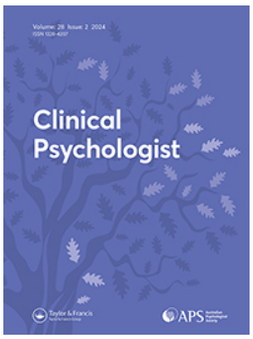

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Experiences of professional mental health help-seeking and engagement with services among emerging adult men identifying as gay

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ABSTRACT

Objective: Gay men have higher rates of psychological distress and greater dissatisfaction with mental health services than heterosexual men. Emerging adulthood is a vulnerable period representing a crucial period of sexual identity formation. Understanding of experiences during engagement with professional mental health services by gay men remains limited, especially in emerging adulthood. This study explored emerging adult gay men's experiences during their engagement with professional mental health help-seeking.

Method: In-depth semi-structured interviews were conducted with seven gay-identifying cisgender men. Data were analysed using reflexive thematic analysis.

Results: An overarching theme of perseverance was identified, with two themes of navigating anticipatory heterosexism and renegotiating pathology. Navigating anticipatory heterosexism included subthemes of selective disclosure and seeking "safe" practitioners. In renegotiating pathology, interviewees described delineating distress, thereby separating sexual identity from their mental health presentation, as well as normalising distress resulting from experiences of prejudice and minority stress. These themes encapsulate how participants reported navigating sexual identity-based challenges during the help-seeking process, thereby persevering and continuing with help-seeking.

Conclusions: Results highlight how mental healthcare can be navigated and underscore the need to: 1) enhance signalling safety to sexually diverse client groups, and 2) increase practitioner cultural competency to reduce stigma or heterosexism in experiences of healthcare.

KEY POINTS

What is already known about this topic:

(1) Gay men have higher rates of psychological distress than their heterosexual counterparts.
(2) Emerging adulthood is a particularly vulnerable period for mental health amongst sexual minorities.
(3) Gay men report greater dissatisfaction with mental healthcare than heterosexual men and encounter challenges when seeking professional mental health help.

What this topic adds:

(1) Challenges encountered during the help-seeking process were navigated through self-advocacy in the form of renegotiating pathology.
(2) Emerging adult gay men reported managing anticipated heterosexism through appraising practitioners for 'safety' and selectively disclosing sexual identity.
(3) Results underscore the value of practitioner cultural competence training, signalling safety and engaging in culturally affirming practices.

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KEYWORDS

Help seeking behaviour; healthcare; mental health; sexual identity; LGBTQIA+; service utilisation

Evidence routinely demonstrates that gay men experience disproportionately higher rates of psychological distress compared to heterosexual males (e.g., Handlovsky et al., 2018; King et al., 2008; Lea et al., 2014; Marshal et al., 2011; McDermott et al., 2017). Emerging adulthood (i.e., 18–29 years; see Arnett, 2007; Arnett et al., 2014) is the life stage between adolescence and full-adulthood (Arnett, 2010). During the period of emerging adulthood, gay men may especially be vulnerable to mental health difficulties. Not only does emerging adulthood represent an age at which many psychiatric disorders first develop (Alonso et al., 2004), but this life stage also typically involves a heightened period of sexual identity exploration and formation (Arnett, 2007; Frost et al., 2015; Morgan, 2013; Torkelson, 2012), during which

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many key sexual identity milestones take place (Hall et al., 2021). Sexual identity formation occurs alongside the need to navigate heteronormative environments, including education and the workforce, that may be incongruent with one's emerging sexual identity (Frost et al., 2015; Wilson et al., 2010), and the need to negotiate associated stigma (Pachankis et al., 2018). In line with these vulnerability factors, evidence points to elevated rates of psychological distress, mental health diagnoses, and suicide ideation and attempts among gay men during emerging adulthood (National LGBTI Health Alliance, 2020; Robinson et al., 2014). The rates of mental health help-seeking in emerging adults remain low (Alonso et al., 2004; Australian Bureau of Statistics, 2022) and it is also well established that men seek mental health help far less than women (Australian Bureau of Statistics, 2022; Reavley et al., 2010). These findings underscore the need to enhance our understanding of the mental health service experiences and help-seeking of gay men, especially during the emerging adult life stage, so that clinical care can better be offered in an informed and responsive manner.

Help-seeking is an active and intentional sociocognitive coping mechanism beginning with identification of a problem that exceeds personal coping abilities, which leads to the decision to engage with an external source of help (Chan, 2013; Cornally & McCarthy, 2011). Although there is a lack of clear consensus on the definition of mental health help-seeking specifically, Rickwood and Thomas (2012) propose the following: "In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern" (p. 8). The help-seeking process begins with identification of a problem, and then moves towards willingness and intention to seek help, and then accessing and engaging with external sources of help (Rickwood & Thomas, 2012). The field of mental health help-seeking literature is broad and research can refer to different forms of help (e.g., attitudes and/or intentions towards help-seeking or current and/or past help-seeking behaviours) and stages of help (e.g., identification of a problem, investigating sources of help, active engagement with a mental health professional, etc.). The term "external assistance" in mental health help-seeking literature can refer to seeking support from informal (e.g., friends, family, etc.), semi-formal (e.g., religious figures, teachers, online, support groups) and/or formal (e.g., mental health professionals, GPs) sources. Due to the scope of the mental health help-seeking literature, researchers commonly first seek to understand the specific experiences of individuals who have successfully accessed (i.e., past help-seeking) formal treatment/support options (i.e., from a mental health professional). The current study focuses on this later stage in the help-seeking process, that of engaging with mental healthcare services.

While there is a body of literature that has investigated mental health help-seeking and barriers to help-seeking among men, including during young and emerging adulthood (e.g., Clark et al., 2020; Lynch et al., 2018; Seidler et al., 2016), less research attention has been given to sexually diverse populations and the variability and intersectionality of their experiences (Parent et al., 2018). To date, research that has explored mental health help-seeking among gay men has largely focused on barriers to service access, with a range of unique barriers to initiating help-seeking among sexually diverse men identified. For example, structural barriers stemming from discrimination and stigmatisation have been reported (McDermott et al., 2017; Zeeman et al., 2019). Further barriers to seeking help include fear of homophobic response from health professionals (Koh et al., 2014; Lynch et al., 2018) and overt professional focus on sexuality when irrelevant to the presenting concern (Kalra et al., 2015).

Despite these barriers, gay men are more likely to seek professional help for their mental health than heterosexual men (Filice & Meyer, 2018; Parent et al., 2018). However, it is important to note that rates of mental health disorders and distress remain elevated in gay men (e.g., Handlovsky et al., 2018), suggesting that current clinical provision may not optimally meet the needs of this population. Further, gay and lesbian individuals report higher rates of dissatisfaction with mental health services than their heterosexual peers (Baams et al., 2018; Kidd et al., 2016), yet there is limited understanding why satisfaction is lower. While barriers to mental health help-seeking have been examined in gay men, less is understood regarding the experiences of gay men throughout the mental health help-seeking process and their engagement with mental healthcare, after initiating access.

Notably, mental health professionals may not demonstrate cultural competence when working with sexually diverse clients (Bishop et al., 2021) nor have received training in cultural competence (Blackwell, 2015; Fell et al., 2008). This reduced competence may lead to therapist anxiety, especially around discussing sexuality (Harris & Hays, 2008), and may influence the care received (Fell et al., 2008). It is plausible, therefore, that this reduced competence may influence the experiences of sexually diverse groups when accessing professional mental healthcare. The limited literature to

date suggests that a range of negative experiences may be encountered during mental health help-seeking by sexually diverse clients, including therapist discomfort during conversations around sexuality, and experiences of discrimination within healthcare settings (McNamara & Wilson, 2020). However, knowledge remains limited around the experiences of gay men when accessing professional mental health help, especially during emerging adulthood.

Further, there is minimal knowledge of how gay men overcome or navigate these reported difficulties and challenges (i.e., McNamara & Wilson, 2020) when accessing professional mental healthcare. The physical healthcare literature indicates that gay men may need to navigate stigma when accessing healthcare (Lane, 2023), such as through engaging in self-advocacy for health-related needs as the focus of healthcare provision (Handlovsky et al., 2018; Koh et al., 2014). Less remains known around how gay men navigate experiences of stigmatisation or other such challenges within mental healthcare, although it has been reported that experiences of stigmatisation may contribute to disengagement from mental health services (Zeeman et al., 2019). Given that gay men may disengage and discontinue treatment, there is a critical need to better understand their experiences when accessing professional mental healthcare to inform future service provision.

Taken together, despite higher rates of mental health help-seeking than heterosexual populations (Filice & Meyer, 2018; Parent et al., 2018), emerging adult gay men have been found to have poorer mental health outcomes, and display greater dissatisfaction with professional mental health services (Baams et al., 2018; Kidd et al., 2016). Gay men are largely underrepresented within the current body of mental health help-seeking research (Handlovsky et al., 2018; McDermott et al., 2017). The literature suggests that there is a need for greater exploration as to how younger gay men experience and navigate the professional mental health help-seeking process, in order to facilitate competent and responsive mental healthcare for this population. Therefore, this study aims to examine:

(1) What are the experiences during the mental health help-seeking process for emerging adult gay men?
(2) How do emerging adult gay men navigate engagement with professional mental healthcare?

Method

Participants

Inclusion criteria were: a) identify as a gay man; b) self-report having accessed mental health treatment/therapy from a professional (including psychologist, psychiatrist, or mental health clinician) within the past 12 months; and c) currently within the period of emerging adulthood (aged 18–29 years). While there has been some variability in proposed age range of emerging adulthood, contemporary research generally considers 18–29 years as representing this life stage (Arnett, 2007; Arnett et al., 2014).

In total, seven men participated in interviews. The utility of data saturation has been questioned as a determinant of sample size (Braun & Clarke, 2021); thus, we considered information power (Malterud et al., 2016) in determining the final sample (see Braun & Clarke, 2021 for a more detailed discussion on sample size in thematic analysis). Given the scope of the research questions, the focused sample, and the adequacy of the data collected through in-depth interviews (which yielded substantial detail and richness), the sample was deemed sufficient to provide information power, and the sample size is in line with other recent work exploring experiences of sexual minority groups (e.g., Gamio Cuervo et al., 2023; Pitt et al., 2023).

Procedure

Ethics approval was obtained through the University of New England's Human Research Ethics Committee (HE20–059). Participants were recruited from Headspace, as well as various social media communities that: a) identified as having a gay audience, or b) that were dedicated to mental health support/help-seeking. Interested volunteers contacted the research team by email and were provided with the information sheet and asked a brief series of questions to assess eligibility. After eligibility was determined, an interview time was arranged. All interviews were conducted via Zoom. Interviews were recorded and transcribed verbatim. All names and any potentially identifying information (e.g., names of practitioners) were omitted, and pseudonyms were assigned to ensure confidentiality.

Interview

After providing recorded consent, each participant took part in a semi-structured interview with the second author. Interviews lasted approximately 1 h (range 45 min to 1.5 h). The interviews explored participants' experiences of navigating help-seeking

for their mental health. Due to the online nature of the interview, the interviewer spent a longer period of time in conversation aiming to build rapport before delving into the interview questions (Heiselberg & Stępińska, 2022). The interview questions were open-ended in nature and designed to elicit accounts of participants' experiences of help-seeking for their mental health. Initially, interviewees were asked to broadly describe their experience of mental health help-seeking (e.g., "Describe your experience of seeking help"), before moving into more specific questions about their experiences (e.g., "Can you tell me what it was like being a gay man seeking help for your mental health?"; see Supplementary Material).

Data analysis

Reflexive thematic analysis (Braun & Clarke, 2019) was used to examine the experiences of help-seeking. Data were analysed inductively at the latent level, within a critical realist epistemological framework. A critical realist approach to reflexive thematic analysis seeks to understand how individuals extract meaning of their lived experiences, with consideration as to how social contexts influence such meaning (Fletcher, 2017).

Thematic analysis (Braun & Clarke, 2013, 2019) focused on how the participants described their experiences of help-seeking for mental health, including how they navigated the mental healthcare process. Data analysis was an iterative and recursive process, which involved moving between the stages of analysis and the data. Initially, one analyst (A2) established familiarity with the data by reading and re-reading verbatim transcripts and re-listening to audio recordings to detect initial points of interest within the data. The data were then manually coded. Codes were then reviewed and refined according to their salient features and in reference to the research questions. The data and codes were then reviewed and further refined by another author (A1) in order to identify wider patterns of meaning across the dataset and to generate initial themes. Once initial themes were generated, corresponding data and codes were collated and further scrutinised by two authors (A2, A1) to establish the coherence and robustness of each theme. Themes were further discussed and reviewed to ensure that they adequately encapsulated the data. During this phase, themes were rigorously reviewed a number of times by the two authors and disaggregated to form an overarching theme, which operated through two key themes, with corresponding subthemes developed. Following this, themes were further refined and given an interpretative name to capture the fundamental quality of the patterns of meaning that had been generated from the data. The analysis was then further reviewed by the other authors (A3, A4).

To ensure rigour and validity throughout data analysis, peer debriefing was carried out between the authors. Peer debriefing involves presenting emerging findings for critical inquiry and feedback and as an ongoing reflexive process (Franklin et al., 2010). This process was also guided by reflexive practice and used to consider how the researchers' positions may influence the interpretation of the research (Dodgson, 2019). The first, third and fourth authors are female heterosexual-identifying mental health professionals with expertise in qualitative (A1), help-seeking (A4) and sexuality (A3) research, and the second author is a gay-identifying cisman with lived experience of mental health help-seeking. These unique vantage points were continually considered in reflections across the interview and analysis process. All stages of the analysis were undertaken and reviewed by authors. Ongoing review of the analysis by multiple authors with different fields of expertise and positionality across all analytic stages helped to ensure the rigour, consistency, and truth value of the analysis (Noble & Smith, 2015).

Results

Participants in the study were aged between 21 and 28 years ($M = 24.14$, $SD = 2.91$). All participants identified as gay men and resided in major metropolitan areas of Australia. Interviewees had seen a range of mental health professionals throughout their lives as well as the past 12 months, most commonly psychologists, and predominately for depression or anxiety (see Table 1). All interviewees described a range of positive experiences, but also oriented to negative experiences and challenges encountered in the help-seeking process. Challenges included individual and social barriers such as shame, denial, embarrassment, and stigma. Especially prominent across interviews were participants' descriptions of challenges relating to heterosexism and experiences of associated difficulties when navigating mental healthcare. An example of such challenges is provided below. This extract comes from David and forms part of his response to being asked why he had changed mental healthcare providers previously:

> ah mainly kind of like underlying levels I dunno I I just to me it seems like there'd be an underlying level of

Table 1. Description of participants.

Pseudonym	Age	Type of professional help (past 12 months)	Type of professional help (lifetime)	Mental Health presentation	Occupational Status	Ethnicity/Cultural background
David	22	Psychologist	Counsellor, Psychiatrist, Psychologist	Depression	Student	Anglo/White European
Patrick	21	Psychiatrist	Psychologist, Psychiatrist, Mental Health Social Worker	Depression	Employed in health sector	Anglo/White Australian
Sam	24	Psychiatrist, Psychologist	Psychologist, Psychiatrist, Mental Health Social Worker, Mental Health nurses	Depression, Anxiety	Student	South American
Scott	21	Psychologist	Counsellor, Psychologist	Anxiety	Student	European
Jackson	27	Psychologist	Psychologist, Psychiatrist	Autism, ADHD, PTSD	Employed in arts	Anglo/White Australian
Kyle	26	Psychologist	Psychologist	Anxiety	Employed in health sector	Asian
John	28	Psychologist	Psychologist	Anxiety	Employed in health sector	Anglo/White Australian

ADHD: Attention-deficit hyperactivity disorder; PTSD: Post-traumatic stress disorder.

> homophobia kind of underneath that [response from practitioner] (David)

Notably, a common challenge described by interviewees was finding a professional who was perceived as understanding or able to empathise with the unique experiences posed by being a gay man, as evidenced by Sam:

> how much they [gay men] how often they come again-come up against professionals who are ill-equipped to deal with um stress around sexuality and gender (Sam)

In describing their continued help-seeking experience and engagement with services despite the challenges, an overarching theme of perseverance was identified. Participants described a need to persevere and to continue to seek or access professional help. This theme was oriented to throughout participants' accounts of their help-seeking experiences and was described as what guided their ongoing attempts to continue with accessing help and navigate mental healthcare settings. In accounts of how they negotiated, navigated, and experienced mental healthcare in order to persevere, two key themes were identified: navigating anticipatory heterosexism, and renegotiating pathology. Each key theme also contained two subthemes, and these themes and subthemes reflect ways in which perseverance, the overarching theme, was enacted. See Figure 1 for a thematic map.

Perseverance

Participants described multiple instances of accessing help over their lives, and all oriented to a need to persevere and continue with help-seeking, despite challenges. Participants identified the need to engage with a professional as a means to remedy distress and achieve a desired state of psychological wellbeing. Participants provided accounts of recognising a psychological crisis point as incongruent to their desired psychological health, with perseverance then

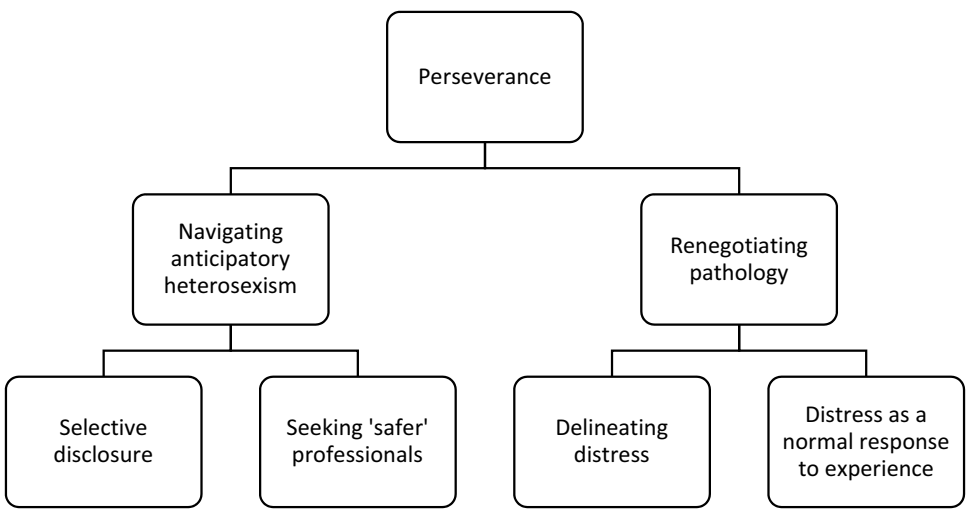

Figure 1. Thematic map.

driven by the desire to achieve wellbeing. The example below comes from the interview with Jackson:

> I want these emotions to stop so I need therapy or the more extreme would be suicide but I would never like I don't I don't wanna do that so for me that just seemed like the only option was therapy (Jackson)

Participants thus described their perseverance in help-seeking as through the volition of their help-seeking self. Participants described that, irrespective of the challenges they navigated during help-seeking with regards to their sexuality, perseverance was what saw them continue to seek help in order to pursue a "healthy self". Thus, participants described the pursuit of a "healthy self" as a motivating factor through which perseverance was enacted. Described as an end goal, or imagined self, perseverance was identified as a mechanism through which to achieve this goal. The below quote provides an example. It follows a section of talk where described how he felt within himself after he sought help:

> when I started seeking therapy myself that was the point where like that was the first step towards me being that man that I wanna be (Jackson)

Several interviewees also described having reached a state of being healthy due to their perseverance with help-seeking. An example is provided below. This extract comes from an interview with David during which he describes that his help-seeking led him to becoming well and achieving a healthy self:

> I wouldn't be in the position I'm in now I wouldn't be healthy now (David)

Navigating anticipatory heterosexism

Routinely, interviewees reported feeling wary of encountering potential heterosexism throughout their help-seeking experiences. Participants described appraising their help-seeking environment for evidence of potential judgement, as well as to assess their psychological safety with regard to their sexual identity. Throughout interviews, participants described anticipatory heterosexism, including uncertainty over how their sexuality would be received by a mental health professional, as is illustrated by John:

> like there's still this idea that you don't know ah how people are going to respond [to sexuality] (John)

Navigating potential judgement regarding sexuality from a mental health professional throughout the help-seeking process was commonly reported. Despite reporting an awareness of non-judgemental practice as part of the training to be a mental health professional, knowledge of such training was reported by participants as insufficient to negate feelings or worries of judgement over their sexual identity. An example comes from the interview with Patrick:

> I feel like obviously a mental health professional is supposed to um reserve judgement um and work through the process with you um it sometimes I felt quite judged um and it was it made it hard and reluctant for me to come forward and reluctant for me to um disclose any more information with the ah with whoever I was speaking to (Patrick)

Such anticipated heterosexism was navigated through processes of selective disclosure, and seeking perceived "safer" mental health professionals. These subthemes are outlined below and are ways in which interviewees were able to navigate anticipatory heterosexism to persevere with help-seeking.

Selective disclosure

A process through which participants navigated anticipatory heterosexism was through selective disclosure. That is, participants described appraising the perceived safety of the mental healthcare environment and selectively disclosing only when feeling sufficiently safe to do so. Thus, participants described instances of not disclosing (e.g., "*I have not disclosed in the past when I have felt unsafe*", Sam), or of delayed disclosure of sexual identity to mental healthcare providers. For example, the following extract comes from David, who reported that he had not yet disclosed his sexual identity to his current psychologist:

> if he openly asked I probably would tell him but I'd be a bit ergh about it I probably wouldn't be too thrilled about saying it openly but um that's only because I know judgement comes with that (David)

Conversely, where interviewees appraised the practitioner and felt safe, they described being able and willing to disclose sexual identity, as is outlined below. This extract comes from an interview with Scott, who had disclosed his sexuality immediately to his psychologist based on feelings of rapport and safety:

> I can tell you know I I think a lot of us can you have an intuition and you can tell if someone is like you know when the sexuality is mentioned and they're not comfortable you can tell and speaking to this professional from the beginning I could tell that she was completely comfortable with it it was a safe space (Scott)

Seeking 'safer' professionals

Interviewees also described certain characteristics of mental health professionals that were perceived as potentially more or less safe with regard to their sexuality and were used to appraise sense of safety with a given practitioner. Individuals reportedly actively sought "safer" professionals in order to navigate anticipatory heterosexism, as well as using these appraisals to guide disclosure of sexual identity. A range of factors were reported in ascertaining a "safe" professional including age, gender, progressiveness, location/neighbourhood (i.e., clinicians located in "gaybourhoods", traditionally conservative areas etc) in which the professional worked, and religious orientation. All participants described relying on appraising such characteristics in order to find or determine a "safe" professional. While interviewees oriented to various factors, all interviewees routinely reported a perception that male mental health professionals, especially those who were straight-identifying, were potentially less safe. Consequently, participants reported being less likely to disclose to these individuals. Participants routinely indicated a reluctance to seek help from male care providers, as outlined by Scott:

> I just feel more comfortable with women and I confide more in women and with women um so I I think that and I know it shouldn't matter but I think that if I had had a male psychologist that was for example identified as straight um I think there would be a bit of discomfort there for me (Scott)

Subsequently, in describing a reluctance towards seeking help from a male mental health professional and a preference for female clinicians, many interviewees reported that they had specifically sought a female professional in their help-seeking, as evidenced by Kyle:

> another reason why I went to seek out a female over a male was because I was a gay man and experiences taught me kind of growing up that you know with a man you don't necessarily know whether like if they were open if they weren't open even thought I knew they were a professional I was like maybe they would judge me (Kyle)

Accordingly, gender was a key way in which safety of professionals was ascertained. In seeking "safe" professionals and selectively disclosing, interviewees described ways in which they selected, managed, and navigated interactions with mental health practitioners, enabling them to safely persevere in engaging with mental health help-seeking.

Renegotiating pathology

A second aspect of the experience of persevering in navigating mental health help-seeking is encapsulated in the theme renegotiating pathology. As part of the ongoing process of navigating help-seeking, interviewees disavowed their sexuality as pathological or as the underlying cause of distress. Routinely, interviewees oriented to a perception that mental healthcare providers viewed their distress in relation to sexuality. That is, there was a perception that therapists conceptualised their presentation and provided subsequent treatment differently due to their sexuality, or a belief that sexuality might be the cause of distress. Such a perception was commonly reported, for example:

> when trying to come up with a treatment plan to deal with the situations that I've been faced and then it being shrugged off by oh it's because you're gay or um along those lines it made it kind of sometimes confronting to be like um no coz I I know deep down inside and I hear it from a lot of people it's not because of that it's because the situation that happened (Patrick)

Rather, interviewees routinely reframed their distress and mental health needs as separate from, albeit at times related to, their sexuality. There were two competing ways in which this was achieved, with many interviewees orienting to both patterns of accounting at various times throughout their interviews. In negotiating the source of pathology, sexuality was either completely disavowed as related to distress (as encapsulated in the subtheme of "delineating distress"), or sexuality was invoked as relevant, but with distress reported as a normative and expected response to experiences that are encountered uniquely by people who are not heterosexual (the subtheme "distress as normal"). Through both patterns, interviewees depathologised their sexuality for themselves and practitioners, which was described as a key way through which they navigated mental healthcare in order to persevere with the help-seeking process.

Delineating distress

Most commonly, participants largely delineated their sexual identity from their current psychological distress. In navigating accessing mental healthcare, interviewees described resisting assumptions that being gay was a source of pathology. An example of the perception of sexuality as relevant by the practitioner, and the disavowal of this assumption by the interviewee, is provided below:

> I guess it seemed like you know there were things that would like relate back to it [sexuality] and I think that

> being a young gay man it it was like interesting I was like I was just thinking like you know these things happen to everyone and like you know being bullied or harassed it happens to everyone no matter what their sexuality or gender, I was like I wond I wondered would the approach to this whole thing be different from the psychologist point of view if I was straight or I didn't identify as part of the LGTBQIA+ community (Scott)

Participants actively reported rejecting assumptions that their sexuality was a cause of their distress within their help-seeking experience by advocating for their sexuality as irrelevant to their overall mental health concerns. That is, interviewees presented themselves as needing mental health support irrespective of their experiences as gay men, for example:

> I didn't necessarily go I'm a gay man in need of help for my mental health it was just I'm a person in need of help with my mental health (Kyle)

Routinely, participants normalised their psychological distress as something faced by all people, irrespective of sexuality, thereby disaggregating their sexuality from their mental health concerns. By disentangling sexuality and mental health as separate from each other, participants framed the role of their sexuality as peripheral or irrelevant to their psychological distress. Distress was presented as universal and something that can be experienced by anyone, such as:

> the other thing is that gay men don't just have problems with their mood or their mental health because of being gay it's like one as- facet of their life that they then have to deal with the rest of life and like everyone else gets you know job stress relationship stress (John)

Distress as a normal response to experience

Less common, but also evident across the data, when outlining how they navigated and continued with help-seeking, was the subtheme of distress as a "normal" response to their experiences. Interviewees described experiences and life events that were unique to non-heterosexual identifying individuals, such as coming out, minority stress, prejudice regarding sexuality, and navigating a heteronormative world. While these experiences reportedly influenced wellbeing, and had sometimes precipitated earlier help-seeking experiences, interviewees also depicted distress resulting from these experiences as normal. That is, rather than pathologise sexuality or attribute distress to sexuality per se, interviewees depicted their distress as a normal or inevitable response to these experiences. Interviewees described this de-pathologising as another means through which they navigated and persevered with help-seeking. The below extract provides an example of this normalising of distress and thus de-pathologising of sexuality, and is part of one account in which aspects of unique experience are presented as necessarily leading to distress:

> I guess inner turmoil that's there that you suppress for so long um and at some point it's going to affect you and um yeah that's obviously it (Kyle)

As can be seen in the above extract, distress was presented as a reasonable rather than pathological response to these situations and stressors, and a trigger to help-seeking for anyone who had encountered such experiences. Interviewees depicted such responses as "normal" and what anyone encountering such stressors would feel, rather than distress or sexuality as pathological. The following quote illustrates the normative distress experienced by gay men:

> every gay man should be in therapy because of how fucked up this heteronormative world has um has fucked us up (Sam)

Thus, in renegotiating pathology through both patterns of delineating distress and normalising responses to experiences, both for themselves and mental health professionals, interviewees described being able to navigate and continue to persevere with help-seeking in order to continue to pursue a healthy self.

Discussion

Gay men seek mental health help at higher rates than their heterosexual peers, but they report both worse outcomes (Filice & Meyer, 2018; Parent et al., 2018), and lower satisfaction (Baams et al., 2018; Kidd et al., 2016). Thus, in building on the limited research to date, this study provides insights into emerging adult gay men's experiences of engagement with professional mental health help-seeking and how they navigate challenges faced during accessing mental healthcare. Despite encountering negative experiences, as previously highlighted by McNamara and Wilson (2020), our results showed an overarching theme of perseverance. Two key themes of navigating anticipatory heterosexism and renegotiating pathology were identified, through which interviewees reported navigating such challenges and enacting perseverance as part of the help-seeking process.

In line with earlier research outlining experiences of heterosexism in healthcare (Handlovsky et al., 2018) and a common fear of encountering homophobic responses from health professionals (Koh et al., 2014;

Lynch et al., 2018), interviewees reported both anticipating and experiencing heterosexism in their engagement with mental healthcare services. While heterosexist assumptions can contribute to disengagement with health services (Zeeman et al., 2019), results highlight strategies that are used for navigating potential and anticipated heterosexism to continue engagement. It has previously been reported that up to one-third of gay individuals do not disclose their sexual identity to counsellors (Foy et al., 2019), and the present results highlight the use of selective disclosure with regard to sexuality as one way in which interviewees navigated anticipated heterosexism. Consistent with previous research by Koh et al. (2014), being vigilant to the reactions and perceived safety of the practitioner was used to guide if and when a disclosure of sexual identity was made. Interviewees outlined a number of factors which were considered in appraising the safety of their practitioner. Previous studies have highlighted that characteristics such as therapist age and sexual identity are used in appraising safety (Bishop et al., 2021), with a preference for sexually diverse therapists previously reported (King et al., 2008). Notably, in the present study, a preference for sexually diverse therapists was not explicitly described, although a reluctance to access help from straight-identifying males was noted. Further, the present study also identified that characteristics such as gender, progressiveness, and location of the service provider were appraised in ascertaining a "safe" practitioner. Most notably, a preference for female practitioners was reported. Such appraisals of female practitioners as "safer" may reflect perceptions of male mental health professionals as embodying dominant masculine ideologies (Wilson et al., 2010).

In describing experiences of navigating mental healthcare, participants actively resisted and disavowed notions of sexuality as pathological or as the cause of their distress, despite a perception that many practitioners viewed their presentation and treatment in line with sexuality. Connecting sexual identity to pathology is a negative experience encountered within mental healthcare by sexually diverse clients (Kelley, 2015; McNamara & Wilson, 2020), with a focus on sexuality by the practitioner, when this is not viewed by the client to be relevant to the presenting concern, acting as a barrier to help-seeking (Kalra et al., 2015). While previous research has suggested that practitioners may connect pathology or trauma as underlying sexual identity (McNamara & Wilson, 2020), the present results also highlight the rejection of sexual identity as the cause of distress, or as relevant in treatment, further underscoring the need for practitioners to disentangle sexuality and pathology. Rather than a focus on sexuality as pathological leading to disengagement (Kalra et al., 2015), renegotiation of pathology was used as means to persevere with help-seeking. Similarly, a need to self-advocate for health-related needs as the focus of service utilisation has previously been reported in physical healthcare (Handlovsky et al., 2018), and our results demonstrate this need to negotiate pathology and treatment focus within the context of mental healthcare also. Additionally, in renegotiating pathology interviewees, at times, also drew on unique challenges, such as minority stress, encountered by gay people, which are often poorly understood by practitioners (Foy et al., 2019; Utamsingh et al., 2016). Rather, interviewees reframed distress related to these experiences, in order to disconnect distress from sexual identity in and of itself. Conflation of sexuality with pathology is also understood as a form of clinicians' stigma (Kidd et al., 2016). Accordingly, renegotiation of pathology may also be a means through gay men need to navigate stigma within mental healthcare.

This study extends limited understanding and knowledge around help-seeking and professional mental healthcare access during emerging adulthood. Emerging adulthood is a vulnerable life stage, with gay men in this age range reporting high levels of psychological distress (National LGBTI Health Alliance, 2020; Robinson et al., 2014). Notably, results demonstrate numerous challenges encountered when trying to access mental health services, but also highlight how some individuals are able to navigate and overcome such challenges. While older gay men have been shown to advocate for their health needs (Handlovsky et al., 2018), our results also show that younger and emerging adult men self-advocate, suggesting a need for self-advocacy from a young age in order to navigate professional mental healthcare settings. Given that this life stage appears to be especially vulnerable for gay men, and gay men report greater dissatisfaction with mental health services (Baams et al., 2018; Kidd et al., 2016), results from the present study are valuable to inform future service provision around how best to support emerging adult gay men during their help-seeking experiences.

Results underscore the need to provide safe spaces for gay individuals in therapy (e.g., Lee et al., 2017), including to promote disclosure of sexual identity. All interviewees described encountering negative experiences during their help-seeking, indicating a need for clinicians to upskill to improve service provision for sexual minorities. Many clients report a lack of practitioner awareness of the unique challenges

encountered by gay men and sexually diverse people (Foy et al., 2019), while therapists who demonstrate understanding around minority stress are likely to develop better rapport with sexually diverse clients (Burckell & Goldfried, 2006). The present results further support the value of upskilling clinicians regarding the unique experiences and stressors that may be encountered by sexually diverse groups. Especially for younger and emerging adult gay men, practitioners displaying understanding of diversity is strongly valued (Bishop et al., 2022).

Results highlighted resistance to stigmatising views such as conflating pathology with sexual identity, highlighting that it is important for practitioners to conceptualise cases without necessarily having a focus on sexuality. Rather, clinicians should be guided and informed by the client as to if and how sexuality is pertinent in the formulation. Being guided by the client with regards to the case formulation may help to minimise the need for self-advocacy among emerging adult gay men regarding the focus of their mental healthcare. Openly acknowledging that sexuality may not be relevant to presenting concerns, and being guided by clients as to when and if sexuality is relevant, may also help to reduce perceptions of different treatment or overt focus on sexuality and, thus, reduce experiences of stigma.

There also remains a continued need for clinician training to reduce stigmatising beliefs (Kidd et al., 2016) and our results further support the need to enhance cultural competence of practitioners (McNamara & Wilson, 2020; Zeeman et al., 2019). While a focus on cultural responsiveness is a requirement of psychologists' training in Australia (Australian Psychology Accreditation Council [APAC], 2019), there is not a stated requirement for such training to include a focus on sexual minorities. Inclusion of sexual minorities as part of cultural responsiveness training may thus be an important addition to postgraduate training programs. Evidence points to even very short trainings and workshops in cultural competence during tertiary education enhancing competence and knowledge (Riggs & Fell, 2010), although others argue for a need to extend beyond cultural competence training to facilitate cultural responsiveness (Bishop et al., 2021). Where practitioners have not received such training in their tertiary education, clinicians may benefit from seeking additional training through continuing professional development in order to better provide care for sexual minority groups. In addition to educating around minority stress and unique experiences of sexual minorities, training might also include guidance around language use, in order to avoid accidental use of language that is viewed as discriminatory or offensive. Clinicians may also benefit from a focus on checking in with clients around language used and demonstrating a willingness to learn or be guided by the client. This education may help to reduce potential for unintentional ruptures to the therapeutic alliance and help to ensure cultural safety. Training programs may also explicitly address conflation of sexual identity with presenting concerns to reduce stigma. Gay men, especially younger men, are more likely to access culturally competent services (Bishop et al., 2022); thus, it is critical for practitioners to gain and convey cultural competency in order to support this vulnerable population.

Results provide further support for the value of clinicians signalling their safety to sexually diverse clients, including to promote disclosure of sexual identity. Signals may include visual cues such as rainbow flags in waiting rooms or pamphlets for sexual minorities (Bishop et al., 2021). Clinicians can also be mindful to avoid heteronormative assumptions to further signal safety. For example, using gender neutral terms when exploring or asking questions about partners/relationships, or by explicitly asking about pronouns. Using language that is open to sexual diversity may foreground an openness and reduce fears around judgement and may facilitate earlier disclosure of sexual identity. Results also suggest that enhancing modifiable clinician traits to demonstrate safety, inclusiveness and cultural competence, may especially be pertinent where non-modifiable traits are more likely to be appraised as unsafe (Bishop et al., 2021). In particular, male clinicians and those in certain geographic locations might especially benefit from clearer cueing of safety for sexually diverse clients.

Greater engagement from practitioners with culturally affirming practices is also needed, with gay affirming practices (e.g., demonstrating support to sexual minorities) reported as a key means of demonstrating cultural competence (Bishop et al., 2022). Clinicians might overtly state or convey comfort with and non-judgement of diversity, including sexual diversity, at the commencement of therapy and during rapport building. Conveying safety and competence may facilitate continued engagement with services by reducing perceived judgement and helping to overcome anticipated heterosexism, and also promote greater rapport. Given that many gay clients disengage (Utamsingh et al., 2016; Zeeman et al., 2019), and are more likely to report poor experiences and dissatisfaction with mental healthcare (Baams et al., 2018; Kidd et al., 2016), it is critical that psychologists and the field of

clinical psychology take such steps to improve service delivery for gay men.

The study is presented with several limitations. This study focused on the experiences of gay-identifying men and all participants were cis-men. Therefore, results may not reflect the experiences of trans men and gender diverse groups, although there remains a need to differentiate sexual identity and gender identity in research exploring experiences of mental healthcare (McNamara & Wilson, 2020). However, ongoing research to understand the experiences of other sexual minority groups is needed. Further, help-seeking in this study was self-reported and was limited to professional sources of help, and thus does not include the experiences of informal/semi-formal help-seeking or self-help. The sample was also largely White, thus results may less well reflect the intersectionality of experiences of gay men from diverse cultural backgrounds.

The study aimed to address a gap in the literature through an exploratory investigation of the experiences of mental health help-seeking and engagement with professional mental healthcare among emerging adult gay men. Results highlighted that gay men encountered a range of challenges; however, they were able to persevere and seek a healthier self through self-advocacy in the form of renegotiating pathology, as well as managing anticipated heterosexism through appraising safety in selecting a practitioner and in order to selectively disclose sexual identity.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

Deidentified data are available upon reasonable request from the authors.

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