonewall.
- DIMOLIATIS, Y. 2006. Is health equality possible within an environment of social inequality? In: DOLGERAS, A. & KYRIOPOULOS, Y. (eds.) *Equality, effectiveness and efficiency in health services*. Greece: Themelio.
- DODDS, C., KEOGH, P. & HICKSON, F. 2005. It Makes me Sick, Heterosexism, Homophobia and the Health of Gay Men and Bisexual Men. Sigma Research.
- DONALDSON, A. A., LINDBERG LD FAU - ELLEN, J. M., ELLEN JM FAU - MARCELL, A. V. & MARCELL, A. V. 2013. Receipt of sexual health information from parents, teachers, and healthcare providers by sexually experienced U.S. adolescents. *Journal of Adolescent Health*, 53, 235-240.
- ECONOMOU, C. 2010. Greece: Health system review. *Health Systems in Transition*, 12, 1-180.
- ECONOMOU, C. 2012. The legal framework of health care in Greece. Athens: GSEE Labour Institute
- ECONOMOU, C., KAITELIDOU, D., KENTIKELENIS, A., SISSOURAS, A. & MARESSO, A. 2014. The impact of the financial crisis on the health system and health in Greece. World Health Organisation, European Observatory on Health Systems and Policies.
- ECRI 2015. ECRI Report on Greece (fifth monitoring cycle). Council of Europe: European Commission Against Racism and Intolerance.
- ELIASON, M., J., DIBBLE, S., L., , DEJOSEPH, J. & CHINN, P. 2009. *LGBTQ Cultures: What Health Care Professionals Need to Know About Sexual and Gender Diversity*, Philadelphia Lippicott Williams & Wilkins.

- ELIASON, M. & SCHOPE, R. 2001. Original Research: Does "Don't Ask Don't Tell" Apply to Health Care? Lesbian, Gay, and Bisexual People's Disclosure to Health Care Providers. *Journal of the Gay and Lesbian Medical Association*, 5, 125-134.
- ELLIS, S. J., BAILEY, L. & MCNEIL, J. 2014. Trans People's Experiences of Mental Health and Gender Identity Services: A UK Study. *Journal of Gay & Lesbian Mental Health*, 19, 4-20.
- ESCOFFIER, J. 1998. *American Homo : Community and Perversity*, London, University of California Press, Ltd.
- EVANS, D. 2001. The stigma of 'sexuality': Concealability and course. In: MASON, T., CARLISLE, C., WATKINS, C. & WHITEHEAD, E. (eds.) *Stigma and Social Exclusion in Healthcare*. London: Routledge.
- FABENI, S. & MILLER, A. M. 2007. The Importance of Being Perverse: Troubling Law, Identities, Health and Rights in Search of Global Justice. *The Health of Sexual Minorities*. USA: Springer.
- FARREL, C., MCAVOY, H., WILDE, J. & AGENCY, C. P. 2008. Tackling Health Inequalities- An-All-Ireland Approach to Social Determinants. Dublin: Combat Poverty Agency and Institute of Public Health in Ireland
- FASSINGER, R. E. & MILLER, B. A. 1997. Validation of an Inclusive Model of Sexual Minority Identity Formation on a Sample of Gay Men. *Journal of Homosexuality*, 32, 53-78.
- FAUSTO STERLING, A. 2000. *Sexing the Body: Gender Politics and the Construction of Sexuality*, USA, Basic Books
- FERGUSON, D. M., HORWOOD, L. & BEAUTRAIS, A. L. 1999. IS sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*, 56, 876-880.
- FIELAND, K., C., WALTERS, K., L., & SIMONI, J., M. 2007. Determinants of Health Among Two-Spirit American Indians and Alaska Natives. In: MEYER, I. H. & NORTHRIDGE, M. E. (eds.) *The health of sexual minorities*. USA: Springer.
- FINE, G., A. 1993. Ten Lies of Ethnography. *Journal of Contemporary Ethnography*, 22.
- FISH, J. 2006. *Heterosexism in health and social care*, New York, Palgrave Macmillan.
- FISH, J. 2008. Navigating Queer Street: Researching the Intersections of Lesbian, Gay, Bisexual and Trans (LGBT) Identities in Health Research. *Sociological Research Online*, 13, 12.
- FISH, J. 2009. Lesbian and bisexual women: a review of the worldwide literature using systematic methods. NHS Cervical Screening Programme.
- FISH, J. & ANTHONY, D. 2005. UK National Lesbians and Health Care Survey. *Women & Health*, 41, 27-45.
- FISHER, B. & AKMAN, J. S. 2002. Normal Development in Sexual Minority Youth. In: JONES, B. E. & HILL, M. J. (eds.) *Mental Health Issues in Lesbian, Gay, Bisexual, and Transgender Communities*. Washington, DC: American Psychiatric Publishing.
- FORD, C. L. 2006. Usage of "MSM" and "WSW" and the broader context of public health research. *American Journal of Public Health*, 96, 9.
- FORSEY, M., G. 2010a. Ethnography and the myth of participant observation. *Studies in Qualitative Methodology* 11, 65-79.
- FORSEY, M., G. 2010b. Ethnography as participant listening. *Ethnography*, 11.

- GALANOU, M. 2013. Stop now the pogroms of the Greek Police against trans people. *Antivirus Magazine* [Online]. Available: <http://www.avmag.gr/archives/33596> [Accessed 20/12/13].
- GALANOU, M. 2014. *Identity and Gender Expression: Definitions, Discriminations, Stereotypes and Myths*, Greece, Greek Transgender Support Association
- GALOBARDES, B., LYNCH, J. & SMITH, G. D. 2007. Measuring socioeconomic position in health research. *British Medical Bulletin*, 81-82, 21-37.
- GLICK, P. & FISKE, S. T. 2001. An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality. *American Psychologist*, 56, 109-118.
- GLUCKMAN, A. & REED, B. (eds.) 1997. *Capitalism, Community, and Lesbian and Gay Life*: Routledge.
- GOFFMAN, E. 1963. *Stigma : notes on the management of spoiled identity*, Englewood Cliffs, Prentice-Hall.
- GOLDBERG, L., HARBIN, A. & CAMPBELL, S. 2011. Queering the birthing space: Phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care. *Sexualities*, 14, 173-192.
- GOLDSTONE, S., E. 1999. *The Ins and Outs of Gay Sex: A Medical Handbook for Men*, Dell Publications.
- GOOLD, S. & LIPKIN, M., JR. 1999. The doctor-patient relationship. *Journal of General Internal Medicine*, 14, 26-33.
- GRAHAM, H. 2006. *Unequal lives: Health and Socioeconomic Inequalities*, Open University Press.
- GRAHAM, H. & KELLY, P. M. 2004. Health inequalities: concepts, frameworks and policy.
- GRANT, J., M., MOTTET, L., A., TANIS, J., HARRISON, J., HERMAN, J., L., & KEISLING, M. 2011. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.
- GREEK TRANSGENDER SUPPORT ASSOCIATION 2013. Daily arbitrary arrests of transgender people in Thessaloniki. Athens: Greek Transgender Support Association
- GREEK TRANSGENDER SUPPORT ASSOCIATION 2015. G.T.S.A. strongly protests for the archiving of a group-lawsuit because of the pogrom against the trans people in Thessaloniki and the illegal custody of the lawyer who defended their rights. Athens.
- GREENE, B. 2007. Delivering Ethical Psychological Services to Lesbian, Gay and Bisexual Clients. In: BIESCHKE, K., J., PEREZ, R., M., & DEBORD, K., A. (eds.) *Handbook of Counseling and Psychotherapy with Lesbian, Gay Bisexual, and Transgender Clients*. second ed. Washington: American Psychological Association.
- GREENFIELD, J. 2008. Coming Out: The Process of Forming a Positive Identity In: MAKADON, H., J., , MAYER, K., H., POTTER, J. & GOLDHAMMERS, H. (eds.) *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. Philadelphia American College of Physicians
- HANKIVSKY, O., CORMIER, R. & MERICH, D. D. 2009. *Intersectionality: Moving women's health research and policy forward*, Vancouver: Women's Health Research Network.

- HANSEN, H., HOLMES, S. & LINDEMANN, D. 2013. Ethnography of Health for Social Change: Impact on public perception and policy. *Social Science & Medicine*, 99, 116-118.
- HECKATHORN, D. D. 2007. Extensions of respondent-driven sampling: Analysing continuous variables and controlling for differential recruitment *Sociological Methodology*, 37, 151-207.
- HEKMA, G., OOSTERHUIS, H. & STEAKLEY, J. 1995. Leftist sexual politics and homosexuality: a historical overview. *Journal of Homosexuality*, 29, 1-40.
- HENDERSON, J. 2001. 'He's not my carer—he's my husband': Personal and policy constructions of care in mental health. *Journal of Social Work Practice*, 15, 149-159.
- HEREK, G., CHOPP, R. & STROHL, D. 2007. Sexual Stigma: Putting Sexual Minority Health Issues in Context. In: MEYER, I. H. & NORTHRIDGE, M. E. (eds.) *The Health of Sexual Minorities*. Springer.
- HEREK, G., COGAN, J. & GILLIS, J. R. 2002. Victim Experiences in Hate Crimes Based on Sexual Orientation. *Journal of Social Issues*, 58, 319-339.
- HEREK, G. M., COGAN, J. C., GILLIS, J. R. & GLUNT, E. K. 1997. Correlates of internalized homophobia in a community sample of lesbians and gay men. *Journal of the Gay and Lesbian Medical Association*, 2, 17-25.
- HERMAN, J., LEWIS 1992. *Trauma and Recovery: The aftermaths of violence* New York, Basic Books.
- HEYES, C., DEAN, M. & GOLDBERG, L. 2015. Queer Phenomenology, Sexual Orientation, and Health Care Spaces: Learning From the Narratives of Queer Women and Nurses in Primary Health Care. *Journal of Homosexuality*.
- HINCHLIFF, S., GOTT, M. & GALENA, E. 2005. 'I daresay I might find it embarrassing': general practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. *Health and Social Care in the Community*, 13, 345-353.
- HITCHCOCK, J. M. & WILSON, H. S. 1992. Personal risking: lesbian self-disclosure of sexual orientation to professional health care providers. *Nursing Research*, 41, 178-83.
- HOEY, B., A. 2014. A simple introduction to the practice of ethnography and guide to ethnographic fieldnotes. *Marshall Digital Scholar*.
- HOFFMAN, L. G., HEVESI, A. G., LYNCH, P. E., GOMES, P. J., CHODOROW, N. J., ROUGHTON, R. E., FRANK, B. & VAUGHAN, S. 2001. Homophobia. *Journal of Gay & Lesbian Psychotherapy*, 4, 5-53.
- HUGHES, J. A. & SHARROCK, W., W. 1997. *The philosophy of social research*, London, Longman.
- HUGHES, M. 2007. Older Lesbians and Gays Accessing Health and Aged-Care Services. *Australian Social Work*, 60, 197-209.
- HUNTER, J. & BAER, J. 2007. HIV Prevention and Care for Gay, Lesbian, Bisexual, and Transgender Youths: "Best Practices" from Existing Programs and Policies. In: MEYER, I. H. (ed.) *The Health of Sexual Minorities*. USA: Springer.
- HYPHANTIS, T. 2013. The "depression" of mental health care in general hospitals in Greece in the era of recession. *Journal of Psychosomatic Research*, 74, 530-532.

- IFANTI, A. A., ARGYRIOU, A. A., KALOFONOY, F. H. & KALOFONOS, H. P. 2013. Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care.
- ILGA 2016. Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe Brussels: ILGA-Europe.
- INSTITUTE OF MEDICINE 2011. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, DC: The National Academies Press.
- IOAKIMIDIS, V. & TELONI, D.-D. 2013. Greek social work and the never-ending crisis of the welfare state. *Critical and Radical Social Work*, 1, 31-49.
- JENNESS, V. 2013. Social movement growth, domain expansion, and framing processes: The gay/lesbian movement and violence against gays and lesbians as a social problem. *Social Problems*, 42, 145-170.
- KAITELIDOU, D. & KOULI, E. 2012. Greece: the health system in a time of crisis. *Eurohealth incorporating Euro Observer*, 18, 12-14.
- KALAFATI, M. 2012. How Greek healthcare services are affected by the Euro crisis. *Emergency Nurse*, 20, 26-27.
- KANTSA, V. 2014. The price of marriage: Same-sex sexualities and citizenship in Greece. *Sexualities*, 17.
- KENTIKELIS, A., KARANIKOLOS, M., PAPANICOLAS, I., BASU, S., MCKEE, M. & STUCKLER, D. 2011. Health effects of financial crisis: omens of a Greek tragedy. 378. [Accessed 12/2/14].
- KENTIKELIS, A., KARANIKOLOS, M., REEVES, A., MCKEE, M. & STUCKLER, D. 2014. Greece's health crisis: from austerity to denialism. *The Lancet*, 383, 748-753.
- KING, M., MCKEOWN, E., WARNER, J., RAMSAY, A., JOHNSON, K., CORT, C., WRIGHT, L., BLIZARD, R. & DAVIDSON, O. 2003. *Mental health and quality of life of gay men and lesbians in England and Wales*.
- KING, M., SEMLYEN, J., TAI, S., KILLASPY, H., OSBORN, D., POPELYUK, D. & NAZARETH, I. 2008. *A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people* [Online]. Available: <http://dx.doi.org/10.1186/1471-244x-8-70> [Accessed 8 Dec 2015].
- KITZINGER, J. 1994. The methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health & Illness*, 16, 103-121.
- KONDILIS, E., GIANNAKOPOULOS, S., GAVANA, M., IERODIAKONOY, I., WAITZKIN, H. & BENOS, A. 2013. Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case. *American Journal of Public Health*, 103, 973-979.
- KOObAK, R. & THAPAR-BJORKERT, S. 2014. Writing the place from which one speaks. In: LYKKE, N. (ed.) *Writing Academic Texts Differently* New York: Routledge.
- KORELL, S., CHAVEZ; & LORAH, P. 2007. An Overview of Affirmative Psychotherapy and Counseling with Transgender Clients. In: BIESCHKE, K., J., PEREZ, R., M., & DEBORD, K., A. (eds.) *Handbook of Counseling and Psychotherapy with Lesbian, Gay Bisexual, and Transgender Clients*. Washington DC: American Psychological Association
- KORT, J. 2008. *Gay Affirmative Therapy for the Straight Clinician: The Essential Guide*, W.W. Norton.

- LABAREE, R. V. 2002. The risk of 'going observationalist': negotiating the hidden dilemmas of being an insider participant observer. *Qualitative Research*, 2, 97-122.
- LAWRENCE, A., A.; 2007. Transgender Health Concerns. *In*: MEYER, I. H. (ed.) *The Health of Sexual Minorities*. Springer.
- LEE, A. 2008. Finding the Way to the End of the Rainbow: a Researcher's Insight Investigating British Older Gay Men's Lives. *Sociological Research Online*, 13.
- LEIGH, P. 2011. Ordinary Greeks turning to NGOs as health system hit by austerity. Available: <http://euobserver.com/social/113841> [Accessed 12/2/14].
- LEVESQUE, J. F., HARRIS, M., F; & RUSSELL, G. 2013. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12.
- LIAROPOULOS, L. 1998. Ethics and the Management of Health Care in Greece. *In*: DRACOPOULOU, S. (ed.) *Ethics and Values in Health Care Management*. London: Routledge.
- LISS, M., ERCHULL, M. J. & RAMSEY, L. R. 2011. Empowering or Oppressing? Development and Exploration of the Enjoyment of Sexualization Scale. *Personality and Social Psychology Bulletin*, 37, 55-68.
- LOGIE, C. 2012. The Case for the World Health Organization's Commission on the Social Determinants of Health to Address Sexual Orientation. *American Journal of Public Health*, 102, 1243-1246.
- LORDE, A. 1984. *Sister Outsider*, USA, Crossing Press.
- LYKKE, N. 2010. *Feminist Studies: A Guide to Intersectional Theory, Methodology and Writing*, Routledge.
- MAALOUF, A. 2000. *In the Name of Identity: Violence and the Need to Belong*, New York, Penguin Group Inc.
- MAANEN, V., J. 1988. *Tales of the Field*, Chicago, The University of Chicago Press.
- MACDONNELL, J. A. & DALEY, A. 2015. Examining the Development of Positive Space in Health and Social Service Organizations: A Canadian Exploratory Study. *Journal of Gay & Lesbian Social Services*, 27, 263-301.
- MADIANOS, M., ECONOMOU, M., ALEXIOU, T. & STEFANIS, C. 2011. Depression and economic hardship across Greece in 2008 and 2009: two cross-sectional surveys nationwide. *Soc Psychiatry Psychiatr Epidemiol*, 46, 943-952.
- MAHON, C. 2009. Sexual orientation, gender identity and the right to health. *Realizing the Right to Health*. SWISS HUMAN RIGHTS BOOK.
- MAIES, C. 2015. The Greek Homosexual Liberation Movement (AKOE): gendered resistance in the era of political changeover in Greece. *Entropia*, 5.
- MALLIORI, M., TETZIDOU, M., PARASKEVIS, D. & HATZAKIS, A. 2011. HIV/AIDS among IDUs in Greece: Report of a recent outbreak and initial responses policies. European Monitoring Centre for Drugs and Drug Addiction
- MARMOT, M. 2005. Social determinants of health inequalities. *Lancet*, 365.
- MARRAZZO, J. M., STINE, K. & KOUTSKY, L. A. 2000. Genital human papillomavirus infection in women who have sex with women: A review. *American Journal of Obstetrics and Gynecology*, 183, 770-774.

- MARSHALL, C. & ROSSMAN, G. B. 2011. *Designing Qualitative Research*, UK, Sage Publications Inc.
- MASON, G. 2002a. *the spectacle of violence*, Routledge.
- MASON, J. 2002b. *Qualitative Researching*, SAGE Publications Ltd
- MATTHEWS, C., R. 2007. Affirmative lesbian, gay, and bisexual counseling with all clients. *In: BIESCHKE, K., J., PEREZ, R., M., & DEBORD, K., A. (eds.) Handbook of Counseling and Psychotherapy with Lesbian, Gay Bisexual, and Transgender Clients*. Washington, DC: American Psychological Association.
- MAVROUDI, Z. 2013. RUINS: Chronicle of an HIV witch-hunt. Omniatv & Unfollow.
- MCCALL, L. 2005. The Complexity of Intersectionality. *Signs*, 30.
- MCCARN, S., R., & FASSINGER, R. E. 1996. Revisioning Sexual Minority Identity Formation: A New Model of Lesbian Identity and Its Implications for Counseling and Research. *The Counseling Psychologist*, 24, 508-534.
- MCCORMACK, M., ADAMS, A. & ANDERSON, E. 2003. Taking to the streets: the benefits of spontaneous methodological innovation in participant recruitment. *Qualitative Research*, 13, 228– 241.
- MCILVEEN, H. 2008. *The Challenges of Improving Access to Sexual Health Services to Improve the Sexual Health of the Nation*. Doctor of Philosophy, Durham University
- MCLAREN, S., JUDE, B. & MCLACHLAN, A. J. 2008. Sense of Belonging to the General and Gay Communities as Predictors of Depression among Australian Gay Men. *International Journal of Men's Health*, 7, 90-99.
- MCNAIR, R., P., 2003. Lesbian health inequalities: a cultural minority issue for health professionals. *The Medical Journal of Australia*, 178, 643-645.
- MCNAIR, R. P. & HEGARTY, K. 2010. Guidelines for the primary care of lesbian, gay, and bisexual people: a systematic review. *Annals of Family Medicine*, 8.
- MEADS, C., CARMONA, C. & KELLY, P. M. 2012. Lesbian, gay and bisexual people's health in the UK: a theoretical critique and systematic review. *Diversity and Equality in Health and Care*, 9, 19-32.
- MEEKS, C. 2011. Gay and straight rites of passage. *In: SEIDMAN, S. (ed.) Introducing the New Sexuality Studies*. Routledge
- MEGALOECONOMOU, T. 2012. Against the Psychiatry of the Memorandum *Notebooks of Psychiatry* 119.
- MENKEN, D. 2001. *Speak out! Talking about love, sex and eternity*, USA, New Falcon Publications
- MEYER, I. H. 2003. Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychol Bull*, 129, 1-39.
- MEYER, I. H. & WILSON, P. A. 2009. Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology*, 56, 23-31.
- MILLER, M., ANDRE, A., EBIN, J. & BESSONOVA, L. 2007. Bisexual health: An introduction and model practices for HIV/STI prevention programming. New York: National Gay and Lesbian Task Force Policy Institute, The Fenway Institute at Fenway Community Health.
- MONRO, S. & RICHARDSON, D. 2010. Intersectionality and Sexuality: The Case of Sexuality and Transgender Equalities Work in UK Local Government. *In:*

- TAYLOR, Y., HINES, S. & CASEY, E., MARK (eds.) *Theorizing Intersectionality and Sexuality*. UK: Palgrave Macmillan.
- MOSSIALOS, E., ALLIN, S. & DAVAKI, K. 2005. Analyzing the Greek Health System: A Tale of Fragmentation and Inertia. *Health Economics*, 14.
- MYERS, J. 2003. *The A to Z of the Lesbian Liberation Movement*, United Kingdom, The Scarecrow Press.
- NAMASTE, V., K. 2000. *Invisible Lives, USA*, The University of Chicago Press.
- NAMASTE, V., K. 2011. Transsexual, transgender, and queer. In: SEIDMAN, S., FISCHER, N. & MEEKS, C. (eds.) *Introducing the New Sexuality Studies*. Routledge.
- NAPLES, N., A. 1996. A Feminist Revisiting of the Insider/Outsider Debate: The "Outsider Phenomenon" in Rural Iowa. *Qualitative Sociology*, 19, 83-106.
- NES, F. V., ABMA, T., JONSSON, H. & DEEG, D. 2010. Language differences in qualitative research: is meaning lost in translation? *European Journal of Ageing*, 7, 313-316.
- NEUBERGER, R., J.; & COKER, N. 2002. Managing diversity and countering discrimination in health services. In: TOMLINSON, D., R.; & TREW, W. (eds.) *Equalising Opportunities, Minimising Oppression: A critical review of anti-discriminatory policies in health and social welfare*. London: Routledge.
- O'BRIEN, J., G., THIBAUT, J., M., TURNER, C., L., & LAIRD-FICK, H., S. 2000. Self-Neglect: An Overview. *Journal of Elder Abuse & Neglect*, 11, 1-19.
- O'HANLAN, K., CABAJ, R., SCHATZ, B., LOCK, J. & NEMROW, P. 1997. A Review of the Medical Consequences of Homophobia with Suggestions for Resolution. *Journal of the Gay and Lesbian Medical Association*, 1, 25-39.
- PHARR, S. 1997. *Homophobia: a weapon of sexism*, California, USA, Chardon Press.
- PHOENIX, A. 1987. Theories of gender and black families. In: WEINER, G. & MADELEINE, A. (eds.) *Gender Under Scrutiny: New Enquiries in Education*. London: Open University Press.
- POTTER, J., GOLDHAMMERS, H. & MAKADON, H., J., 2008. Clinicians and the Care of Sexual Minorities. *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*. USA: American College of Physicians.
- POTTS, K. & BROWN, L. 2005. Becoming an anti-oppressive researcher. In: BROWN, L. & STREGA, S. (eds.) *Research As Resistance: Critical, Indigenous, and Anti-Oppressive Approaches*. Canada: Canadian Scholars' Press.
- PRICE, E. 2011. LGBT sexualities in social care research. NIHR School for Social Care Research.
- PRITCHARD, A., MORGAN, N. & SEDGLEY, D. 2002. In search of lesbian space? The experience of Manchester's gay village. *Leisure Studies*, 21, 105-123.
- PSAROULIS, D., K., 2008. *Forensics: from theory to practice*, Athens, University Studio Press.
- PUWAR, N. 2004. *Space Invaders: Race, Gender and Bodies Out of Place*, United Kingdom, Berg.
- QUEERTRANS 2015. Transphobia in Exarcheia and Elsewhere (and Everywhere). Athens, Greece: Queertrans.
- RANDAZZO, T., J. 2005. Social and Legal Barriers: Sexual Orientation and Asylum in the United States. In: LUIBHEID, E. & CANTU, L., JR. (eds.)

- Queer Migrations: Sexuality, U.S. Citizenship, and Border Crossings*. USA: University of Minnesota Press.
- REMAFEDI, G., FRENCH, S., STORY, M., RESNICK, M. D. & BLUM, R. 1998. The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, 88, 57-60.
- RIEDEL, B. S. 2005. *Elsewheres: Greek LGBT Activists and the Imagination of a Movement*. PHD, Rice University.
- RIGGS, D. W. 2014. What makes a man? Thomas Beatie, embodiment, and 'mundane transphobia'. *Feminism & Psychology*, 24, 157-171.
- RITTER, K., Y., & TERNDRUP, A., I. 2002. *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men*, London, The Guilford Press.
- ROBERTS, C. 2011. Medicine and the making of a sexual body. In: SEIDMAN, S., FISCHER, N. & MEEKS, C. (eds.) *Introducing the New Sexuality Studies*. Routledge.
- ROCHLIN, M. 1982. Sexual orientation of the therapist and therapeutic effectiveness with gay clients. In: GONSIORREK, J., C. (ed.) *Homosexuality & Psychotherapy* Haworth Press Inc.
- RONDAHL, G., INNALA S FAU - CARLSSON, M. & CARLSSON, M. 2006. Heterosexual assumptions in verbal and non-verbal communication in nursing. *Journal of Advanced Nursing*, 56, 373-381.
- ROSENTHAL, A. N., PANOSKALTSIS, T., SMITH, T. & SOUTTER, W. P. 2001. The frequency of significant pathology in women attending a general gynaecological service for postcoital bleeding. *BJOG: An International Journal of Obstetrics & Gynaecology*, 108, 103-106.
- ROSS, M. W. & ROSSER, B. R. 1996. Measurement and correlates of internalized homophobia: a factor analytic study. *Journal of Clinical Psychology*, 52.
- ROTER, D. & HALL, J. 2006. *Doctors talking with patients/patients talking with doctors : improving communication in medical visits*, Praeger Publishers.
- RUBIN, A. & BABBIE, E. R. 2001. *Research methods for social work*, Australia; Belmont, CA, Wadsworth/Thomson Learning.
- RUBIN, H. 2003. *Self-Made Men*, USA, Vanderbilt University Press.
- RUTHERFORD, K., MCINTYRE J FAU - DALEY, A., DALEY A FAU - ROSS, L. E. & ROSS, L. E. 2012. Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education*, 46.
- RVRN 2015 Racist Violence Recording Network 2015 Annual Report.
- RYAN, B. 2003. *A new look at homophobia and heterosexism in Canada*, Canadian AIDS Society.
- SANCHEZ, N. F., SANCHEZ, J. P. & DANOFF, A. 2009. Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City. *American Journal of Public Health*, 99, 713-719.
- SAVIN-WILLIAMS, R. C. & COHEN, K. M. 2007. Development of Same-Sex Attracted Youth. In: MEYER, I. H. (ed.) *The Health of Sexual Minorities*. USA: Springer.
- SCARCE, M. 1999. *Smearing the Queer: Medical Bias in the Health Care of Gay Men*, USA, The Haworth Press Inc.

- SCHOPE, R. D. 2002. The Decision to Tell: Factors Influencing the Disclosure of Sexual Orientation by Gay Men. *Journal of Gay & Lesbian Social Services*, 14, 1-22.
- SCHULZ, A. J. & MULLINGS, L. (eds.) 2006. *Gender, Race, Class and Health*, San Francisco: John Wiley & Sons, Inc.
- SCHWEITZER, M., GILPIN L FAU - FRAMPTON, S. & FRAMPTON, S. 2004. Healing spaces: elements of environmental design that make an impact on health. *Journal of Alternative and Complementary Medicine*, 10, 71-83.
- SEE, H. & HUNT, R. 2011. Bisexuality and Identity: The Double-Edged Sword: Stonewall Research into Bisexual Experience. *Journal of Bisexuality*, 11, 290-299.
- SEIDMAN, S., MEEKS, C. & TRASCHEN, F. 1999. Beyond the Closet? The Changing Social Meaning of Homosexuality in the United States. *Sexualities*, 2, 9-34.
- SEN, A. 1992. *Inequality Reexamined*, New York, Oxford University Press Inc.
- SHAKESPEARE, T. 2000. Disabled Sexuality: Toward Rights and Recognition. *Sexuality and Disability*, 18, 159-166.
- SHAW, I. & GOULD, N. 2001. *Qualitative Research in Social Work*, Sage Publications Inc.
- SHERNOFF, M. 2006. *Without Condoms, Unprotected sex, gay men & barebacking*, New York, Routledge.
- SISKOU, O., KAITELIDOU, D., PAPAKONSTANTINOY, V. & LIAROPOULOS, L. 2008. Private health expenditure in the Greek health care system: Where truth ends and the myth begins. *Health Policy*, 88, 282-293.
- SMITH, T., L. 1999. *Decolonizing methodologies : research and indigenous peoples*, London, Zed Books.
- SNOW, D. A., MORRILL, C. & ANDERSON, L. 2003. Elaborating Analytic Ethnography: Linking Fieldwork and Theory. *Ethnography*, 4, 181-200.
- SUE, W., DERALD 2010. *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*, New Jersey, John Wiley & Sons Inc.
- TAUCHES, K. 2011. Transgendering *In: SEIDMAN, S. & FISCHER, N. (eds.) Introducing the New Sexuality Studies*. Routledge.
- TAYLOR, Y. 2007. *Working-Class Lesbian Life*, UK, Palgrave.
- TAYLOR, Y. 2010. Complexities and Complications: Intersections of Class and Sexuality. *In: TAYLOR, Y., HINES, S. & CASEY, E., MARK (eds.) Theorizing Intersectionality and Sexuality*. Palgrave Macmillan.
- TAYLOR, Y., HINES, S. & CASEY, E., MARK (eds.) 2010. *Theorizing Intersectionality and Sexuality*. Palgrave Macmillan.
- TGEU 2013. TGEU Statement on Transgender Arrests to improve image of Thessaloniki. Transgender Europe.
- THEODORIDIS, A. 2015. Country report Non-discrimination Greece. Luxembourg: European Commission.
- TOUNTAS, Y., KARNAKI, P. & TRIANTAFYLLOU, D. 2004. Greece. *In: MACKENBACH, J. P. & BAKKER, M. (eds.) Reducing Inequalities in Health: A European Perspective*. London: Routledge.
- TSENG, W.-S. 2001. *Handbook of Cultural Psychiatry*, San Diego, Academic Press.
- VALENTINE, G. 2007. Theorizing and Researching Intersectionality: A Challenge for Feminist Geography*. *The Professional Geographer*, 59, 10-21.

- VASSILIOU, A. 2011. Homophobia and Trauma. *In: VLACHAKIS, N. (ed.). Positive Magazine: Kentro Zois.*
- WALDBY, C. 1996. *Aids and the Body Politics*, New York, Routledge.
- WARD, J. & WINSTANLEY, D. 2003. The Absent Presence: Negative Space within Discourse and the Construction of Minority Sexual Identity in the Workplace. *Human Relations*, 56, 1255-1280.
- WEINBERG, M., S., WILLIAMS, C., J. & PRYOR, D., W. 1994. *Dual Attraction: Understanding Bisexuality*, New York, Oxford University Press Inc.
- WHITMAN, J., CORMIER, S. & BOYD, C. 2000. Lesbian Identity Management at Various Stages of the Coming Out Process: A Qualitative Study. *International Journal of Sexuality and Gender Studies*, 5, 3-18.
- WHO 2016. GREECE: Profile of Health and Well-being. WHO Regional Office for Europe.
- WILKINSON, R. & MARMOT, M. 2003. Social determinants of health, The solid facts, 2nd edition. Denmark: International Centre for Health and Society.
- WILKINSON, R. G. & PICKETT, K. 2010. *The spirit level : why equality is better for everyone*, London, Penguin.
- WILLIAMS, H., VARNEY, J., TAYLOR, J., FISH, J., DURR, P. & ELAN-CANE, C. 2013. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document. UK: National LGB&T Partnership, Public Health England, Department of Health.
- WILTON, T. 2000. *Sexualities in health and social care: a textbook*, Buckingham, Open University Press.
- WOLCOTT, H. 1995. Making a Study "More Ethnographic". *In: MAANEN, V., J. (ed.) Representation in Ethnography* Thousand Oaks: Sage Publications.
- WPATH 2012. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. 7th ed.
- YEKANI, E. H., MICHAELIS, B. & DIETZE, G. 2010. "Try again. Fail again. Fail better". Queer interdependencies as corrective methodologies. *In: TAYLOR, Y., HINES, S. & CASEY, E., MARK (eds.) Theorizing intersectionality and sexuality*. Palgrave Macmillan.
- YOUNG, R. M. & MEYER, I. H. 2005. The trouble with "MSM" and "WSW": erasure of the sexual-minority person in public health discourse. *American Journal of Public Health*, 95, 1144-1149.