Research Article

Stigma, Anxiety, and Depression Among Gay and Bisexual Men in Mixed-Orientation Marriages

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Abstract

The mental health of gay and bisexual men in mixed-orientation marriages is poorly understood. In this article, the authors explore the development of anxiety and depression among gay and bisexual men in heterosexual marriages. Sixteen men, living in the Australian states of New South Wales, Queensland, Victoria, and Tasmania were interviewed throughout 2016 and 2017. An analysis of interviews identified four main themes, namely, compulsory heterosexuality, existential distress, compartmentalization, and integration and resolution. Participants reported experiencing anxiety and depression, which were exacerbated by the stigmatization of same-sex attraction and by an overwhelming distress from feelings of shame and guilt regarding their marital infidelity. Findings indicate that gay and bisexual men in mixed-orientation marriages develop anxiety and depression in response to the exigencies of compulsory heterosexuality and the compartmentalizing of same-sex attraction and identity during heterosexual marriage. Coming-out as same-sex attracted resolved men's distress by facilitating an integrative self-structure.

Keywords

families; masculinity; gender; men's health; depression; mental health and illness; sexuality; sexual health; bisexuals; stigma; qualitative methods; in-depth interviews; Australia

Introduction

Mixed-orientation marriages are those where one spouse is same-sex attracted and the opposite-sex spouse is not (Kays, Yarhouse, & Ripley, 2014). In this article, the authors explore mixed-orientation marriages among gay and bisexual men and consider a relationship between the stigmatization of same-sex attraction and the development of depression and anxiety in men.

The size of the population of men in mixed-orientation marriages is difficult to determine. Estimates published in 2011 indicate that the population of men who have sex with men (MSM) in Australia is 190,000 (United Nations, 2011) and in a national study of MSM, Rawstorne and National Centre in HIV Social Research (2008) reported that 8% were currently living with a female partner. Generalizing this proportion to the estimated size of the MSM population in 2011, plus adjustment for population growth, the authors estimate that more than 17,000 men in Australia are sexually attracted to men but are currently in relationships with women (Hopwood, Treloar, & de Wit, 2017). In the United States, it is estimated that at least two million men and women who are or were heterosexually married come out as gay, lesbian, or bisexual (Buxton, 2008b).

A review of the scholarly literature on mixed-orientation marriage reveals there is relatively little published in the area, much of it is dated, and the majority is focused upon gay and bisexual men. Several authors such as Ortiz and Scott (1994) cited cultural and religious socialization as the primary force behind gay men's decisions to marry women, and Higgins (2004) highlighted how fundamentalist religious beliefs within men's family backgrounds encourage heterosexual marriage. Similar findings are described by Kissil and Itzhaky (2015) in their study of Orthodox Jewish gay men in mixed-orientation marriages. Higgins (2002) also described a relationship between internalized homophobia in gay and bisexual men and their decisions to marry women, where marriage was often an attempt to resolve concerns over their sexual identity. The findings of a literature review by Hernandez, Schwenke, and Wilson (2011) and a study by Ben-Ari

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and Adler (2010) highlighted the complexity of integrating same-sex desire with societal expectations of monogamy in heterosexual marriage. Often, therapeutic intervention is required to assist men to accept their same-sex attraction (Alessi, 2007; Coleman, 1982; Cornett, 2007). A comprehensive literature review of men in mixed-orientation marriages (Hudson, 2013) found that most research is focused upon why gay and bisexual men choose to marry, why heterosexual women remain married after a husband's disclosure, the coping strategies and adjustment modes of men and women in mixed-orientation marriages, and men's sexual practices. Studies indicate that most mixed-orientation marriages end in separation and divorce (Bozett, 1982; Buxton, 2008a, 2008b); Currently, there is a gap in the research literature regarding the mental health of gay and bisexual men in mixed-orientation marriages.

Lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people are at increased risk of mental health problems including depression, anxiety disorders, self-harm, suicidal ideation, and suicide (Couch et al., 2007; Hillier, Edwards, & Riggs, 2008; Hillier et al., 2010; Ritter, Matthew-Simons, & Carragher, 2012). Indeed, the rate of suicide attempts for LGBTQI people is estimated to be between 3.5 to 14 times higher than the rate for the general population (Bagley & Tremblay, 1997; Garofalo, Wolf, Kessel, Palfrey, & Du Rant, 1998; Herrell et al., 1999; King et al., 2008; Nicholas & Howard, 1998; Remafedi, French, Story, Resnick, & Blum, 1998. Meyer (1995, 2003) suggests that these health disparities can largely be explained by proximal and distal stressors, such as stigmatization and discrimination, and internalized homophobia. There is also some empirical evidence that supports the link between structural stigma and health disparities among same-sex-attracted people, including psychological distress, reported health behaviors, and mortality (see, for example, Hatzenbuehler, 2011, 2017; Hatzenbuehler et al., 2014; Hatzenbuehler, Flores, & Gates, 2017; Perales & Todd, 2018; Rostosky, Riggle, Horne, & Miller, 2009; van der Star & Bränström, 2015). No studies have explored the stigmatization of same-sex attraction and the onset of anxiety and depression among gay and bisexual men in mixed-orientation marriages, and there remains little qualitative research that engages with the lives of these men (Hudson, 2013). To address this gap, the authors conducted an interview-based study that investigated participants' reports of mental health from childhood through to heterosexual marriage and beyond. The authors' aim in this article is to explore gay and bisexual men's reports of stigmatization and the development of anxiety and depression while in a mixed-orientation marriage.

Method

Research Design

This study employed a constructivist grounded theory approach (Apramian, Cristancho, Watling, & Lingard, 2017; Mills, Bonner, & Francis, 2006) to identify and conceptualize the latent social patterns and structures that affect the mental health and well-being of gay and bisexual men in mixed-orientation marriages. A constructivist grounded theory repositions the researcher "as the author of a reconstruction of experience and meaning" (Mills et al., 2006, p. 26); "reality" is co-constructed between researchers and study participants through "an interactive process and its temporal, cultural and structural contexts" (Charmaz, 2000, p. 524). A constructivist grounded theory design was used to collect data, to identify themes, and to build propositions that could account for the relationship, as observed by researchers and participants, between the social stigma of same-sex attraction and marital infidelity, and the emergence of anxiety and depression disorders among affected men. The authors aimed to generate propositions regarding social-sexual norms, changes to self-structure and mental health, and the stigmatization of same-sex attraction. The method used to collect data was semi-structured, in-depth, telephone interviews. This method was chosen because telephone interviewing enabled men from across Australia to participate in the study, and it offered anonymity and convenience, which the researchers believed would encourage participation from this hidden population. A semi-structured format was employed because the study aimed to explore stigma, depression, and anxiety to inform the development of online resources.

Participants and Procedure

This study was conducted with men who identified as gay or bisexual, who were aged 18 years or above, and who were currently in a heterosexual marriage, or who were previously married. The research team aimed to recruit a diverse sample of men (i.e., age, employment and socio-economic status) through the New South Wales (NSW) chapter of an international peer support organization, the Gay and Married Men's Association (GAMMA NSW). Recruitment commenced in late September 2015 and proceeded until October 2016. Prior to commencing interviews, a detailed study information statement was read to each participant over the phone before verbal consent was obtained. A semi-structured interview schedule explored participants' backgrounds, their marriages, their mental health, their coping strategies, their management of same-sex attraction, and their experiences of sexuality-related stigma. The following is an example of interview

questions: *When did you become aware of your sexual attraction to other men? Please tell me how you met your wife? Please tell me about your marriage, including the circumstances that shaped your relationship? Have you experienced sexuality-based stigma? If so, how does/did stigma affect you? Have these experiences affected your mental health and wellbeing? If so, how does/did your mental health impact your life, including your marriage? Please tell me about your experience of accessing mental health services? What is your connection, if any, to a gay community? How do you manage sexual risk practice, such as condomless sex?* From the initial interview, the schedule was modified to explore novel issues as they were raised by participants, while keeping a focus upon men's reports of stigmatization, anxiety, and depression. Sampling was guided by analysis of incoming data and their relation to the developing theory concerning stigma and mental health. The sample size was determined by the search for contrasts needed to clarify the analysis and to achieve saturation of identified categories. Each telephone interview ranged from 45 to 90 minutes in duration, and participants were not reimbursed for their involvement in the study. Interviews were audio-recorded, transcribed verbatim, and all identifying information was removed. Ethics approval for this study was provided by the Human Research Ethics Committee of UNSW Sydney [HC15439].

Analysis

Qualitative software program NVivo Version 11 was used for open and axial coding of interview data (Minichiello, Aroni, Timewell, & Alexander, 2000; Strauss & Corbin, 1990). Themes were derived from conceptual categories that underpinned higher-level stigma and mental health codes. The stigma-related categories included "public perceptions of gay/bisexual men," "how gay/bisexual men perceived themselves," "internalized affect," "experiences of childhood," "early homosexual experiences," "sexuality and sexual citizenship," "compulsory heterosexuality," "homophobia," and "religiosity." The conceptual categories that underpinned mental health codes were "anxiety and depression," "alcohol and other drug use," "internalized stigma," "current social life," "current well-being," "level of social support," "coping strategies," "coming-out," "religiosity," and "self-description." Following saturation of stigma and mental health conceptual categories, the authors conducted an iterative process of developing themes and refining propositions (Braun & Clarke, 2006). They critically reflected on the analysis, examined conceptual interrelationships, searched for slippages and inconsistencies, identified divergent patterns in men's narratives, and made clarifications to original interpretations.

Coding reliability and conceptual consistency in this study were assisted by the authors' experiences of conducting studies around issues affecting gay and bisexual men, such as HIV prevention (e.g., De Wit & Adam, 2014), community attitudes to homosexuality (e.g., Hopwood & Connors, 2002), and changes in HIV/AIDS medicine (e.g., Hopwood et al., 2013). Furthermore, participants' subjective interpretations of phenomena were interrogated during interviews via an interactive process that negotiated with each participant the precise meaning of the collected information. This analysis, framed within a specific context, is a co-construction of the "reality" of mixed-orientation marriage, which helps to enhance the trustworthiness of the findings.

Trustworthiness (Guba, 1981; Shenton, 2004) is also assisted by transferability, as the authors argue that similarly conservative, heterosexist rural and regional environments exist in many other developed countries of the world, and the scholarly literature cites research into mixed-orientation marriages from cultures not too dissimilar from Australia, such as the United States. While generalizing the study's findings to other countries and contexts is not possible, because phenomena are closely tied to the times and the dynamics in which they are located, the findings nonetheless enable researchers to develop working hypotheses that relate to similar "fit" contexts (Guba, 1981). Furthermore, the purposive sampling frame recruited a diverse group of individuals to maximize the range of information collected. The purposive sampling process was guided by the identification of relevant information and resulted in the collection of thick descriptive data from men who were from different socioeconomic circumstances, with diverse employment experiences, and who reported a wide range of ages (i.e., more than 30 years). Moreover, almost all interviews contained detailed discussion about men's varied experiences of mixed-orientation marriage. While these factors alone do not guarantee the transferability of the study findings to other rural, regional, and suburban settings, the recruitment of a diverse sample and the collection of thick descriptive data help to increase the trustworthiness of the analysis.

Dependability is difficult to demonstrate (Shenton, 2004) and while the study design is replicable, ultimately the findings of future studies from similar contexts are needed. To achieve dependability and confirmability (Guba, 1981; Shenton, 2004) and to demonstrate that the findings presented are constructed from the data, several elements helped to increase the probability of trustworthiness. First, a stepwise replication was conducted during data collection whereby the evolving analysis and findings were identified before meeting with the full research team to compare and discuss the final analysis. In addition, a detailed overview of the findings was

presented and discussed with a study advisor from GAMMA NSW, who has personal experience of mixed-orientation marriage, and in counseling men in these marriages. Furthermore, although the study did not use multiple methods to triangulate data, the research team's final analysis was compared with the contents of a documentary film produced by a participant about his experience of mixed-orientation marriage in a religious family. The authors did not access the film until the study's analysis was completed; however, the film's contents, combined with discussion and feedback from the study advisor, helped to establish referential adequacy (Guba, 1981), and together these elements supported the confirmability of the authors' final analysis.

Results

Sixteen participants were interviewed via telephone, with the self-selected sample comprising men from Queensland, NSW, Victoria, and Tasmania. Fifteen participants were born in Australia from the 1940s to the 1980s, in suburban, rural, and regional areas. One participant was born in rural England during this period. Ages ranged from the mid-30s to the late-60s, and all participants were White, working- or middle-class men, who at the time of interview were married ($n = 3$), and separated or divorced ($n = 12$). Participants had been married from 7 to 33 years, and each married couple had from one to three children. Currently, 11 of these men identify as gay and five men identify as bisexual. All participants had come out as same-sex attracted to their wives and children, and some to friends, colleagues, and employers from 10 to 25 years prior to the interview, with five men having come out since 2010. Therefore, all interviews are retrospective reports of participants married lives; one report of coming-out and separating from a female spouse occurred as recently as 2015. Most men in this study were not gay community attached (Chapple, Kippax, & Smith, 1998); instead, most still lived in rural, regional, and suburban areas across the four states. Three men had relocated to inner-city gay communities following the end of their marriages.

Thematic Analysis

The main themes regarding stigma and mental health were compulsory heterosexuality, existential distress, compartmentalization, and integration and resolution. These themes accounted for men's experiences of being heterosexually married, situated within a sociohistorical context where emotional and sexual development during early childhood, adolescence, and young adulthood was prescribed by the tenets of heteronormativity (Warner, 1993). The findings of this analysis extend established theories of heteronormativity/compulsory heterosexuality (Kitzinger, 2005; Martin & Kazyak, 2009; Rich, 1980; Warner, 1993) and compartmentalization and integration (Showers & Zeigler-Hill, 2007) by highlighting an interrelationship between the stigmatization of same-sex attraction, patterns of maladaptive coping, and the development of anxiety and depression.

Compulsory heterosexuality: "Jack, you can't be a hairdresser." Heteronormativity is a term widely used in contemporary critical theory to describe the social, legal, cultural, organizational, and interpersonal practices that support taken-for-granted presumptions about gender and sexuality, such as the naturalness of sexual attraction between men and women (Kitzinger, 2005). As Martin and Kazyak (2009) have argued, "heteronormativity structures social life so that heterosexuality is always assumed, expected, ordinary, and privileged" (p. 316). In this world view, heterosexuality is seen as innate; popular culture reinforces heterosexuality by representing sexual attraction between men and women as normal, unproblematic, desirable, and indeed compulsory (Rich, 1980). Compulsory heterosexuality (Rich, 1980) is fundamental to heteronormativity and is reinforced by social institutions that repress same-sex attraction and erase notions of sexual diversity. Noncompliance with heterosexuality is considered deviance, a violation of an obligation to preserve gender-role norms.

However, heterosexuality is not normal; it is just common, and it is the weight of numbers that produce, perpetuate, and legitimize the stigmatization of same-sex attraction (Parker & Aggleton, 2003). The disciplining effects of compulsory heterosexuality on the formation of gender and sexual identity is key to the process of stigmatization. Homosexuality was considered a psychiatric disorder in Australia until 1973 (Kirby, 2003), gay male sexual conduct did not become formally legal in all Australian states and territories until 1994 (Human Rights (Sexual Conduct) Act 1994), and throughout the late 20th century reports of homophobia and antigay violence were not uncommon in rural and urban areas of Australia (Hopwood & Connors, 2002; Roberts, 1996). Particularly apparent among men's narratives was their compliance with compulsory heterosexuality, an overarching theme in participants' lives from childhood to adulthood. Compulsory heterosexuality shaped participants' social, religious, and family backgrounds and encouraged men's decisions to marry women. Men's reports of the stigmatization of same-sex attraction, and the obligation to be heterosexual, reinforced how "Living within heteronormative culture means learning to 'see' straight, to 'read' straight, to 'think' straight" (Warner, 1993, p. xxi):

> [My mother] sat my sister and myself down and I would have been 13 at the time, she sat us down and told us that she could forgive us for being all sorts of things, but she would never forgive us if we were homosexual, which in hindsight was a defining moment . . . (Participant aged 50-60 years)

Compulsory heterosexuality was so powerfully present in these data that it inhibited participants from coming-out and acknowledging their same-sex attraction, even to themselves, sometimes well into mid-life. The fear of being revealed as gay or bisexual and/or the fear of acknowledging one's homosexual desire incentivized everyday performances of heterosexual masculinity and aspirations toward family life, which enabled participants to "fit in" with the dominant social-relational landscape:

> . . . [I] grew up knowing what family was and understanding that you know that's what you do . . . so you grow up, you find someone to marry, you get married and you have children and that's life . . . [that meant] I was of this mind of "I can't be gay, I don't want to be gay, I'm not identifying with this . . . (Participant aged 40-50 years)

During their formative years, participants had no positive alternative conceptions of gender, sexuality, and family available to them. On reflection, men perceived that their life course was determined by the constraints of compulsory heterosexuality and the fear of not measuring up to the norms of heterosexual masculinity:

> As a 14-year-old, I remember saying to my brother and my father, "I'd like to be a hairdresser." Their words were, "Jack, you can't be a hairdresser, you'll be a poofter if you become a hairdresser" . . . So immediately, I shut the gate on that . . . (Participant aged 50-60 years)

Participants were socialized and indoctrinated within institutions that were explicitly and implicitly intensely heterosexist and homophobic. Psychiatry and the law, as well as schools, sports clubs, and churches, were some of the structural mediums through which compulsory heterosexuality was communicated and enacted.

Existential distress: "That's why young men kill themselves." A second major theme in these data, and one that intersected with compulsory heterosexuality was existential distress, which refers to participants' experiences of extreme poor mental health. Participants reported a wide range of psychological and emotional conditions, disorders, and outcomes including internalized stigma, depression, anxiety, suicidal ideation, and attempted suicide, which were attributed to their feelings of guilt and shame about being same-sex attracted in a social environment where homosexuality was mostly invisible, and where visible, derided. While not all participants reported extreme levels of distress about their value as human beings, as fathers and/or as husbands, all participants were acutely aware of widespread negative attitudes to homosexuality, and of family and community expectations to marry a woman, to be monogamous, to raise children and to observe social sanctions against extra-marital relations. The proscriptive nature of compulsory heterosexuality, its devaluing of same-sex attraction, coupled with marital infidelity, produced stigma layering, a term describing the occurrence of multiple stigmatized attributes within an individual or a social group (Lekas, Siegel, & Leider, 2011). For example, individuals co-infected with HIV and hepatitis C can experience higher rates of internalized and enacted stigma from the overlaying of two highly stigmatized conditions (Lekas et al., 2011). Stigma layering can increase internalized (i.e., felt) stigma, and in this study, internalized stigma was an important factor that underpinned an existential distress and shaped men's sense of esteem. Self-descriptions of "underlying insecurity," "low self-esteem," and "self-loathing" (Participant aged 50-60 years) indicated how stigma layering facilitated an internalization of shame and guilt, creating an existential distress that lasted many years, and which defined participants' perceptions of their marriages:

> There's no question in my mind that I lived a tortured life for most of my married life. (Participant aged 60-70 years)

Existential distress materialized as panic attacks, irrational thinking, insomnia, acute paranoia, feelings of isolation, anger at society, self-harm, and mental anguish about deceiving wives and abandoning children, with some men reporting an "emotional crash" (Participant aged 50-60 years) and "complete meltdown" (Participant aged 50-60 years) during their marriages. One man described the effects of his distress as

> Waves of massive guilt, for you know, what was I doing to my family? Waves of terror about what it would mean if I was found out . . . Feelings of financial ruin, I'm going to lose my house, I'm going to have nothing after working so hard for so long. I'm going to lose my children. My children might not want to love me anymore. My mother will not want me anymore or she'll hate me, or she'll think that I've you know, that I'm a bad person, all these things. It was very overwhelming at the time. (Participant aged 40-50 years)

Existential distress was a product of a palpable sense of guilt and shame about being sexually and emotionally attracted to men in a heterosexist environment, with participants often expressing feelings of heterosexual inadequacy ("I could not be a full man for my wife"; Participant aged 30-40 years). Reinforcing reports of guilt, shame, and feelings of inadequacy was confusion about the

nature of sexuality; how can a man who wants to be a father and who wants to have a normal family be sexually attracted to men? One participant said, "the cognitive dissonance, it tears you apart" (Participant aged 60-70 years). Despite some men in this study being highly educated, their narratives often reflected remarkably unsophisticated understandings of gender and human sexuality, particularly regarding homosexuality. For example, a participant, aged 60 to 70 years, said, "I didn't understand the concept of sexual orientation," because his religion had taught him that homosexuality was "just a temptation, you're not allowed to do that." Indeed, participants from Christian backgrounds said that religious observance "adds the extra layer of shaming and guilt, because of your moral beliefs and what your parents have taught you and what your Church keeps saying" (Participant aged 60-70 years). In this study, heteronormative values, religiosity, and internalized stigma were behind participants' myopic conceptualizations of sexuality and intensified their existential distress. This meant that most men took full personal responsibility for their circumstances, rather than seeing their situation and their distress as at least partially a product of socialization into a patriarchal and restricted conceptualization of gender and sexuality (i.e., compulsory heterosexuality), constructed to perpetuate powerful interests such as institutionalized religion.

Existential distress was a precursor to marital discord and in some instances the antecedent to suicidal ideation and attempted suicide. Participants spoke of their personal contemplation of, and efforts at, suicide and they cited men they had known who had ended their lives to avoid coming-out: "[His family] knew he was depressed and anxious and now he's taken his life and they have absolutely no idea why . . ." (Participant aged 40-50 years). Men said they often felt trapped in a marriage and "unloved," or so confused and alienated by their circumstances that life became overwhelming: "I think it's important that I say this . . . but there was one point that I attempted suicide during that period [crying]" (Participant aged 40-50 years).

One study participant had spent most of his adult life in the defense forces. He did not want to be attracted to men, he wanted to be "normal," and he wanted the privileges associated with heterosexual masculinity: children, a family life, and the respect of his friends and his defense-force colleagues. Below, he referred to his experience of sex with men at beats (i.e., spaces such as public toilets, change-rooms, and parks) during his 12-year marriage. He saw an interrelationship between compulsory heterosexuality, existential distress, and suicide among younger men in mixed-orientation marriages:

> [T]he amount of married men that I ran into in beats and stuff was ginormous. It's absolutely incredible how many are doing it and I think for me it's a big problem. I think the whole sexuality thing is behind a lot of suicides, a lot of depression and it's unspoken about . . . [later] . . . They [the mental health experts] need to know that this happens . . . I think they'd solve so many young men killing themselves, because those answers never come out and I reckon underneath it all, that this is the problem. That's why young men kill themselves. You know when they sit there and say, "We had no idea why he did it," this is why! This secret is so easy to keep inside your body yourself, it destroys you inside, but it's so easy to hide from everybody else. (Participant aged 30-40 years)

In the heteronormative, hyper-masculine, and conservative environments of the military, gender and sexually diverse people such as gay-identified men are at an increased risk of suicidality (both ideation and behavior; Matarazzo et al., 2014). How suicidality operates among younger men in the military who are same-sex attracted but heterosexually married is unclear, as this area of research is unexplored. The key issues of poor mental health, low social support, perceived burdensomeness, victimization, and (failed) belongingness, which are associated with suicide among openly gay men in the military (Matarazzo et al., 2014), may similarly affect closeted military men. Moreover, the stigma layering of marital infidelity and same-sex attraction contributed additional internalized stressors for men in mixed-orientation marriages and may, as was reported, lead some to suicide. Like the military, religious organizations are predicated upon a restricted patriarchal conceptualization of gender and sexuality. This meant that one participant, who was instructed by his religion to view homosexuality as "just a temptation," had considered removing himself from his family because he saw his life as a failure, despite a successful career practicing specialty medicine and helping to raise his family. Given the central role that religion had played in his life, and given an absence of gender and sexual diversity within religious doctrine, this man saw little value in himself and little purpose in his future, which led him to consider suicide or another form of self-erasure:

> Well what should I do, should I just disappear, should I disappear at sea or somewhere. I don't want to put people through grief. But then I thought I'd go overseas and gradually lose contact with everyone . . . then just gradually fade out of their lives. (Participant aged 60-70 years)

In men who reported depression, anxiety, and suicidal ideation, these conditions were often chronic, self-managed, and left unchecked because there was, as participants explained, a lack of awareness about mixed-orientation marriages and gender and sexual diversity among mental health professionals, and a concomitant lack of appropriate mental health services to consult.

Compartmentalization: "It was sort of like going to the movies." A further overarching theme in these data, which intersected with compulsory heterosexuality and existential distress, was compartmentalization (Showers & Zeigler-Hill, 2007). At a social-structural level, heteronormativity compartmentalizes sexual identity into a "straight-gay" (i.e., normal–abnormal) binary, reflecting the way most people have been socialized to think about human sexuality as fundamentally heterosexual (Herek, 1992). People who are same-sex attracted are motivated to avoid stigmatization and homophobic violence and some work to fit in with the dominant relational form by compartmentalizing their same-sex attraction to identify as heterosexual. At an individual level, compartmentalization refers to the process where people construct contextualized selves that organize positive and negative beliefs about the self in a way that serves either implicit or explicit self-goals. Compartmentalization allows conflicting ideas about oneself to co-exist (i.e., it is a process to reduce cognitive dissonance; Festinger, 1957; Frasca, Ventuneac, Balan, & Carballo-Dieguez, 2012). Participants' practice of compartmentalizing same-sex attraction within the context of heterosexual marriage was to satisfy a sexual curiosity and to achieve sexual fulfillment. In this study, compartmentalization in some instances helped to bolster men's self-esteem by reducing the emotional significance of same-sex attraction in their lives and by emphasizing a distinction between love and sex (e.g., I love my wife, whereas men are just sex). By disassociating love and sex, participants attempted to integrate same-sex attraction and practice into their married lives:

> . . . I think I was able to compartmentalize [sex with men] and just, "Yeah, that was an event and yeah, that was fun, and I liked that." It was sort of like going to the movies. (Participant aged 40-50 years)

Participants characterized their sexual fantasies and interactions with other men as episodic, casual, anonymous, and emotionless, and from their perspective, a compartmentalized same-sex attraction represented no threat to the marriage. Men split their lives into disconnected segments and controlled assiduously for any overlap that might reveal their extramarital activities. Some were more adept at the practice than others, for example, men who traveled for work were provided with more opportunity to meet other men and to compartmentalize same-sex behavior, partially integrating sex with men into their emotional and professional lives. Other men had tightly structured work and family lives that prevented the same opportunities for compartmentalizing and exploring same-sex attraction. However, the strategy of compartmentalizing did not always reduce internal conflict, or cognitive dissonance, as theory suggests it should. Instead, in this study, it often resulted in increased feelings of guilt and shame about being same-sex attracted. This is indicated by an example of the practice described below:

> I would save up cash and I would buy a gay porno . . . and so I would put that on, on my day off when [my wife] was working and the kids were at school and have a masturbation session to that. And then I'd feel . . . so guilty that I would take a hammer to the video and smash it to smithereens. Then I would take it down to the waterfront to a whizz bin . . . and bury it low down in the whizz bin and I felt so guilty and horrible that I would go a few weeks, before I decided, "Oh this is ridiculous, I need to enjoy this" and I would buy another video, and so be it. (Participant aged 50-60 years)

Not all participants engaged in compartmentalization; however, there were significant examples described throughout the study. Compartmentalizing sexual identity and practice was both adaptive and maladaptive; it enabled men to explore their sexuality, for example, by watching gay pornography or seeking casual sex at beats. Yet the stress evoked by attempts to integrate (Showers & Zeigler-Hill, 2007) men's self-concepts (i.e., I'm married to a woman/I want sex with men) was significant. Participants used a range of coping strategies, including self-medicating with alcohol, to manage the distress they experienced from compartmentalizing same-sex attraction. Few men were able to access support via friendship networks, professional one-on-one counseling, or group counseling. Participants repeatedly referred to the limited pool of mental health professionals who were trained to assist them. Unlike in the larger LGBTQI communities of capital cities in Australia, mental health professionals and support networks are rare in sparsely populated rural and regional areas and among those practicing, few see men in mixed-orientation marriages.

Integration and resolution: "The best thing that ever happened to me . . . ." Repression of same-sex attraction laid the foundation of men's existential distress, their maladaptive coping strategies, and their eventual coming-out as gay or bisexual. The stress of managing disparate, compartmentalized sexual identities, and practices in the context of heterosexual marriage exacerbated feelings of stigma, anxiety, and depression, as participants' self-concepts and social identities were not sufficiently integrated. Men were unable to build an integrative self-structure (i.e., having a healthy balance between one's positive and negative self-concepts) due to internalizing stigma, which in turn reinforced low self-esteem and perpetuated negative emotional states (i.e., existential distress; Zeigler-Hill & Showers, 2007). The decision to come out as same-sex attracted simultaneously resolved and integrated men's

compartmentalized behaviors and their distress, despite coming-out being a traumatic event that usually heralded the end of married life. Integration was a major theme in these data and was identified by the authors and the participants. Coming-out meant that the compartments participants had constructed to separate their private persona from their public married life could be dismantled, and an integrated self-structure could begin to emerge. For the most part, men's reports of depression and anxiety, and the well-being of their wives and families, gradually improved following coming-out and the renegotiation of the terms of marriage or separation. Coming-out was an epiphany and a major milestone in participants' lives, despite sometimes taking decades, because it enabled these men to finally develop an authentic integrated identity and sexual citizenship:

> "The best thing that ever happened to me after I came-out was . . . to integrate my whole being into one for the first time in my life, and that was the best thing that ever happened to me. (Participant aged 60-70 years)

The process of self-acceptance and integration was often arduous and circuitous, involving an ongoing internal dance of approach-and-avoidance of the topic over the course of many years. For most men, the decision to come out was mediated by fear and anxiety about the implications of openly identifying as gay or bisexual, particularly in relation to how it would affect their wives and families' social status and well-being:

> I had reached the conclusion in my mind that I was homosexual. I wasn't bisexual . . . and I needed to be honest with my wife, so I told her first how I felt, and she obviously went through a range of emotions over those weeks that followed . . . so you can imagine how devastated she was. We spent sort of six months trying to understand what it meant, whether we could just continue on, whether we should separate, whether she'd allow me to see someone or you know, what our future would be, if anything. (Participant aged 40-50 years)

While participants were relieved of an existential distress wrought by the onerous psychological burden of secrecy and deception, their wives, most of whom were completely unsuspecting, bore a heavy emotional burden. The process of resolution for the partners of men followed identifiable stages of loss:

> Probably the first minute [after I came-out to my wife] was, you know, denial. Within the first couple of days it was devastation, sadness, overwhelming grief, like she'd lost me. You know she couldn't compete with this. It was not something that she could make herself prettier . . . so I could see that she was really suffering. But then her emotions turned to rage, very strong anger, wanting to get revenge and harm me, not physically, but financially. (Participant aged 40-50 years)

In some instances, participants' wives responded with empathy following their husbands' coming-out. Among a minority of participants who remained married, or partnered, their relationships were renegotiated: for example, one woman had accepted her husbands' attraction to men but did not want to share him with a man, whereas another woman permitted her husband to have a male lover, provided they remained a married couple:

> . . . I was quite surprised I must say when I did tell [my wife that I was gay] and all I got was support and I thought that was fantastic. (Participant aged 50-60 years)

For some participants, integration and resolution (i.e., coming-out) was partial and provisional; it meant being openly gay or bisexual within limited contexts to protect the reputation of families and to fend off outsiders' criticisms of women who stayed in relationships with their husbands:

> I'm not completely out about my bisexuality, my wife knows, my two children know and there are some family members like my parents, my wife's parents and few other people that know, but generally speaking to the outside world, I am still a married heterosexual man . . . part of it is to deal with the culture of [my workplace], a lot of it is to do with respecting the wishes of my wife and one of my two children . . . (Participant aged 40-50 years)

These families aimed to maintain control over disclosure, often to protect husbands and their adolescent children from the risk of workplace and school-yard homophobic bullying.

Discussion

Propositions derived from the study findings suggest that (a) compulsory heterosexuality cultivates mixed-orientation marriages; (b) compartmentalized identity and practice lead to and/or exacerbate internalized stigma, depression, and anxiety among gay and bisexual men in mixed-orientation marriages; and (c) coming-out as gay or bisexual enables one's self-structure to become integrated, which reduces internalized stigma, anxiety, and depression. The study findings support a theoretical interrelationship between heteronormativity/compulsory heterosexuality, the adoption of maladaptive coping strategies, an onset of anxiety and depressive disorders, and a resolution via integrating one's self-structure. The findings suggest that among participants who had cultivated a heterosexual identity consistent

with their socialization, denying their same-sex attraction (or misunderstanding their sexuality) contributed to the development of mental health problems. As young people, participants had learned to repress their same-sex attraction to conform to the tenets of heteronormativity and to reflect the common heterosexual relationship patterns they saw around them. This was despite some men being aware of their same-sex attraction from an early age. However, integrating stigmatized same-sex identity and practice with the demands of compulsory heterosexuality within conservative, rural or regional, and religious social contexts was not possible. While compartmentalizing assisted some men to explore their sexuality during marriage, our data support a proposition that a lack of integration between self-concept and a stigmatized social identity and practice (Zeigler-Hill & Showers, 2007) compounded men's experience of strong negative emotional states, which remained unresolved until an integrative self-structure was forged through coming-out as gay or bisexual.

These findings are unique given a dearth of scholarly literature about the development of anxiety and depression among men in mixed-orientation marriages. Nonetheless, there are similarities with previous research findings from other populations that show there may be hidden costs to mood and self-esteem from compartmentalized self-concepts (Ben-Ari & Adler, 2017; Showers & Zeigler-Hill, 2007; Zeigler-Hill & Showers, 2007). The current study findings are also consistent with previous research showing high levels of anxiety and depression and other physical and mental health disorders among gay and bisexual men (Higgins, 2002, 2004; Hillier et al., 2008; King et al., 2008; Meyer, 1995, 2003). Earlier research found that most mixed-orientation marriages eventually end in separation and/or divorce (Ben-Ari & Adler, 2017; Bozett, 1982; Buxton, 2008b; Coleman, 1982; Hudson, 2013), and most men in this study had separated or divorced from their spouse. Similarly, these findings reinforce the important role of social environment (Kissil & Itzhaky, 2015; Ortiz & Scott, 1994), independent of individual risk-factors, for increasing the risk of suicide among gay and bisexual men, which is identified in previous research (Hatzenbuehler, 2011; Hatzenbuehler et al., 2014; Perales & Todd, 2018). The findings of this current study suggest that compartmentalization is at best a short-term coping strategy. Over the longer term, men and women in mixed-orientation marriages require interventions from appropriately qualified mental health professionals.

However, some men in this study reported difficulty in accessing a mental health professional with experience of working with gay and bisexual men, and even fewer mental health professionals were said to have experience of mixed-orientation marriages. A lack of mental health expertise highlights a need for innovative interventions such as online resources targeted at affected individuals, including family members, and a need for workforce development programs to familiarize and upskill mental health professionals about mixed-orientation marriages. A scaling-up of mental health and support services for all members of affected families will improve access to appropriate modes of support. Interventions to improve mental health among affected men, women, and children must begin with an examination of the exigencies of heteronormativity. To move beyond compulsory heterosexuality, communities and mental health professionals must come to terms with gender and sexual diversity. This will be a challenge, given the rise of a conservative political populism over recent years where programs of gender and sexual diversity in education and health are often positioned as "politically correct," of relevance only to minorities, and therefore a low priority for government funding and support.

This study had several limitations, which may have affected the findings. All participants were middle-aged White men, mostly low- to middle-income earners, and they self-selected to be part of the study, so the findings are not generalizable to all men in mixed-orientation marriages. Furthermore, the wives and children of gay and bisexual men were not interviewed for this study. Another limitation was the method of data collection. Telephone interviewing has disadvantages including the loss of visible indicators such as body language and facial expressions, which can further inform the analysis or alert researchers to participants' discomfort during interviews of a sensitive nature. Despite these limitations, most transcripts contained detailed narratives comprising thick descriptions of participants' lives, which suggested that participants were comfortable with the method of data collection. Telephone interviewing also has advantages; it is convenient (for participants and researchers), low cost, and relative to face-to-face interviewing, anonymous. Arguably, in-depth telephone interviewing in the hands of a skilled interviewer can enhance the intimacy and intensity (focus) of an interview because there is only one channel of communication (i.e., a voice).

While the authors did not recruit men from culturally and linguistically diverse populations within Australia, it is possible that these communities are exposed to equally prescriptive beliefs about marriage, gender, and sexuality. Diverse approaches are required to target affected populations because as these findings show, mixed-orientation marriages are evident in a range of socioeconomic contexts, including in religious communities, many of which are culturally and linguistically diverse. Interventions among all population groups need to challenge the "naturalness" of heterosexuality to instead naturalize gender and sexual diversity. Interventions that disrupt the

hegemonic binary constructions of gender and sexuality are likely to require significant political will to implement and extended time frames for their effects to be measurable. While the times are changing, expanding people's understandings and acceptance of nonheterosexual sexual identities is a major challenge for health promotion education.

Innovative resources are needed to sensitize people to the existence of mixed-orientation marriages and to provide information without reinforcing negative stereotypes of gay and bisexual men (Hillier et al., 2008). Innovative resources may be discreetly and sensitively targeted at men via publications such as print and online sporting and lifestyle magazines and websites. Developing resources that will open a conversation may be the first step to neutralizing stigma related to same-sex attraction in a context of heterosexual marital infidelity and to improving the mental health and well-being of men, women, and children in mixed-orientation marriages.

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