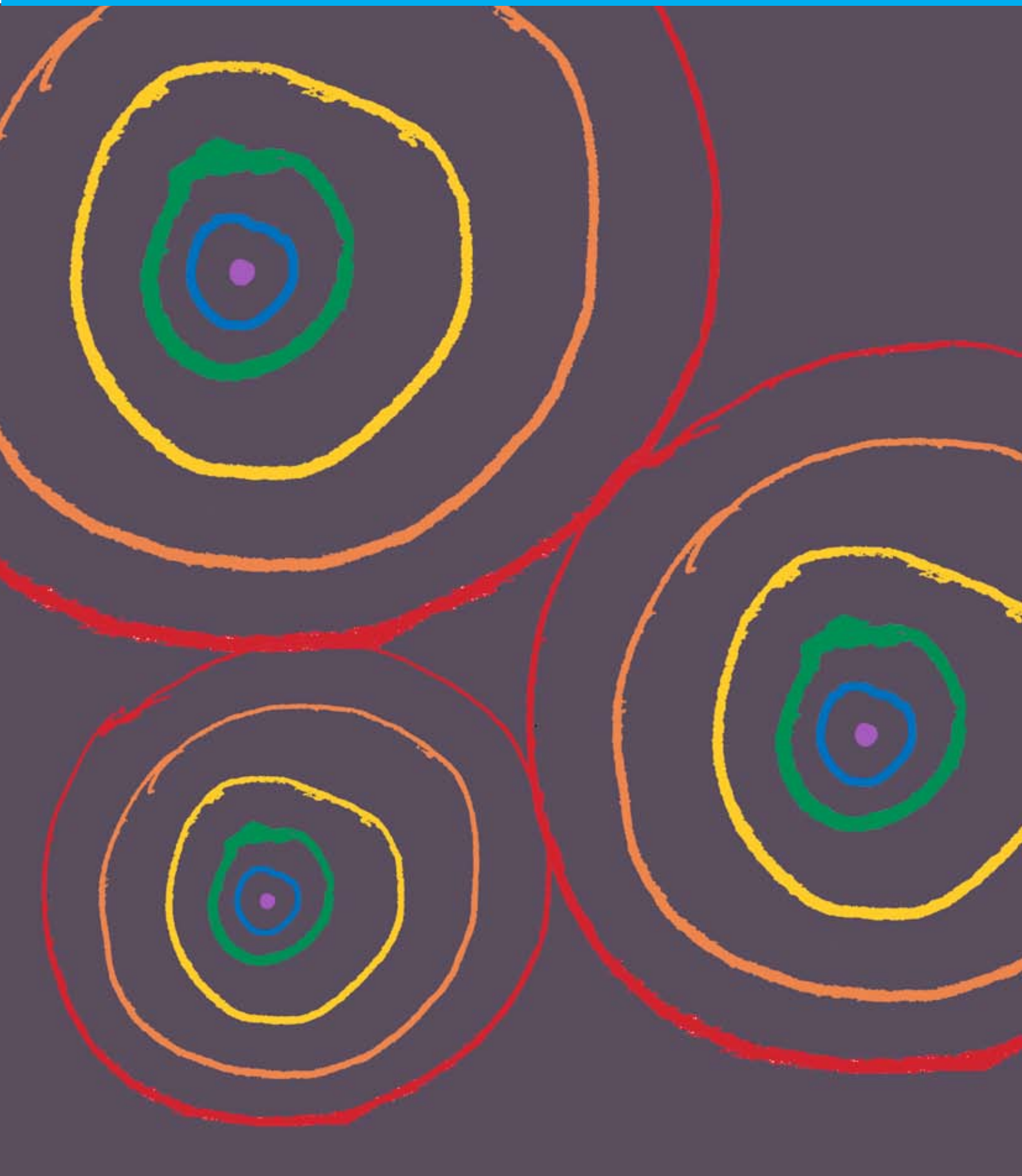
SUPPORTING LGBT LIVES: A STUDY OF MENTAL HEALTH AND WELL-BEING

PAULA MAYOCK, AUDREY BRYAN, NICOLA CARR, KARL KITCHING

The research was commissioned by the Gay and Lesbian Equality Network (GLEN) and BelongTo Youth Project and is funded by the National Office for Suicide Prevention (NOSP) of the Health Service Executive.



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Odhrán Allen (Chairperson), Director of Mental Health Strategy, Gay & Lesbian Equality Network
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Catherine Brogan, Mental Health Specialist, Health Service Executive
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Lynda Sheridan, Support & Outreach Coordinator, Gender Identity Support Ireland
Dónal Walsh, Community Education Facilitator, Galway Vocational Education Committee

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ABOUT THE AUTHORS

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Dr. Audrey Bryan is a lecturer in the School of Education, University College Dublin. Previously, she worked as a researcher at Trinity College Dublin and Columbia University, New York. Her background is in Sociology, and she earned her PhD in Comparative and International Education from Columbia University. She has a particular interest in the school-based experiences of racialised and sexual minority youth. She has previously published on intercultural and anti-racism policies and practices in Irish schools and society. Her current interests include representations and understandings of diversity and development in the second-level curriculum in an Irish context.

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Karl Kitching is a lecturer in education in University College Cork. Prior to that he worked as a full-time researcher and also as a primary school teacher. He is currently writing up his doctoral research on race, ethnicity and success in Irish post-primary schools. His main research interests include the critical analysis of race, class, gender and sexuality, multilingualism, youth cultures and media.

PREFACE

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EXECUTIVE SUMMARY

THE STUDY

There is a dearth of research on lesbian, gay, bisexual and transgender (LGBT) people in Ireland. Stark gaps exist in the knowledge and understanding of the issues and everyday life experiences impacting on the mental health and psychological well-being of people who identify as LGBT. This research set out to examine mental health and well-being, including an investigation of suicide vulnerability (risk) and resilience, among LGBT people in Ireland.[1]

RESEARCH METHODOLOGY

The research adopted an exploratory multi-modal approach to the study of mental health and well-being among LGBT adults and young people. A combination of quantitative and qualitative research techniques was used. This involved the administration of a primarily quantitative on-line survey, the conduct of a Community Assessment Process and the conduct of in-depth individual interviews with 40 individuals who identify as lesbian, gay, bisexual or transgender.

ANONYMOUS ON-LINE SURVEY

A survey instrument, which took approximately 15-20 minutes to complete online, was designed to capture the experiences of LGBT people living in Ireland in a variety of settings and contexts. The survey was built with the use of a popular online survey design tool, the link to which was hosted on a webpage with the domain name **www.lgbtlives.ie**. This instrument included demographic variables, schooling experiences, perceptions of belonging, victimisation and harassment, workplace experiences, and patterns of alcohol use. Indicators of mental health and well-being were also ascertained, including history of self-injurious behaviour and attempted suicide.

COMMUNITY ASSESSMENT PROCESS

This phase of the research aimed to promote knowledge of, and participation in, the study by informing a range of professionals in the LGBT community about the research aims and data collection procedures. It also sought to collect data on the perceived prevalence of mental health problems in the LGBT adult and youth populations. A total of 14 interviews were conducted. The Community Assessment Process facilitated entrée to field settings and helped to inform the sampling and recruitment of interview respondents.

QUALITATIVE IN-DEPTH INTERVIEWS

The interviews focussed to a large extent on the life 'stories' of LGBT people. For example, respondents were encouraged to talk about their everyday lives, their experiences of school, family life and peer relationships as well as their social life and leisure activities. Specific interview topics and questions targeted experiences that may have been challenging, difficult or stressful (e.g. experiences of discrimination, homophobic bullying, stress associated with 'coming out' to family and peers). Questions also focussed where relevant on respondents' experience of depression, anxiety and loneliness and on their use of alcohol and/or drugs. Other sections of the interview concentrated on positive experiences and protective factors.

1 See Appendix I for a glossary of terms used in this report.

RESPONDENT PROFILES

ONLINE SURVEY SAMPLE

Demographics

- 1,100 completed surveys were included in the final data set, representing a completion rate of 80%, and enabling an expansive view of the lives of LGBT people in an Irish context.
- Survey respondents ranged in age from 14 to 73 years, with a mean (average) age of 30.5 years. Thirty five percent of the sample were 25 years of age or under, suggesting that young people in general were well represented in the survey. Those in their fifties, and especially those over 60 years of age, were underrepresented.
- Sixty four percent of the sample identified as male and a further 34% identified as female. The remaining two percent identified as 'something else', primarily as Transgender or Gender Queer.
- Over 90% of respondents were resident in the Republic of Ireland at the time of completing the survey; 4% were living in Northern Ireland.
- Over half of the respondents lived in Dublin. LGBT people from all counties, with the exception of Monaghan, were represented.
- Just under 20% lived in a rural area.
- The vast majority (86%) indicated that their primary nationality was Irish.
- Two-thirds of participants were employed, the bulk of whom were employed in a full-time capacity. Almost one quarter were enrolled in college or university and a further 1% were enrolled in further education.
- Fewer than 5% of the sample were enrolled in school, reflecting an under-representation of 14-18 year olds in the sample. Just under 1% were retired, reflecting an under-representation of over 65s in the sample.

LGBT Identification

- Just over four-fifths of the sample identified as gay or lesbian and just over one tenth indicated that they were bisexual. Three percent of respondents indicated that they were questioning or unsure of their sexual orientation while less than 1% of the sample identified as heterosexual. The remaining 4% used a range of terms to describe their sexual orientation, including 'pansexual', 'polysexual', 'dyke', 'queer', 'sexual' and 'bisexual transvestite', while a number indicated that they preferred not to use or be identified with labels of this nature.
- Four percent of the overall sample identified as transgender, a majority of whom described themselves as 'male-to-female' transgender.
- Just over one fifth of those who identified as transgender reported a gay or lesbian sexual identification.
- Four fifths of survey participants indicated that they were 'comfortable' or 'very comfortable' with their sexual orientation, with less than 7% expressing discomfort on this point.
- About 60% of transgender respondents were comfortable with their transgender identity, but a sizeable minority (17%) reported feeling uncomfortable.

LGBT Awareness And Disclosure

- The overwhelming majority of respondents (96%) were 'out' to at least one person in their lives.
- The average age at which participants first became aware of their sexual orientation/transgender identity was 14 years, with most indicating that they were 12 when they first became aware of their LGBT status.
- The average age at which respondents disclosed their LGBT identification was 21 years.

IN-DEPTH INTERVIEW (QUALITATIVE) SAMPLE

- 40 individuals took part in in-depth interviews.
- These participants ranged in age from 16 to 62 years, with an average age of 31 years. Forty percent of the sample were 25 years or under.
- Just over half of the sample was male, all of whom identified as gay.
- Just over two fifths identified as female, the vast majority of whom identified as lesbian. Two female respondents identified as bisexual.
- Transgender people constituted 10% of the sample, one of whom identified as 'female-to-male' and three as 'male-to-female' transgender.
- Urban participants made up three-quarters of the qualitative sample, with the remainder living in either a rural or semi-rural setting. A higher proportion (40%) however, had grown up in a rural setting.
- Ethnic minorities made up 12% of the sample.
- Sixty percent of respondents were in full-time employment, one was employed part-time, four were enrolled in school, five were attending a third-level college or university, five were unemployed, and one was in receipt of a disability allowance at the time of taking part in the research.

MINORITY STRESS

> *"... my mother doesn't get my body yet and she was, she was very shocked at first, then she tried to convince herself that it was just a phase and then she was trying to tell me like that there are some women who are feeling masculine but they are fine with it and I'm, even again when I told her I maybe going on to, like actually going through the hormone therapy, she was like, 'If you're doing that then you're not living here anymore'" (Female-to-Male Trans, 20).*

The minority stress model, which is a conceptual framework for understanding the negative impact on health and well-being caused by a stigmatising social context (Brooks, 1981; Meyer, 1995, 2003), has provided a useful lens through which to better understand LGBT people's lives. The findings indicate that the psychological distress experienced by LGBT people was strongly associated with external stressors such as presumed heterosexuality, homophobia, prejudice and victimisation. Internal stressors were strongly related to the anxiety of coming out. Negative coming out reactions from others also featured, as did the stress of self-concealment in a range of contexts and settings including school and the workplace.

COMING OUT

> *"... I think I was 18, and I told my best friend I was gay and I was coming out of the pub and I was walking up the street and he tripped me up and I fell on my back and I saw him, you know, standing up and I suppose really, it happened very quickly but it was very frightening. He started kicking me, you know, on the ground and he broke my nose and my jaw and I got my skull fractured and I was kind of crying out for help and 'please stop'. And I ended up in hospital and this kind of happened at the stage when, you know, when you're keeping something inside and all the anger builds up. And I told someone I was gay, my best friend at the time, and just the way he reacted I thought you know, like I have to go away so I went to London" (Gay, Male, 24).*

- Over two thirds of online survey respondents were out to all immediate family members (i.e. parents and siblings) and friends. Less than half of all respondents were out to all those in other social contexts, such as the workplace, at school or college, in youth group or other organisational settings.
- The period between the realisation of, and coming to terms with, one's own sexual orientation or transgender identity and coming out was experienced as difficult, daunting, and traumatic by a majority of participants. For many, coming out was associated with a process of self-acceptance, which was often coupled with an awareness of the stigma associated with assuming an 'alternative life script' in social contexts where heterosexuality and gender conformity are presumed and where heterosexism, homophobia, and transphobia exist.
- The need for parental acceptance, affirmation and validation were central features of the in-depth interview narratives on coming out. Reports ranged from outright rejection and/or denial, to bare acceptance or mere tolerance, to a wholehearted embrace of their child's LGBT identification.

"So I told them both I was gay and my father straight away stood up and went over to me, pulled me off my seat, gave me hug and said, do you know what, that doesn't matter one bit, and he was great, and my mother was like, em, they still love me, d'you know, it doesn't matter" (Lesbian, Female, 31).

"Basically what they said was that they wouldn't be happy but they wouldn't kick me out of the house type thing over it. But that doesn't seem to me very accepting of it. Oh we'll tolerate you but we don't really like you, as if it was some kind of personal choice" (Gay, Male, 20).

LGBT VICTIMISATION

- Eighty percent of online survey participants had experienced verbal abuse, and a quarter of all respondents reporting having experienced physical violence, as a consequence of their LGBT identification.
- Two fifths of survey respondents had been threatened with physical violence because they were, or were thought to be LGBT, with a quarter of respondents reporting having been punched, kicked or beaten as a result of their LGBT status.
- Almost 8% reported being attacked with a weapon or implement (such as a knife, gun, bottle, or stick) on at least one occasion.
- Nine percent reported that they had been attacked sexually on at least one occasion as a consequence of being LGBT.

EXPERIENCES AT SCHOOL

- Fifty eight percent of the overall survey sample and half of all current school goers reported the existence of homophobic bullying in their schools. Over half of all online survey respondents reported having been called abusive names related to their sexual orientation or gender identity by fellow students, while 8% admitted to having experienced name-calling by staff while in school.
- Forty percent of online survey participants indicated that they had been verbally threatened by fellow students because they were, or were thought to be LGBT, while 4% of the sample had been verbally threatened by staff.
- A quarter of the overall sample had been physically threatened by their peers. Over one percent had been physically threatened by staff.

WORKPLACE EXPERIENCES

"There was a sense of tolerance of my sexual orientation in [my] job, but no sense that my relationship with my partner of eleven years deserved parity of esteem with my two bosses' heterosexual marriages. My partner was referred to repeatedly as my "friend", despite my repeated correction of the term. This was not bullying per se, but it was blatant inequality. I don't know precisely how it can be addressed" (Female, Lesbian, 35, Survey Participant).

- Just over a quarter of those who had ever been employed reported having been called abusive names related to their sexual orientation or transgender identity by work colleagues.
- Fifteen percent of those who had ever been employed reported that they had experienced verbal threats because they were, or were believed to be, LGBT.
- Almost 7% reported having been physically threatened by a work colleague, while almost 10% admitted to having missed work because they were afraid of being hurt or felt threatened because of their LGBT identity.

MENTAL HEALTH RISKS

The findings on mental health indicators suggest that the stigma and discrimination encountered by lesbian, gay, bisexual or transgender people can result in an extremely negative experience of being LGBT. This caused many to experience depression, and a significant minority to engage in self-injurious behaviour and to experience, and in some cases act upon, suicidal thoughts.

DEPRESSION

> *"It's[depression] an issue for lots of people. People I work with that aren't gay are suffering from depression but I think it's made even more difficult if you're gay because I think your sexuality is part of your make-up. To struggle with that is like struggling without a kidney. I think your sexuality is a very important part of your life and if you're not comfortable with it you can struggle with it all your life" (Gay, Male, 46).*

Prevalence

- The vast majority of online survey participants (86%), and 90% of in-depth interview participants, reported having experienced feelings of depression at some point in their lives.
- Two thirds of respondents to the online survey reported having felt down or depressed in the past 12 months, and over two fifths reported having felt depressed in the previous 30 days.
- Almost 25% of the sample had taken medication prescribed by a doctor for the treatment of anxiety or depression at some stage, and 8% of the sample were currently taking such medications.

Relationship between depression and LGBT identification

- Over 60 % of in-depth interview participants attributed the experience of depression directly to social and/or personal challenges connected with their LGBT identity. They identified a range of psychological and external stressors which contributed to their psychological distress, including the stigma that LGBT people experience, their lack of integration with the community, their social isolation and problems of self-acceptance, low levels of, and/or limited access to, formal or informal mechanisms of social/ psychological support.
- Participants who experienced homophobic bullying or other forms of victimisation were particularly susceptible to depression.

ALCOHOL USE

Prevalence

- Ninety two percent of the survey sample were current drinkers, about half of whom consumed alcohol on a weekly basis.
- The vast majority of survey respondents who drank (84%) also reported that they engaged in heavy episodic or 'binge' drinking either intermittently or regularly, a fifth of whom did so at least twice a week.

Problem drinking

- Over 40% of survey respondents reported that their alcohol consumption made them 'feel bad or guilty' and that almost 60% felt they should reduce their intake of alcohol.
- Responses to standardised measures of alcohol use (CAGE and AUDIT-C) suggest that the alcohol consumption patterns of a significant minority of online survey participants could be characterised as problematic, as they exceeded the threshold for hazardous drinking or probable alcohol misuse.

- Qualitative findings suggest that regular or heavy alcohol consumption was strongly associated with a felt need to 'mask' distressing emotional states and that some used alcohol as a coping mechanism or a form of self-medication.

> *"There was a lot going on and I was confused and in a lot of turmoil. You've all the hormonal urges a lot of teenagers have with no way of articulating them or expressing them. That's very destructive. And you know the distress carried on into my early twenties. And to be honest, for a couple of years, about 23, 24, a lot of it was just being masked by alcohol abuse. So a lot of people though it was just student high jinx whereas I was blotting out how I actually felt. That was not a pleasant time, you*

SELF-HARM

Prevalence

- Twenty seven percent of online survey respondents and a similar proportion of in-depth interview participants indicated that they had self-harmed at least once in their life. However, the proportion of the overall survey sample that had harmed themselves intentionally in the recent past was relatively low.
- Six percent reported that they had harmed themselves intentionally within the previous 12 months, while 3% had self-harmed within the last thirty days.
- The average length of time that survey respondents had self-harmed for was just over four and half years. A number of in-depth interview participants also reported multiple episodes of self-harm over a period of two or more years.
- Forty six percent of those who had self-harmed also reported having attempted suicide on at least one occasion.

Age

- The average reported age of onset of self-harm for online survey participants was 15.87 years. Similarly, for in-depth interview participants, the onset of the behaviour was almost always during the mid-teenage years. It tended to coincide with a period of particular difficulty during adolescence, often linked to the personal struggle of coming to terms with one's sexuality.

Gender

- Female respondents were almost twice as likely to have self-harmed as males, with almost 40% reporting that they had self-harmed at some point, compared with 21% of males.

LGBT Identification

- A quarter of all respondents who identified as gay or lesbian had self-harmed during their lifetime. A greater proportion of bisexual respondents reported self-harm, with over two fifths having self-harmed at some point. Over a third of those who were 'questioning' or 'not sure' about their sexual orientation had self-harmed, whereas two fifths of those who did not identify with these commonly ascribed categories of sexual orientation had self-harmed.
- Forty four percent of transgender participants had self-harmed at some point in their lives, 11% of whom had self-harmed in the previous twelve months.

Relationship between self-harm and LGBT identification

- In-depth interview participants linked their self-harm behaviour to a range of emotions and psychological states, including feeling alone and different, feeling attacked, feeling silenced and angry, and to feelings of anxiety related to perceived rejection on the part of parents, peers and others. For

many of those who self-harmed, the onset of self-injurious behaviour coincided with a particularly difficult or painful period linked to the personal struggle of coming to terms with their sexual orientation or gender identity. These findings strongly suggest that self-harm was a coping response to social contexts characterised by invalidation, and the experience of being regarded as different or in some way unacceptable.

> *"I know personally that it [self-harm] was to do with my sexuality because there were times when, you know when I came out, I'd been out maybe a year and I still had a problem with it even though no one else had a problem with it. So I hurt myself through myself. Then there was the whole problem of internalised homophobia. I'd beat myself up over issues" (Gay, Male, 21).*

SUICIDALITY

Prevalence

- Almost a fifth of online survey respondents (17.7 %), and almost one third of in-depth interview participants had attempted suicide at least once in their lifetime.
- Just under two thirds of survey participants, and over a half of in-depth interview participants who had ever attempted to take their lives, did so on more than one occasion.
- Fourteen percent of the overall survey sample had sometimes or often given serious consideration to the idea of ending their own life within the previous year.

Age

- The average age at first attempted suicide amongst online survey participants was 17.46 years (with an age range of 8 to 42 years).
- Over half of those aged 25 or younger at the time of completing the survey admitted to ever having given serious consideration to ending their own lives while just under 20% reported having attempted suicide.
- Of those aged 25 or under, over a third had thought seriously about ending their lives in the past year, while just under 5% had actually attempted suicide within the previous 12 months.

Gender

- A quarter of all female survey participants (n = 89), compared with 15% of male participants (n = 105) had attempted suicide at least once in their lifetime.

LGBT identification

- Seventeen percent of those who identified as gay or lesbian reported ever having attempted suicide. A higher proportion of those identifying as bisexual (25%) had attempted suicide than those who identified as gay or lesbian.
- Over a quarter (n = 12) of those who identified as transgender (n = 46) indicated that they had attempted suicide at least once, most of whom (n = 10) had tried to take their lives on more than one occasion.

Relationship between suicidality and LGBT identification

- The majority of study participants had never contemplated, planned or attempted suicide, suggesting that LGBT people are not a homogenous 'at risk' group for suicidality, but that a significant minority of those who identify as LGBT are indeed at risk for suicidality.
- Statistically significant associations were found between lifetime suicidal ideation (having ever seriously thought of ending one's life) and having been verbally insulted; physically threatened; physically attacked (i.e., punched kicked or beaten); or sexually assaulted, such that the more

frequently one had experienced these forms of victimisation, the more likely they were to have ever thought about ending their own life.
- Almost half of online survey participants who had ever attempted suicide viewed their first suicide attempt as either 'very related' or 'very much related' to their LGBT identification.
- Many of those who had contemplated, planned, and/or attempted suicide related their suicidality directly (although typically not exclusively) to their LGBT identification, and a range of experiences or feelings associated with this identity. Suicidal distress amongst some who identity as LGBT can be understood as a direct response by some LGBT people to institutionalised discriminatory and homophobic beliefs and practices which they encountered in a number of social institutions and settings such as family, school, and the workplace.

> *"I said ... that my self-harming and suicide attempt were very strongly related to being gay and this was true when I was 21. But it was not being gay that made me do this to myself and that made me feel suicidal. It was all the bullying, the name-calling, the negative ideas about being gay that I was full of from growing up in a homophobic society, and the fact that I had never heard one person say in all my childhood and adolescence that being gay was okay or even good. Without any basic level of nurturance, encouragement or support around being a gay kid how else could I have turned out?" (Gay, Male, 35, Survey Participant).*

LGBT PEOPLE AND SERVICES

> *"She [counsellor] put my nineteen years into one sentence. Oh my god, this stranger, this woman is able to look at my life ... it makes you look at bits of yourself that you didn't want to. She said to me, which I didn't believe at the time, that I was strong. It made me look at things and face up to things" (Lesbian, Female, 51).*

HEALTHCARE ACCESS

- Over a quarter of online survey respondents had accessed mental health counselling services, while a little more than a fifth had accessed an LGBT-specific health service. Almost 11% had attended an HIV-related service, while 3% had accessed substance/abuse/addiction services.
- Other sources of LGBT-specific support which online survey participants accessed included LGBT support groups (23%) and LGBT youth organisations or youth groups (17%).
- Of the 40 individuals interviewed, approximately three-quarters had attended or approached a health care professional (GP, hospital staff, psychologist, psychiatrist, counsellor) or other individual or agency (school personnel, LGBT youth group) with a view to discussing their health needs. Across the in-depth interview sample, counselling or psychological services were the services most commonly accessed, followed by General Practitioners (GPs). Six had attended a psychiatric service and, in other instances, respondents reported seeking help or advice at school, LGBT-specific youth services, LGBT help lines, hospitals and STI clinics.
- Almost a fifth of online survey participants had attended a LGBT youth organisation or group at some time and thirteen of those who were interviewed in-depth had accessed LGBT-specific youth services.

HEALTHCARE EXPERIENCES

> *"The last doctor, well my current doctor didn't really understand what I was trying to say and I was trying to be discrete about it, not because I felt ashamed ... And in the end I had to, you know, just say it very clearly, 'Look my partner is female, you don't seem to be picking up on that. I'm you know, sexually active with another female. And so, you know, he was a bit shocked ..." (Lesbian, Female, 29).*

- While two thirds of survey participants with prior experience of healthcare professionals felt that the health advice they received was generally useful and appropriate, over three quarters were of the opinion that healthcare providers needed to have more knowledge of, and sensitivity to, LGBT issues.
- GPs were aware of survey participants' LGBT identity in only 44% of cases.

- Almost a quarter of those who had prior experience with health professionals reported that they had concealed the fact that they were LGBT when dealing with healthcare professionals because of how they might react.
- The experience of attending GPs was depicted as a negative one by many interview respondents, with the weight of negative attention falling on the claim that their GP did not understand LGBT issues.
- A fifth of survey participants actively sought out LGBT-friendly professionals because of negative experiences they had had in the past, while a similar proportion did not feel respected as an LGBT person by healthcare professionals.
- Specific barriers to healthcare access include a presumption of heterosexuality and a lack of cultural competence on the part of healthcare providers. Several interview respondents experienced homophobia within healthcare settings.
- Accounts of accessing LGBT-specific youth services were overwhelmingly positive, and strongly suggest that these services are important in terms of counteracting experiences of homophobia and promoting positive mental health.
- Transgender people reported specific barriers to health care including difficulty in obtaining the information they needed to access appropriate services, varied responses from GPs, and fears about confidentiality. The financial costs associated with travelling abroad to access appropriate services also emerged as a significant source of stress.
- The LGBT population in Ireland is diverse in terms of people's individual needs. Specific areas requiring more developed service responses include services for LGBT young people, supports and services targeting LGBT people living in rural/isolated locations, transgender people and lesbians.

> *"... what I did first was I went to the GP and I asked him, I told him the way I was and what I was feeling and all that, and he said 'Right well I will try and make appointments for you to see people'. He wrote to I think a guy in [psychiatric hospital] and he said, 'No I can't take anymore patients, I am fully booked'. And he was the only one in the country, so like I was screwed there straight off. There was nobody to go to so I went off to the UK" (Male-to-Female Trans, Heterosexual, 37).*

RESILIENCE

Although many of the study's findings strongly suggest that LGBT people's lives are negotiated under varying degrees of adversity, it would be mistaken to interpret these adversities as the only, or indeed the defining, characteristics of the lives of all LGBT people. In fact, quantitative findings from the online survey based on measures of subjective well-being suggest that LGBT people in Ireland today are, on the whole, more happy than they are unhappy with their lives.

> *"I am happy to conclude by saying that I am now a very content, confident, well-adjusted gay man, fully out and very happy to be gay. I have grown and thrived with the love and support of my friends and two of my sisters ... being gay was never my problem but how people reacted to me being gay was certainly part of what made life very hard in the past" (Gay, Male, 35, Survey Participant).*

Social Sources Of Resilience

Four key sources of social support were identified from the narratives of interview participants and the written accounts of survey respondents: friends, family, LGBT community, and specific social environments including school and the workplace.

Friends as a source of resilience

> *"The more we got talking, the more it just made me feel good. It was just so much better to speak and interact with somebody who basically had the exact same experience as me. I mean they came out, they felt really bad, then they met lots of open gay people and they were, 'You know something, it's not so bad'. It doesn't have to be dreadful; it can be a perfectly happy, rewarding life. And it was through, you know, speaking to her and other people in the GLB [student society] it just made me*

happier about myself like, it was nice to have similar-minded friends" (Lesbian, Female, 25).

- Support from friends was the strongest form of social support amongst the survey sample.
- Friends were also the most frequently cited source of positive well-being among interview respondents, providing advice and support and acting as confidants during times of particular stress or need.
- Friends emerged as key figures during times of transition or change, particularly during the coming out process.
- While most respondents had 'straight' (heterosexual) friends, LGBT people were perceived to be more empathetic, particularly in relation to LGBT-specific issues.
- Overall, friendships emerged as key sources of resilience, helping respondents to cope with experiences that evoked sadness, fear or distress.

Family as a supportive environment

"My Dad goes, 'Oh he's my son'. And at that point I realised that Dad did not have a problem like, he could say it to other people that he had no problem with that aspect of it. It meant quite a lot to me like, that he didn't care. He said it straight away, he didn't have to think about it or anything" (Gay, Male, 17).

- Although many in this study reported that they experienced difficulties due to lack of family support, a considerable number of interview respondents reported positive family relationships. Others noted that family members had become more accepting over time and they typically highlighted the importance of a supportive family environment.
- Those who felt supported by family members benefited in ways that appeared to impact positively on their sense of security and well-being.
- Family relationships characterised by acceptance fostered self-confidence in individuals, and the ability to better manage negative emotions and environments.

LGBT community as a source of resilience

"I went to [LGBT support group] and I did actually meet a couple of women who were married. One woman that is married, still married and identifies as gay and another woman had left her husband and she was gay. So they were in similar situations. So I figured, 'Thank God I'm not the only one'" (Lesbian, Female, 51).

- The themes of connectedness, safety and solidarity featured centrally within respondents' accounts of the benefits of participation in the LGBT community.
- Young people particularly emphasised the confidence and sense of 'belonging' they experienced through their participation in LGBT youth groups.
- Contact with other LGBT people allowed individuals to share specific and sometimes challenging life experiences.
- LGBT community venues were perceived as 'safe spaces' that allowed people to meet and interact without feeling fearful or intimidated.

School and the work place as supportive environments

- A small number of young people mentioned an individual teacher who was particularly empathetic and supportive, providing evidence of the positive effects of school-based affirmation.
- Positive work environments were places where people felt valued and where they did not experience stress related to homophobia, prejudice or discrimination.

'BECOMING' RESILIENT

> *"It was really a stage of my life in my early twenties and I came through the other side. I am so glad I didn't do anything foolish. It was totally 100% to do with me not accepting my sexuality and thinking I was some sort of freak. I think meeting other LGB people my age really helped me and I think for that to happen people need to be able to be open about themselves. I think a lot has changed even since I started college and it is increasingly better for young LGB people to come out earlier and start to develop relationships, sexual and otherwise" (Gay, Male, 28, Survey Participant).*

- There was strong evidence to suggest that resilience was ongoing and emerging rather than simply a trait possessed by some LGBT individuals and not by others.
- Many accounts were suggestive of a 'reframing' of experience over time. In other words, there was evidence that some respondents developed new meanings and interpretations which led them incrementally towards a more positive understanding of themselves and of aspects of social experience.
- Several drew attention to their personal development over time and, in particular, to enhanced self-esteem and feelings of self-worth.
- A considerable number recounted 'turning point' experiences and events that appeared to bolster them at specific, and sometimes crucial, junctures.

RECOMMENDATIONS

The findings of this research highlight the significant role played by social and structural factors in determining the mental health of LGBT people. The recommendations are therefore directed primarily at achieving social and institutional change as a means of tackling LGBT minority stress. While recognising the need for transformation of those political, social, and cultural structures and ideologies that underlie LGBT minority stress, we also identify a number of areas or spaces that offer scope for positive intervention or change, at the personal and interpersonal levels.

LGBT HEALTH AND MENTAL HEALTH

Health/Mental Health Policy

- LGBT mental health related policies and programmes should avoid representing LGBT people, as a whole, as being at risk for poor mental health or suicidality. At the same time, they should recognise that a significant proportion of the LGBT population, particularly young LGBT people, are vulnerable to psychological distress, suicidal behaviour and self-harm related to their experience of minority stress.
- The Department of Health and Children should ensure that the needs of LGBT people are integrated into all health policies, particularly those pertaining to:

  - Mental health
  - Men's health
  - Women's health
  - Older people's health
  - Suicide and self-harm
  - Alcohol and drug (mis)use
  - Health promotion
  - Sexual health

- The HSE should ensure that health and mental health services are provided in a way that is accessible and appropriate to LGBT people.

- Agencies and Departments with responsibility for suicide prevention and mental health promotion should identify and recommend good practice in caring for members of the LGBT population who

might be at risk of suicidal behaviour. In particular, the National Office for Suicide Prevention (NOSP) should ensure that its mental health and Suicide Prevention Strategies are inclusive of—and where appropriate, specific to—LGBT people at risk for suicidality and self-harm.

- The Mental Health Commission should ensure that mental health service standards include care policies for LGBT people.

- The voluntary mental health sector, in collaboration with LGBT organisations, should ensure that its service provision is inclusive of LGBT people.

- Specific attention should be paid to the needs of transgender people within health policy. The Department of Health and Children should develop a national policy on access to healthcare and standards of care for transgender people. The mental health and emotional needs of transgender people should be recognised within health and mental health policy.

Health Professionals

- The HSE should specifically target health professionals (e.g. GPs, A&E doctors and nurses, and hospital liaison psychiatrists) to increase their understanding of LGBT identity as a potential risk factor for self-harm, suicidal behaviour and depression.
- Cultural competency training specific to LGBT populations should be a standard component of all health professional training curricula and be made available to the healthcare workforce through continuing education institutes/initiatives or other appropriate mechanisms. This training should pay particular attention to:

  - The specific health needs of LGBT people.
  - The assumption that all clients are heterosexual (heteronormativity).
  - Responding to individuals who disclose LGBT identity.
  - The 'coming out' process and its potential impact on health and well-being.
  - The impact of stigma and discrimination on the lives and mental health and well-being of LGBT people.
  - Concerns that LGBT people may have in relation to confidentiality.
  - Guidelines for LGBT-inclusive practice.

- Professional bodies and training institutions should provide appropriate training on the standards of care required, and on issues concerning access to health services for transgender people.

Programme/Service development and delivery

- Relevant partners, including the HSE and NOSP, should further resource LGBT-specific groups and organisations nationally to engage in mental health promotion and suicide prevention work.

- The HSE should support front-line responses, in particular the voluntary LGBT helplines throughout the country, to be fully resourced to carry out mental health promotion and suicide prevention work.

- LGBT-specific services, particularly those targeting young LGBT people need to be resourced to provide programmes aimed at transforming internalised homophobia and building individual strengths.

- The HSE should resource LGBT-specific services to develop programmes that are appropriate to the needs of older LGBT people.

- The HSE should resource LGBT-specific services to develop programmes that are appropriate to the needs of LGBT people living in rural areas.

LGBT YOUNG PEOPLE

LGBT young people and education

- Teacher education programmes should offer courses that will assist both early and in-career educators in taking action to challenge heterosexism, homophobia and transphobia in their schools and classrooms. Such interventions should not comprise 'one-off' anti-homophobia lectures and workshops addressing LGBT issues, which are likely to further marginalise LGBT youth, but rather should be infused throughout teacher education programmes (Macintosh, 2007).
- While educators need to be aware of the stressors that affect LGBT young peoples' day-to-day lives, educational interventions should not be premised on the idea that all LGBT young people are victims or that they are inevitably 'at risk' of developing mental health difficulties. Rather, educators must attend carefully to the diverse experiences and concerns of LGBT young people, particularly as they relate to areas that may affect their schooling and well-being both inside and outside the classroom.

- The formal school curriculum, and Social Personal and Health Education (SPHE) and Relationships and Sexuality Education (RSE) in particular, should provide far greater scope for the exploration of minority sexuality and gender identity. LGBT identities should be equally validated through the informal curriculum such as school social events.

- Training packs should be made available to schools by the Department of Education and Science (DES), complete with topics and issues relevant or specific to the experiences and concerns of LGBT students. These packs should include resources to help early and in-career teachers to recognise the presence of heteronormativity in their curricula and classrooms.

- The Department of Education and Science and individual schools should take action on their obligation to ensure the safety of school environments for all students by ensuring that school bullying policies incorporate directives and guidelines that specifically recognise and address the problem of homophobic bullying in schools.

- The DES should provide a dedicated support service to schools and the education partners (e.g. Institute of Guidance Counsellors) on issues related to sexual orientation and gender identity.

- There should be increased recognition within policies and programmes designed to tackle early school leaving that a significant minority of LGBT youth are at risk of dropping out of school early.

LGBT young people in the community

- The youth sector needs to devise clear mechanisms to promote greater awareness of the needs and rights of LGBT young people. This may include developing an LGBT Strategy for the sector, developing comprehensive training packages, holding a national conference on LGBT young people, and ensuring that all policy developed in the sector is inclusive of the needs of LGBT young people.

- The Quality Standards Framework currently being developed for the youth sector should be fully inclusive of LGBT young people.

- The National Youth Work Development Plan should give full recognition to, and be fully inclusive of, LGBT young people.

- All youth work training should offer comprehensive courses that raise awareness of the needs of LGBT youth and also help them to appropriately address and challenge heterosexism, homophobia and transphobia in the context of their work with young people.

- LGBT-specific youth services require further development nationally. Such designated spaces play an important role in helping LGBT young people to access knowledge and social support, make connections and develop confidence and self-esteem. They also provide an appropriate setting in which to address mental health issues with young people.

Parents of LGBT young people

- LGBT youth organisations should be resourced to work with the parents of LGBT young people to provide guidance to them on how best to support their children.

- The Department of Health and Children should develop a booklet and resource pack and make it accessible to the parents of LGBT teenagers.

- The Department of Health and Children and the Health Service Executive should develop a resource and information pack for transgender people and their families.

LGBT PEOPLE IN THE WORKPLACE

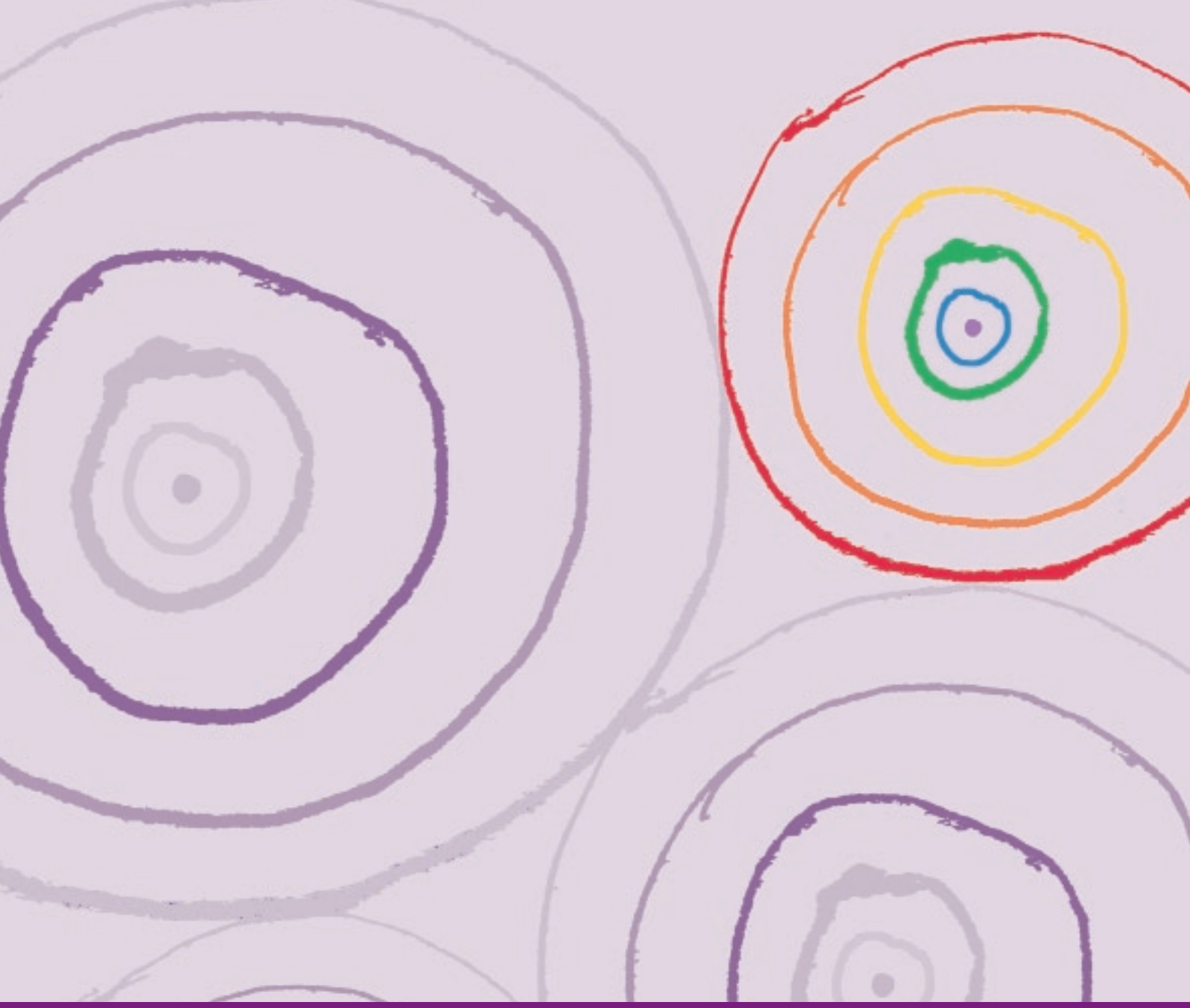
- Existing employment equality legislation exemptions permitting certain religious, educational and medical institutions to take action deemed reasonably necessary to prevent an employee, or a prospective employee, from undermining the religious ethos of the institution should be eradicated. This has particular relevance to LGBT personnel working in, or seeking employment in, schools as it means that many who might otherwise serve as role models for LGBT youth may feel obliged to hide their sexual orientation or gender identity in these settings.

FUTURE RESEARCH

- All national administrative databases in Ireland should include items which capture sexual orientation, gender identity and same-sex partnership/cohabitation.
- General population surveys should include questions on sexual orientation, gender identity and same-sex co-habitation.
- Longitudinal and other large-scale survey research on children, young people and families should include questions on sexual orientation, gender identity and same-sex cohabitation.

Particular LGBT-specific topics where research (including qualitative, quantitative and mixed-methods research) is urgently required include:

- LGBT youth development and identity, with particular attention to the 'coming out' process.
- LGBT youth and schooling.
- Transgender people.
- Older LGBT people.
- LGBT families, partnerships and parenting.



CHAPTER 1 MENTAL HEALTH IN CONTEXT

LGBT MENTAL HEALTH IN CONTEXT

This chapter provides an overview of issues, experiences and societal conditions that impact on the mental health of lesbian, gay, bisexual and transgender (LGBT) people. As a starting point, the concept of minority stress is advanced as a framework for the study of LGBT mental health. This is followed by a review of international and Irish research on the experiences of sexual minority people with specific reference to mental health. Particular attention is directed to the experiences of sexual minority youth, a group who are particularly vulnerable and who are given specific attention in this study. [1]

MINORITY STRESS

The concept of minority stress provides a useful framework for the study of the mental health of lesbian, gay, bisexual and transgender people. Minority stress can be understood as a psychosocial stress derived from minority status (Brooks, 1981). The concept is not found in one theory but is inferred from several social and psychological theoretical orientations (Meyer, 2003). An elaboration of social stress theory, the notion of minority stress posits that conditions in the social environment, not only personal events or 'factors', are sources of stress that may lead to mental and physical ill effects (Mirowsky & Ross, 1989; Pearlin, 1999). According to Meyer (1995: 38), '[t]he concept is based on the premise that LGBT people, like members of other minority groups, are subjected to chronic stress related to their stigmatization'.

Minority stress can be described as being related to the juxtaposition of minority and dominant values and the resultant conflict with the social environment experienced by minority group members (Mirowsky & Ross, 1989; Pearlin, 1999). When the individual is a member of a minority in a stigmatising and discriminating society, the conflict between him or her and the dominant culture can be onerous, and the resultant minority stress significant.

There is general consensus in the international literature that minority group members are exposed to negative life events related to their experience of stigmatisation and discrimination (Brooks, 1981). However, minority stress arises not only from negative events, but from the 'totality of the minority person's experience in dominant society' (Meyer, 1995: 39). At the centre of this experience, then, is the mismatch between the minority person's culture, needs and experience, and societal structures. When applied to lesbians, gay men, bisexual and transgender people, a minority stress model proposes that prejudice based on sexual orientation is stressful and may lead to adverse mental health outcomes (Brooks, 1981; Cochran, 2001; Mays & Cochran, 2001; Meyers, 1995; 2003).[2] Studies have shown that stigma leads LGB people to experience alienation, lack of integration with the community, and problems with self-acceptance (Grossman & Kerner, 1998). For lesbian, gay and bisexual people, minority stress can result from external stressors such as discrimination and hate crime, as well as internal stressors such as internalized homophobia (DiPlacido, 1998; Meyer, 2003). Minority stress can also result from experiences related to self-disclosure, or 'coming out' (DiPlacido, 1998). For same-sex couples, experiences of discrimination, stigmatisation and rejection generate high levels of stress and can lead to internalised homophobia as well as efforts to conceal their sexual identities (Rostosky et al., 2007). At the same time, not all members of sexual minorities experience negative social or health consequences as a result of their minority status and many learn to cope successfully with minority stress. Determining which factors are related to both positive and negative health consequences, therefore, is important, as is the examination of factors or variables that reduce the negative health consequences resulting from minority stress.

The concept of minority stress is an important recent advance within research that seeks to understand the lives and experiences of LGBT people (Brooks, 1981; Lewis et al., 2003; Meyers, 1995; 2003). It is also one that can potentially contribute to the study of experiences that heighten vulnerability to, or

1 See Appendix I for a glossary of terms used in this report.
2 The concept of internalised homophobia is dealt with later in this chapter.

are symptomatic of, mental health problems (depression, self-harm, suicidal behaviour) among LGBT adults and young people. The study of stressors unique to sexual minorities can provide a context for understanding how suicide risk may have specific origins and implications for these individuals (Russell, 2003). Conversely, it is important to examine characteristics that promote psychological health and well-being in lesbian, gay, bisexual and transgender youth.

Prejudice, discrimination and victimisation

Researchers have identified anti-LGBT violence and discrimination as core stressors affecting sexual minority populations. For example, Herek et al's (1999) California-based study of lesbians, gay men and bisexuals found that one-fifth of the women and one-quarter of the men experienced victimisation (including sexual assault, physical assault, robbery, and property crime) because of their sexual orientation. This study also demonstrated that lesbian and gay survivors of hate crimes showed significantly more signs of psychological distress, including depression, stress and anger, than did lesbian and gay survivors of comparable non-bias-motivated crimes. Much of this distress was observed to result from a heightened sense of personal danger and vulnerability associated with their identity as a gay man or lesbian. Furthermore, hate crimes were less likely than other crimes to be reported to the police with only one third of victims of hate crimes reporting the incident(s) to law enforcement authorities (Herek et al., 1999). In a larger probability study of U.S. adults, Mays & Cochran (2001) found that LGB people were twice as likely as heterosexual people to have experienced life events related to prejudice, such as being fired from a job. More recently, a study of gay and bisexual men from three cities in the south-western US found that 37% of men reported experiencing anti-gay verbal harassment in the previous six months; 11.2% reported discrimination and 4.8% reported physical violence (Huebner et al., 2004). Although smaller in scale, a number of published studies in Ireland have documented the prejudice and discrimination experienced by gay and lesbian people (GLEN/Nexus, 1995; Minton et al., 2006).

Research suggests that LGBT youth are even more likely than their adult counterparts to experience victimisation because of their sexual orientation or transgender identity, and that the psychological consequences of this victimisation may be severe. Homophobia and anti-gay violence impact on LGBT youth directly and indirectly. Studies suggest that large numbers of gay, lesbian and bisexual youth experience victimisation, ranging from verbal abuse to physical assault, in a variety of settings including schools (Pilkington & D'Augelli, 1995). Many also drop out on account of the fear of such violence (Garofalo et al., 1998). Research has also demonstrated that the combined effects of bullying or alienation by peers, and difficulties in accepting one's sexual orientation, are correlated with the onset of a number of mental health problems among lesbian, gay and bisexual youth. Such problems have included alcoholism and substance abuse, eating disorders and suicidal ideation (Otis & Skinner, 1996; Pilkington & D'Augelli, 1995; Shaffer et al., 1995).

Internalised homophobia

The concept of internalised homophobia has been defined as 'the gay person's direction of negative social attitudes towards self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard' (Meyer & Dean, 1998: 161). Put differently, many LGBT individuals may internalise significant aspects of the prejudice they experience within a heterosexist society. Plummer (1995: 89) describes the impact of stigma upon an evolving identity in the following terms:

The awareness of stigma that surrounds homosexuality leads the experience to become an extremely negative one; shame and secrecy, silence and self-awareness, a strong sense of differentness – and of peculiarity – pervades the consciousness.

Mental health practitioners and researchers generally agree that internalised homophobia involves negative feelings about one's own homosexuality, although they vary in how they conceptualise, define and use this term (Herek et al., 1999). Despite the considerable challenges in measuring internalised homophobia and lack of consistency in its conceptualisation, research has shown that internalised homophobia is a significant correlate of mental health including anxiety symptoms and depression, substance abuse and suicidal ideation (DiPlacido, 1998; Meyer & Dean, 1998). Research also suggests

a relationship between internalised homophobia and various forms of self-harm (Williamson, 2000). Studies focusing on the perspectives and experiences of lesbian, gay and bisexual people of all ages consistently uncover evidence of internalised homophobia in their 'talk' about coping with everyday life (Barron & Bradford, 2007; Rostosky et al., 2007).

SEXUAL MINORITY YOUTH

LGBT youth are a vulnerable subset of the larger gay, lesbian, bisexual and transgender population and may lack fundamental support systems available to their heterosexual peers (Gonsiorek, 1988). The period of adolescence is a particularly important one in terms of the process of defining and forming sexual identity. As a period characterised by multiple transitions and developmental changes, adolescence is marked by identity challenges in many areas of life. However, those young people with emerging identities that are gay, lesbian, or bisexual, face particular dilemmas (Bagley & D'Augelli, 2000).

Research has demonstrated significant gaps in the social support available to LGBT youth from family, peers and school personnel (Martin & Hetrick, 1988; Muñoz-Plaza et al., 2002). Martin & Hetrick (1988) identified three main categories to describe the social isolation of LGBT youth – cognitive, social and emotional. *Cognitive isolation* was associated with their extremely limited access to information on issues related to sexual orientation; *emotional isolation* the result of constant negative messages about homosexuality from peers, school and family members; and *social isolation* associated with their reluctance or inability to tell peers and family members about their sexuality. While all young people can face potential stresses in their lives (bullying, loss of family members or friends, stress related to poverty, persistent family discord, parental divorce and racism) which may lead to mental health problems, the level and degree of victimisation and bullying faced by LGBT young people can be particularly traumatic. It also leaves a large majority isolated and alone in their quest to learn about their own identity. As Mosher (2001: 169) puts it, '[g]ay, lesbian, bisexual and questioning could potentially be left to forge their own identity with little or no social support'.

Parental knowledge and involvement in the 'coming out' process is a particular concern for lesbian, gay, bisexual and transgender youth. Teenagers typically feel fearful about coming out to their parents (Newman & Muzzonigro, 1993) and, to test reactions, it is not uncommon for some to come out to siblings or other close relatives before telling their parents (Edwards, 1996). Coming out to peers also engenders feelings of fear; young people may feel that, for their own protection, they must conceal their sexual and/or transgender identity. All of this might be viewed as unsurprising since the coming-out process takes place in, what Schneider (2001) terms, a context of heterosexism and homophobia. Hetrick & Martin (1987) described learning to hide as the most common coping strategy of lesbian and gay adolescents.

Schooling and sexuality

LGBT school-goers have been described as an 'invisible' minority and one of the most significant 'at risk' groups of adolescents (Savin-Williams, 1990; Mac an Ghaill, 1994). For many gay and lesbian youth, school is an intimidating environment where they face multiple and sometimes unremitting challenges. Indeed, schools are claimed to be deeply heterosexist institutions (Mac and Ghaill, 1991; Epistein & Johnson, 1998) and classrooms have been identified as the most homophobic of all environments (Elia, 1992; Ramafedi, 1987). One study of lesbian, gay and bisexual adults who had experienced bullying or abuse at school found that 72% had either feigned illness or played truant to escape a hostile school environment (Rivers, 2000).

Both within and outside the classroom, a presumption of heterosexuality dominates (Epstein & Johnson, 1994). Consequently, the school can be an unsafe place for gay and lesbian-identified pupils (Rivers, 1996; Douglas et al., 1997; Warwick et al., 2001). While hostility towards LGBT young people is not limited to educational settings, much of this harassment takes place during school hours on school property (Schneider & Travers, 1997). This makes openly lesbian, gay, bisexual and transgender youth particularly vulnerable to victimisation since attendance is mandatory. The widespread nature of homophobic bullying has been demonstrated by numerous UK and US studies which report that as many as 93%

of young gay, lesbian and bisexual people who are 'out' at school suffer verbal abuse (Mason & Palmer, 1996; Douglas et al., 1997; Hunt & Jensen, 2007). A recent US study found homophobic references to be strikingly represented in 14-15 year olds' reports of abusive name calling, while homophobic verbal abuse was rated much less seriously by students in general than either racist abuse or other taboo slang. The author concluded:

With apparently little concern for their antisocial ramifications, homophobic pejoratives, many of them vitriolic, constitute one of the most predominant categories of abusive language among young adolescents (Thurlow, 2001: 32).

Homophobic bullying has implications for the immediate and longer-term emotional well-being of young people, and their ability to cope and to achieve their full potential. Among other things, harassment of same-sex attracted young people can contribute to sleep loss, nervousness, absenteeism, truancy and underachievement (O'Shaughnessy et al., 2004; Rivers, 2000; 2001; Rivers & D'Augelli, 2001). Social isolation, ostracism, difficulty in maintaining relationships, as well as anxiety, depression and school phobia, are other possible outcomes of negative school experiences among sexual minority youth (Douglas et al., 1997). At-school victimisation among LGB youth may also lead to higher levels of substance use, suicidality, and sexual risk behaviours (Bontempo & D'Augelli, 2002). The experience of homophobic bullying can have long-term, as well as immediate, negative health consequences. Rivers' (2004) study of lesbian, gay and bisexual adults found symptoms of post-traumatic stress in 17% of adult participants who reported having been bullied because of their actual or perceived sexual orientation at the time.

Research suggests that teachers are often aware of bullying aimed at LGBT youth but are confused, unable or unwilling to address the needs of these pupils (Douglas et al., 1997; Norman et al., 2006; Warwick et al., 2001). Teachers can also be complicit in this intimidating behaviour and comments by some of their pupils. Buston & Hart's (2001) study of 25 non-denominational Scottish schools found that teachers did not always challenge the homophobic behaviour of their students and were themselves observed to engage in the teasing of boys about being gay. In this study, classroom observation also revealed instances where homosexuality was pathologised, treated as being about sexual behaviour and/or framed as dangerous. Across the 25 schools studied, Buston & Hart (2001:107) noted a 'strategic silence operating in relation to homosexuality', with teachers lacking the language of sex and sexuality that would permit them to deliver sex education which recognized the possibility of lesbian, gay, bisexual or transgender identities. In Ireland, research conducted by Norman et al., (2006) found that as many as 79% of teachers within second-level schools were aware of verbal or physical bullying that was homophobic in nature. The figure was much higher in boys' single-sex (94%) and co-educational schools (82%), with teachers in girls' single-sex schools least likely (55%) to encounter verbal bullying of a homophobic nature.

Research in both Ireland and the UK indicates that the theme of 'sexual orientation' is not tackled directly in schools' anti-bullying policies and documents (Adams et al., 2004; Norman et al., 2006). This suggests that there is no clear understanding of the need for policies in schools to manage and combat bullying directed at sexual minorities [3].

Likewise, the topic of sexual orientation is all but invisible within school-based Relationships and Sexuality Education (RSE) in Ireland. As a mandatory subject without a mandatory curriculum (Inglis, 1998), individual schools agree on the content of RSE in consultation with parents and the broader school community. Due regard must also be given to schools' (primarily Catholic) ethos, a situation which may present challenges given the level of confusion that apparently exists over the role and impact of 'ethos', as evidenced in a recent national study of the implementation of RSE in second-level Irish schools (Mayock et al., 2007). Sexual orientation is the subject of only two lessons in the resource materials available to teachers for the teaching of RSE at junior cycle and these may be interpreted as optional or discretionary[4] . This is particularly

3 In October 2006, the Equality Authority and the BeLonG To Youth Project launched an initiative to tackle homophobic bullying in second-level schools in the Republic of Ireland. This initiative seeks to promote the visibility of LGBT young people in schools and to address the issue of homophobic bullying through the use of posters and postcards. An information leaflet entitled 'Making your school safe for lesbian, gay, bisexual and transgender students', aimed at encouraging schools and teachers to take actions to tackle homophobic bullying, was distributed to schools nationwide.

4 See Mayock et al., 2007 for a full account of teachers' views on the content and delivery of RSE.

problematic given that the resource materials, and the RSE programme more generally, presupposes a heterosexual identity among the pupils. Kiely (2005: 261) describes the implications of this situation for gay and lesbian pupils succinctly:

The presumption of all students as heterosexual pervades the materials. Any acknowledgement of other identities or ways of being sexual in the world are confined to two lessons at post-primary level, in the name of tolerating different sexual orientations other than heterosexuality ... The omission of discussion on gay and lesbian lived sexualities and the presentation of identity as fixed, rather then contingent, impoverishes students' conceptions of themselves, their sexualities and the relational aspects of their sexual lives ... students identifying as gay, lesbian or bisexual, or students actively questioning their orientation or fearful of being constrained by any one identity or set of practices are not likely to have their sex education needs met in the kind of programme provided.

More recently, Barron & Bradford's (2007) study of fifteen young men aged 16 to 25, who attended an LGBT youth project in Dublin, has highlighted the extent of their marginalisation and exclusion in the school context. Many of the respondents in this qualitative study reported overt homophobic bullying in the form of name calling (e.g. 'faggot', 'bender', 'queer') and/or physical violence. The overwhelming expectation to be 'masculine' (e.g. talking about girls, playing football and generally being 'macho') led a number to devise strategies of self-representation and concealment in an effort to cope with, or resist, the hostility of the school environment. This 'resistance' was described by the authors in the following terms:
Their resistance to violence emphasised the importance of the visual codes of constituting sexuality, and entailed complex reflexive work on the body and on their own "talk repertoires". The idea was to pass as "straight" (Barron & Bradford, 2007: 246-247).

The claim by Epstein & Johnson (1998) that schools need to address pupils' sexual cultures has particular resonance in light of the relatively limited number of studies of LGBT people's school experiences in Ireland. It seems clear, therefore, that school can be a difficult environment for LGBT youth and a site where they experience stress, prejudice and discrimination.

LGBT PEOPLE AND SUICIDE RISK

Suicide in Ireland

Over the past two decades there has been a marked increase in the reported rate of completed suicides in the Irish population (Allen 2005). This increase has been noted in males and females, although the male rate of suicide remains significantly higher than that of females (Allen, 2005; Health Service Executive (HSE), 2005). While Ireland ranks around the mid-range for European countries in terms of its overall suicide rate, Ireland's youth suicide rates are the fifth highest in the European Union and Ireland also has the highest male/female differential in Europe (Allen, 2005). Records of the incidence of self-harm [5] have also shown an increase and, compared to completed suicides, the recorded rates of deliberate self harm are highest amongst females across the age range (Allen, 2005).

There has been significant debate regarding the reliability of available statistics, particularly with regard to the marked rise in recorded completed suicides. Allen (2005), for example, has drawn attention to problems regarding the reliability of reported rates in light of the historical, cultural and legal context in Ireland. Suicide remained an offence under Irish law up until its decriminalisation in 1993 and it is claimed that the marked increases in suicide rates seen in the past decade may be attributable, in large part, to reporting and recording influences (Cantor et al., 1997). However, this position is contested, with Kelleher et al., (1997) arguing that under-reporting was quite limited in the past and that suicide rates have in fact increased. Debates continue regarding the accuracy of reported rates and the reliability of data in this area remains a concern (see Corcoran et al., 2006). Nonetheless, the available literature points to possible under- rather than over-reporting of suicide.

5 The National Strategy for Action on Suicide Prevention – 'Reach Out' recognises that the terms 'Deliberate Self Harm' (DSM), 'para-suicide', 'attempted suicide', and 'Not full suicide behaviour' are often used interchangeably. The strategy document opted to use the term 'Deliberate Self Harm'.

Characteristics of studies of minority sexuality and suicide risk

Several studies have explored the relationship between minority sexuality and suicidality (Skegg et al., 2003; Warner et al., 2004). The term 'suicidality' is variously used to describe and include suicidal ideation, suicide attempts and deliberate self-harm. Some studies have focussed exclusively on adult males (Cochran & Mays 2000; Paul et al., 2002; Hidaka & Operario, 2006), females (Diamond, 2000), or on youth (Safren & Heimberg, 1999; Fergusson et al., 1999; Bontempo & D'Augelli, 2002; Wichstrom & Hegna, 2003), while others have taken a broader sample across variables of age and gender. More recent studies conducted in this area (with a particular emphasis on young people) have included, in addition to lesbian, gay and bisexual populations, the category of 'questioning', to incorporate those who are questioning their sexuality (Bontempo & D'Aguelli, 2002; Hidaka & Operario, 2006).

A significant feature of the available research is the relatively limited number of studies on suicidality risk among the transgender population. Some of the methodological issues involved in researching a sector of this population in the Irish context are highlighted by Collins & Sheehan (2004) and include definitional confusion across the literature and difficulties in accessing this group. However, available research points to high levels of discrimination and stigmatisation experienced by transgender people and increased levels of suicidality (Clements-Nolle et al., 2001).

Critiques of research conducted on the relationship between minority sexuality and suicidality have focussed on what have been identified in some studies as shortcomings in relation to sample size and the lack of comparative demographic groups (Remafedi, 1999; Safren & Heimberg, 1999). However, Eisenberg & Resnick (2006) note that more recent studies have addressed these concerns by using population-based samples and appropriate comparison groups (see for example: de Graaf et al., 2006; Wichstrom & Hegna 2003).

A further methodological issue highlighted is what Wichstrom & Hegna (2003:145) characterise as the 'imprecise manner' in which definitions are operationalised. Across available studies definitions of what constitutes minority sexuality varies, for example, in a population based sample from the Netherlands sexual contact with a member of the same sex in the preceding year was used to categorise respondents as homosexual (de Graaf et al., 2006). Whereas Saewyc et al., (2004) recommend a multi-dimensional assessment of sexual orientation. In Wichstrom & Hegna's (2003:145) population-based sample of Norwegian adolescents, information on sexual orientation was captured across three dimensions: behaviour, attraction and identity.
Wichstrom & Hegna (2003) also suggest that, in some studies, different aspects of gender are not adequately dealt with in statistical analysis which may mask gender-related differences in experiences. In addition, the temporal dimensions of the relationship between suicidality and sexuality are not adequately addressed. This is a point also raised by Hidaka & Operario (2006) in an internet-based study, where the relationship between a suicidal 'event' and sexuality can be confused across time.

Relationship between suicidality and sexuality

In seeking to explain the relationship between evidence of an increased risk of suicidality amongst sexual minorities, much of the research has hypothesised on aspects of stigmatisation associated with sexual orientation (Hidakia & Operario, 2006; Savin-Williams, 1994; Safren & Heimberg, 1999). Specific aspects such as fear of rejection (Bontempo & D'Augelli, 2002; Safren & Heimberg, 1999; Wichstrom & Hegna 2003), higher levels of victimisation and experiences of humiliation (Bontempo & D'Aguelli, 2002; Safren & Heimberg, 1999) have been indicated.

Even in societies characterised as relatively liberal, the process of identity formation associated with 'coming out' takes place against a backdrop of stigma, where social structures and 'sexual scripts' are lacking for sexual minority youth in comparison to their heterosexual peers (Wichstrom & Hegna, 2003:149). In de Graaf et al's (2006:254) study, the authors hypothesised that those in the younger age group in their study would have experienced less discrimination, given the 'increased acceptance of homosexuality in Dutch society'; however, their findings in fact indicated the opposite. The concept of 'minority stress' (Meyer, 1995) has been operationalised to explain aspects of specific stressors relevant to minority groups.

In addition to the increased risks of suicidality evidenced in the LGBT youth population, there is also evidence supporting links with other risk factors, including depression, substance misuse and violence and victimisation (Clements-Nolle et al., 2001; Eisenberg et al., 2006). The particular vulnerability of sexual minority youth is indicated across the literature (Bontempo & D'Augelli, 2002; Fergusson et al., 1999; Wichstrom & Hegna, 2003). However, an important emergent trend in research in this area is the recognition that LGBT youth are not a homogenous 'at risk' group, and that aspects of resilience are also relevant (Borowsky et al., 2001; Eisenberg et al., 2006; Fenaughty & Harré, 2003). Possible differentials across gender (Wichstrom & Hegna, 2003), socio-economic groups, family context (Eisenberg et al., 2006) and school environments (Bontempo & D'Aguelli 2002) have also been noted.

While there is evidence from Northern Ireland that many LGBT people report incidents of self-harm and attempted suicide (Youthnet, 2004), there is no published study in the Republic of Ireland on suicidality in the LGBT population. Internationally, some of this research has been undertaken as part of broader population surveys (Fergusson et al.,1999 [6]; de Graaf et al., 2006 [7]; Eisenberg et al., 2006 [8]). The relatively unexplored nature of this area in the Republic of Ireland – and the absence of established baseline data on suicide risk among LGBT people – strongly suggests that research of this kind is long overdue.

LGBT RESILIENCE

It is only recently that resilience research has focussed specifically on lesbian, gay, bisexual and transgender people. The concept of resilience, particularly when juxtaposed with that of risk, has been the subject of a growing body of research (Garmezy, 1991; Hauser, 1999; Rutter, 1987). While it has been noted that resilience can be an 'elusive concept' (Fraser et al., 1999), it has been variously conceptualised as the achievement of positive outcomes in the context of adversity (Fraser et al., 1999). Ungar (2004: 342) is critical of this narrow definition and argues that resilience should be viewed more broadly 'as the outcome from negotiations between individuals and their environments for the resources to define themselves as healthy amidst conditions collectively viewed as adverse' (Ungar, 2004: 342). Ungar (2004) advocates an approach to understanding resilience that takes adequate account of cultural and contextual differences. Increasingly, resilience is viewed as a dynamic construct (Fraser et al., 1999) and as a process rather than a trait (Connolly, 2005).

Studies have explored the concept of resilience in relation to same-sex partnerships (Connolly, 2005), family networks (Oswald, 2002), and specifically in relation to sexual minority youth (Eisenberg et al, 2006; Trotter, 2000). Indeed critiques of previous research on sexual minority youth have advocated a move from a singular focus on pathology to one that seeks to explore aspects of resilience, strength and positive coping. Savin-Williams (2001a:11) is a lead advocate of approaches to LGBT lives that take account of 'ordinariness' and resilience:

As researchers we must strive to move beyond traditional paradigms to explore how sexual-minority adolescents are like all other adolescents and how they vary among themselves. In this process their resilience and ordinariness will become apparent.

The exploration of resilience can help to provide a framework for better understanding specific ways in which LGBT people protect themselves against stressors and overcome adversity. This is important since we know that, despite a multitude of stressors, lesbian and gay people experience success and happiness (Connolly, 2005; Riggle et al., 2008). Thus, a singular focus on risk, without corresponding attention to processes and mechanisms that are enabling, constructive and healthy, may serve to further marginalise LGBT people through a misrepresentation of their lives and experiences. It may also serve to obscure the multi-faceted nature of their struggle and success in overcoming prejudice and discrimination. To date, however, LGBT people's capacity to successfully manage and negotiate their life circumstances has been neglected in international research and certainly in the Irish context.

6 Data from this study was collected from a 21 year Longitudinal Study focussing on health and development.
7 This study was based on a wider Mental Health Incidence Survey conducted across the Netherlands.
8 Data was derived from a State wide Student Survey which focuses on health, safety and academic issues.

LGBT MENTAL HEALTH: THE POLICY CONTEXT

Policy development

From the early 1990's onwards, there has been significant policy development in Ireland on foot of emerging concern about increasing suicide rates (Allen, 2005). In 1995, the National Task Force on Suicide Prevention was established by the Minister for Health and Children. The subsequent publication of the Task Force report in 1998 (Department of Health and Children, 1998) led to the establishment of the National Suicide Review Group and provided the 'blueprint' for the National Suicide Prevention Strategy (Allen, 2005: 97). The recommendations of the Task Force (1998) also led to the establishment of the National Parasuicide Registry, which collates national information on incidences of self-harm based on reports from hospital Accident and Emergency Units. However, a study focussing on the mental health of young people has indicated that the rate of self-harm among the young may be significantly higher than that recorded on the registry (Sullivan et al., 2004).

In 2005, *Reach Out, National Strategy for Action on Suicide Prevention, 2005-2014* (HSE et al., 2005) set out a 9-year strategy, including the establishment of the National Office for Suicide Prevention. This Strategy places an emphasis on broad-based public health initiatives such as the development of school-based education programmes and public awareness campaigns in addition to a targeted emphasis on what it characterises as the potential 'vulnerability of excluded, marginalised groups in society' (HSE, 2005:37). LGBT people and young people are identified as being particularly vulnerable or 'at risk'. The potential for increased vulnerability among LGBT people has received growing recognition within policy documents of late, including the 2001 Report of the National Suicide Review Group (Chambers & Callanan, 2001) and the most recent Report of the Joint Committee on Health and Children (2006) (see also Crowley 2003). However, the cited research in this area leans heavily on international studies and, to date, no Irish study has focussed specifically on the relationship between minority sexuality and increased vulnerability to suicide risk. *Reach Out, National Strategy for Action on Suicide Prevention*, 2005-2014 (HSE et al., 2005:37) explicitly recognises that suicide risk among LGBT people is an area requiring further investigation.

The healthcare needs of LGBT people have also gained some attention within the broader policy context, including the *National Women's Strategy, 2007-2016 (Government of Ireland, 2007) and the Report of the Commission of Assisted Human Reproduction* (Department of Health and Children, 2005). These developments indicate that the health needs of LGBT people, and equality of access to health care, are issues that have garnered increased attention in the Irish policy context.

In addition to the developments specific to LGBT health noted above, there have been significant policy developments across the mental health sector in the past decade. *Vision for Change: Report of the Expert Group on Mental Health Policy* (Department of Health and Children, 2006a) set out the agenda for the development of community-based, holistic mental health services. This document highlights specific problems related to child and adolescent mental health service provision and argues for the development of services appropriate to the needs of children and young people. It also makes reference to the specific needs of the LGBT population (Department of Health and Children, 2006a:162) and recommends further research in this area.

LGBT healthcare access – service and policy context

LGBT people are claimed to be an invisible minority in the health services arena and they face documented structural, financial, personal and cultural barriers when attempting to access health care services (Clover, 2006; Diamant et al., 2000; Jillson, 2002). These barriers tend to alter individuals' behaviour and attitudes towards health care providers and may adversely affect their willingness to access services and supports. Conversely, a safe healthcare environment that is affirmative to LGBT people disclosing their sexual and transgender identities positively influences health outcomes (Hart & Flowers, 2001). However, research has highlighted differential use of healthcare provision by LGBT clients (Heck et al., 2006). For example, a recent US study reported higher Accident & Emergency access by LGB clients that their heterosexual counterparts (Sanchez et al., 2007).

The international literature has consistently noted differential access and treatment of LGBT people

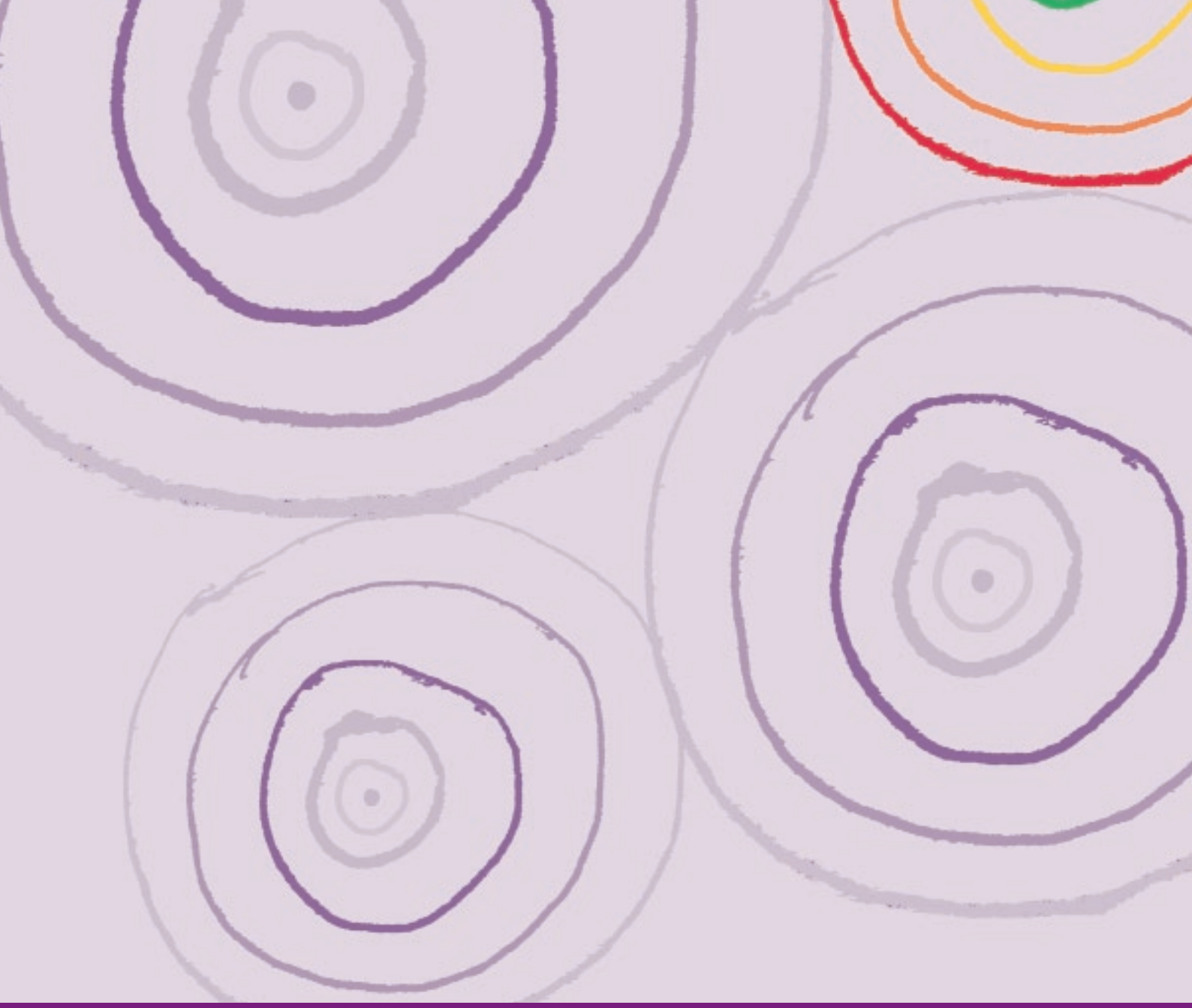
within healthcare settings (Bonvicini & Perlin, 2002; Diamant et al, 2000; Fish, 2006). Much of the research in this area notes that healthcare providers tend to operate within a 'heterosexual frame of reference' (Neville & Henrickson, 2006: 409) and that lesbian, gay and bisexual clients may not receive appropriate healthcare because their specific needs are ignored or negated. Lesbian, gay and bisexual people may be reluctant to discuss their sexuality with healthcare providers because of fears of possible negative consequences, including breaches of confidentiality and overt homophobia (Jillison, 2002; Seaver et al, 2008). The findings of an Irish study by Dillon & Collins (2004) based on reports from service providers, indicate that lesbians and gay men may be extremely reluctant to discuss sexuality issues with mental health professionals.

Young LGBT people may be particularly reluctant to engage with or access healthcare services because of specific concerns regarding confidentiality. In contexts where they are not 'out', many fear that their parents may be informed about their sexuality (Ginsburg et al., 2002; Ryan, 2003). Research has also demonstrated that the specific mental health needs of LGBT clients may not be recognised in healthcare settings (Robertson, 1998) and questions have been raised about the capacity of mental health services to meet the needs of LGBT clients (Dean et al., 2000). For transgender people, problems of access to appropriate healthcare have been consistently noted in the international literature (Bockting at al, 2004; Hines, 2007; Sperber et al., 2005). Irish research has similarly highlighted the absence of appropriate services and the lack of understanding and awareness among health care providers of the healthcare needs of transgender people (Collins & Sheehan, 2004).

Other issues affecting the quality of healthcare that LGBT people receive include a presumption of heterosexuality, failure to adequately recognise partners and LGBT family structures, and a failure to address certain health-related issues. For example, several studies on lesbians' experience of healthcare note the inadequacy of gynaecological services that focus exclusively on the sexual and reproductive health of heterosexual women (Seaver et al., 2008; Westerstahl et al., 2002). While much of the literature on healthcare access among LGBT people has been conducted in the US and UK, a number of Irish studies have highlighted problems of access to healthcare. These have consistently expressed concern about the adequacy and quality of health and wider social care available to LGBT people in Ireland (Collins & Sheehan, 2004; Dillon & Collins, 2004; Foreman & Quinlan, 2008; Gibbons et al., 2007).

CONCLUSION

Internationally, investigators over the past 30 years have documented the considerable empirical support linking LGBT populations with mental health problems such as depression, anxiety, substance abuse and suicidality. With suicide attempt rates that often triple those of heterosexuals, LGBT individuals may experience a lifetime spiral of personal victimisation, social and cultural stigmatisation without adequate sources of support. The result is 'minority stress' and consequent mental health problems. However, little is known in an Irish context about the kinds of experiences that can potentially contribute to mental health problems among LGBT people. This study aims to address this gap in knowledge and to examine elements of the broader social context that impact the mental health and well-being of LGBT people in Ireland. The following chapter outlines the research methodology.



CHAPTER 2 RESEARCH METHODOLOGY

RESEARCH METHODOLOGY

As highlighted in the previous chapter, there is a dearth of research on LGBT people in Ireland and stark gaps in knowledge and understanding of the issues and everyday experiences that impact on the mental health and psychological well-being of people who identify as LGBT. This research set out to examine mental health and well-being among LGBT people in Ireland with specific attention to:

- The identification of experiences that heighten vulnerability to suicidal behaviour among LGBT people in Ireland, with special emphasis on young people.
- The identification of experiences that strengthen resilience in the lives of LGBT people.

A core aim of the study was to make policy, service delivery and practice recommendations related to mental health promotion and suicide prevention.

RESEARCHING LGBT MENTAL HEALTH AND SUICIDE RISK

The definition of suicidal behaviours is not straightforward (Kerfoot, 2000; Russell, 2003) and there are several methodological challenges associated with the investigation of suicide risk. Likewise, the conduct of research with sexual minorities or those who identify as transgender presents methodological and ethical challenges (McManus, 2003). The research strategy outlined in later sections was formulated with due regard to the following methodological and ethical considerations:

1. Identifying sample populations:

Given the lower prevalence of same-sex orientation and transgender identity in the general population, very large samples are required for population-based studies to yield the numbers of sexual minority people suitable for analysis of predictive risk factors for suicide [1]. Time and budgetary constraints did not permit the generation of a large-scale representative sample of LGBT people in the context of the current study.

2. Measuring/assessing suicide risk:

The measurement or assessment of suicide risk is notoriously fraught and is conceptualised differently across existing studies. Most available studies are based on multiple self-reported indicators of suicidality, including suicidal thoughts, intent and plans, as well as the number and severity of actual suicide attempts (Russell, 2003).

3. LGBT and suicide research in Ireland:

To our knowledge, no published research has specifically investigated suicide risk among LGBT people in the Republic of Ireland. This low base of previous knowledge suggested that an exploratory approach would be best suited to establishing a reliable baseline picture. Operating within what they described as a 'virtual research vacuum', Hubbard & Rossington (1995: 20) similarly adopted a mixed-method exploratory approach when researching the housing and support needs of lesbians and gay men in the UK.

4. Researching sensitive topics and vulnerablepopulations:

The topic of suicide is clearly a sensitive area of research. Likewise, researching LGBT people poses challenges. LGBT young people, in particular, may not be open about their sexual orientation or

1 There is acknowledgement and extensive discussion of the problems involved in constructing representative samples of LGBT people (e.g. GLEN and NEXUS, 1995; Webb & Wright, 2001). The preferred approach to sampling depends on the purpose, subject, methodology and resourcing of a project (McManus, 2003).

transgender identity (D'Augelli & Grossman, 2006) and they may be reluctant to participate in research projects. While surveys have the advantage of yielding large volumes of data, qualitative methods need to be considered for 'how' and 'why' questions (McManus, 2003).

RESEARCH STRATEGY

This research adopted an exploratory multi-modal approach to the study of mental health and well-being, including the investigation of suicide vulnerability (risk) and resilience, among LGBT adults and young people in an Irish context. A combination of quantitative and qualitative research techniques (described in detail in later sections) was used, involving the following data collection methods:

- The administration of a primarily quantitative, anonymous on-line survey
- A 'Community Assessment Process'
- The conduct of in-depth qualitative interviews

ANONYMOUS ON-LINE SURVEY

Since large-scale surveys based on random sampling techniques tend to be very expensive to administer and also tend to identify very few LGBT individuals, an online survey was developed with a view to accessing a sufficiently large community sample. The internet, which is a comparatively new method of recruitment where LGBT research is concerned, offers one of the most targeted, easily accessible and affordable means of generating a relatively large sample size. Internet-based surveys have been identified as especially useful in the context of research of a deeply personal and sensitive nature as they allow for a greater degree of anonymity with an increased likelihood of participation compared with other recruitment methods. Moreover, survey data collected via the internet has been identified an acceptable method for collecting large, heterogeneous samples with hard-to-reach populations (e.g. Birnbaum, 2004; Rhodes et al., 2003).
A survey instrument, which took approximately 15-20 minutes to complete online, was designed to capture the experiences of LGBT people living in Ireland in a variety of settings and contexts. The survey instrument included demographic variables, information about gender identity, sexual orientation, behaviour, attraction, school and workplace experiences. Perceptions of belonging, victimisation and harassment were surveyed, as well as levels of verbal and physical abuse experienced by individuals. Items and measures capturing various correlates, dimensions and indicators of psychological well-being, including alcohol use, self-esteem, family and social support, history of self-injurious behaviour and attempted suicide were also included.(A copy of the survey instrument is appended).

The survey was built using a popular survey design tool, the link to which was hosted on a webpage with the domain name **www.lgbtlives.ie**. A variety of recruitment strategies were used in an effort to maximise participation in the online survey, including 'flash banners', logos, and hyperlinks on websites related to LGBT groups and issues. Over 600 posters and 6000 postcards containing the link to the survey and information about the study were displayed or distributed at relevant LGBT-related venues and events, health services and public libraries. Advertisements were placed in the LGBT press and in a small number of provincial newspapers. The survey went live on November 1st, 2007 and was active for a period of three months.

While the survey was constructed primarily for the purposes of gathering quantitative data, a text box was included to provide participants with the opportunity to make general comments or to discuss issues that had not been covered in the questionnaire. Over 400 respondents (out of a total of 1,110) used this facility, in many cases offering detailed explanations of their responses, or in-depth accounts of their experiences. Thus qualitative comments from the online survey complement data garnered from the in-depth interview dimension of the research (described in more detail below), and were used to inform the analysis as a whole.

COMMUNITY ASSESSMENT PROCESS

A Community Assessment Process (CAP) (Clatts et al., 2002; 2005) was initiated early in the data collection process [2]. The objectives of this phase, which was essentially one of engaging with a range of professionals across the LGBT community sector, were two-fold. First, the CAP aimed to inform professionals in the LGBT community and wider health sectors about the study, its aims and data collection procedures. It was hoped that this strategy would promote awareness of, and participation in, the study. A second aim was to investigate the perceived prevalence of mental health problems in the LGBT adult and youth populations. Particular emphasis was placed on gathering information about the service needs of LGBT people, the availability of services, and barriers to service access and use among LGBT adults and young people.
Contact was made with professionals in a variety of mainstream mental health and LGBT-specific services nationally. Researchers then invited a selection of individuals to participate in a semi-structured interview. These interviews targeted key informants at government, national and service-levels. At service-level, the research team sought access to organisations with a specific remit in the provision of social/health care to LGBT adults and young people. A total of 14 individuals were interviewed individually during this phase of the research process.

By providing researchers with opportunities to begin informal discussion with a network of key informants, the CAP also facilitated entrée to field settings for the purpose of recruiting participants for individual in-depth interview (see below). Professionals working at service level were qualified to provide important information about the LGBT population and they were also well positioned to provide introductions to potential respondents. During interviews with service providers researchers sought their advice on how best to recruit participants for individual interview. The research team thus accumulated 'local knowledge' incrementally as the CAP interviews progressed and this, in turn, guided the sampling process (see later section).

QUALITATIVE IN-DEPTH INTERVIEWS

In a review of health issues facing young people, Aggleton (1996) concludes that it is useful to think of young people moving in and out of different *cultures* and *context*s of health. Young people, he suggests, may engage with, and disengage from, multiple health risks associated with these contexts at different points in their lives. This helps us move away from an *individualised perspective of risk*, to think about the contexts within which lesbian, gay, bisexual and transgender people of all ages live their lives. Since it is often specific contexts and circumstances that promote, or damage, people's sense of mental health and well-being (Warwick et al., 2000), the qualitative interview provides an ideal means for investigating the social, personal, educational, familial and economic contexts that can potentially impact on the lives and experiences of LGBT adults and young people. Qualitative interviewing privileges participants' 'stories', accounts and interpretations (Krippendorf, 1980). It is, therefore, particularly suited to uncovering experiential dimensions of risk and resilience.

The study aimed to conduct 30-40 semi-structured in-depth interviews with lesbian, gay, bisexual and transgender adults and young people. Semi-structured interviews have the advantage of having a list of predetermined questions whilst permitting the order of questions to be modified based on the interviewer's perception of what seems most important (Fielding, 2003). The interview schedule was designed following a thorough review of existing national and international research on LGBT adults and youth. A core aim was to examine the experiences (social, educational, familial, peer-related) of LGBT people and the influence these had on their mental health status, including any links to suicide risk. The interview also sought to identify resiliency factors that help to distinguish LGBT people who cope successfully with stress from those who show increased mental health problems.

2 A 'Community Assessment Process' has been used previously in the conduct of research on marginalised or 'at risk' groups in an Irish context (Mayock & Carr, 2008; Mayock & O'Sullivan, 2007).

The in-depth interview

The interviews focused on the life 'stories' of LGBT people. Respondents were encouraged to talk about their everyday lives, their experiences of school, family life and peer relationships, as well as their social life and leisure activities. Specific interview topics and questions targeted experiences that may have been challenging, difficult or stressful (e.g. experiences of discrimination, homophobic bullying, stress associated with 'coming out' to family and peers). Questions also focussed directly on any experience of depression, anxiety or loneliness and on respondents' use of alcohol and/or drugs. Other sections of the interview concentrated on positive experiences and protective factors. Respondents were asked about their coping strategies and the social supports available to them, as well as individuals, groups and agencies/institutions that have acted as supports or enablers in their lives. Finally, the interview sought respondents' experiences of service access and use, including primary health care services, sexual health services, LGBT-specific services and counselling/psychological services.

Throughout the interview, considerable emphasis was placed on accessing respondents' *perceptions* and *understandings* of risk, an approach which does not assume a particular experience of risk (for suicide or other mental health problems) in people's lives. In other words, the interview gave considerable scope for respondents to identify and discuss *experiential dimensions of risk* (and coping) that were relevant to their everyday lives. The interview itself was conversational in style, both young people and adults were encouraged to take the lead in the identification of topics and issues that were personally relevant.

Locating the sample

A core task for the research team was to generate a sample by identifying geographic, physical or organisational locations suitable for the recruitment of LGBT adults and young people for interview. The research team concentrated its efforts initially on the following access routes:

- LGBT organisations, services and interventions
- LGBT venues and clubs

Identifying appropriate 'gatekeepers' within the LGBT population or community was a critical first step in this process. Professionals who work directly with LGBT people were positioned to provide an insider perspective, to identify access routes to potential participants and to endorse the value of the research. Nonetheless, introductions alone did not automatically lead to the conduct of interviews. Establishing credibility, and building trust and rapport with participants, was essential to the recruitment process.

Sampling strategy

Mixed sampling strategies were used to select adults and young people for in-depth interview. These strategies included purposive, snowball, and targeted or critical case sampling techniques (as outlined below). The selection and use of these sampling strategies allowed for emergent design flexibility, permitting the addition of new and appropriate approaches to sampling as the study progressed. One of the advantages of using combined sampling strategies is that it helps to maximise the number of people with a chance of being selected (McManus, 2003). It also helped to ensure relevant *diversity* across key variables such as gender, age, ethnicity and sexual orientation. While the qualitative sample makes no claim to being 'representative' of the LGBT population, the sampling strategies were utilised *systematically* with the aim of including adults and young people who have a diverse and illustrative range of experiences.

Purposive sampling enabled the research team to build up a sample that satisfies the needs of the research/evaluation project and its specific aims (Robson, 2002). Efforts were made to access interviewees through contact with LGBT services and organisations, the Community Assessment Process assisted with this.

Snowball sampling, a technique frequently used in the study of sensitive topics, particularly where the study group is 'hard-to-reach' (Lee, 1993) and/or unenumerated (Martin & Dean, 1993), was also used. This involved asking respondents to suggest others who may be eligible and agreeable to taking part. The

technique of snowballing was used only when deemed appropriate as the research team was mindful of the risk of sampling bias that can occur through an over-reliance on networks of peers whose members are likely to be similar in age, gender and sexual orientation (Biernacki & Waldorf, 1981). Finally, targeted or critical case sampling was used as the study progressed to 'target' particular individuals or groups that could potentially contribute to the study of variability of experience. For example, groups considered to be particularly marginalised or 'at risk' – including early school leavers – were targeted for participation. This was achieved through the team's use of new and existing access routes to socially excluded groups.

DATA ANALYSIS

Quantitative data analysis

Quantitative data were analysed with the use of the Statistical Packages for the Social Sciences programme (SPSS). The analysis sought to provide an overall descriptive profile of the social and psychological experiences of members of the LGBT population in an Irish context.

Qualitative data analysis

Verbatim transcripts of all interviews conducted with stakeholders, service providers, adults and young people were prepared. The qualitative data analysis process was sensitive to the following stages and sequence of analysis:

Generative and emergent stage: Analysis began when team members started to generate ideas for making sense of the data while still in the field. Ideas about directions for analysis were recorded and new hypotheses also emerged that informed subsequent fieldwork.

Confirmatory stage: Later stages of fieldwork enabled the team to move towards confirmatory data collection, deepening insights into, and confirming (or disconfirming), emerging patterns in the data.

Systematic analysis following fieldwork: Writing case studies and conducting cross-case analyses based on rigorous review of interview transcripts. To facilitate an in-depth analysis of interviews with stakeholders, service providers and LGBT adults and young people, NVivo, an integrated software package for qualitative data analysis, was used to organise the data into more manageable 'chunks'. This in turn facilitated multi-level narrative and thematic analyses. These coded data were analysed for key themes (or variables). Some of the themes were anticipated but new themes also emerged throughout the analytic process. Pattern coding (Krippendorf, 1980) facilitated the analysis of configurations of factors such as gender, age and personal circumstances that impact on the lives and experiences of LGBT adults and young people.

In the presentation of study findings, representations of respondents' experiences and perspectives are supported by excerpts from interview transcripts and the comments of online participants. All quoted excerpts are presented as closely as possible to participants' own words. In some cases minor editing was required to make narratives more comprehensible to the reader. All major identifiers (names of towns or other local areas, names of family members, friends and so on) have been removed to preserve confidentiality and anonymity. At the end of each narrative excerpt, the speaker is identified by sexual orientation (gay, lesbian, bisexual), gender and age. The terms 'male-to-female trans' or 'female-to-male trans' are also included as identifiers in the case of participants who identified as transgender . The term 'survey participant' is also included where appropriate to denote that the narrative is derived from the online survey.

ETHICAL, CONSENT AND CONFIDENTIALITY PROCEDURES

This project was reviewed and approved by the Ethics Committees at the Children's Research Centre, Trinity College Dublin, and University College Dublin, respectively.

Ethical procedures

All adults and young people were informed about the nature and purpose of the research prior to their participation in the study. An accessible written account of the study's aims was made available to all prospective participants and individual interviews were conducted only after researchers had given a detailed verbal account of precisely what the interview would entail. Written documentation of voluntary informed consent was obtained from all participants prior to the conduct of individual interviews. Parental consent was attained in the case of all participants under the age of 18 years.
All participants reserved the right to refuse to participate in the study and to withdraw from the study even after participating in an interview. Participants received assurances of confidentiality, including the assurance that their name or other identifying information would not be mentioned in any written dissemination of the research findings. Equally however, participants were informed that if they disclosed information indicating they were at risk or in danger, it was the obligation of the researcher to inform an appropriate individual.
To ensure confidentiality and anonymity, the following specific procedures were adhered to:

- Code numbers were assigned to identify data
- All data were stored in locked files and separated from identifying information
- All identifiers (place names, names of family members or friends, etc.) were removed from the transcript material

Protecting research participants

This study focuses on a highly sensitive area of investigation and it was recognised that participants may be placed at risk unless appropriate protective mechanisms were in place from the outset. Prior to the initiation of the recruitment and interviewing processes, all interviewers participated in Applied Suicide Intervention Skills Training (ASIST) [3]. This two-day interactive course provides training in 'suicide first-aid' and aims to train participants to reduce the immediate risk of suicide, where a person is suicidal, and to increase the support available to that individual. This training was undertaken to equip researchers to respond appropriately to participants disclosing suicidal intent in an interview context.

There was a risk of respondents becoming upset or distressed during interview. This possibility is acknowledged in the literature on the conduct of research that is deemed sensitive, or that deals with the private realm of experience and emotion (Lee, 1993; Renzetti & Lee, 1993)[4] . A protocol outlining the procedures and safeguards to be implemented when conducting individual interviews was drawn up and made available to all members of the research team. This document outlined specific procedures that researchers were to adhere to in the event of a respondent showing signs of psychological distress during the interview. At the end of the interview all respondents were given an information pack with contact details for organisations and agencies offering support and advice, along with literature and official publications related to equality for LGBT people.

3 The course is co-ordinated by the NOSP at the national level and delivered by regional trainers across the country.
4 Although 'sensitive' interviewing may be an emotionally charged experience for some participants (Platzer & James, 1997), equally, research has demonstrated that such interviews can be a cathartic or pseudo-therapeutic experience for participants (Lowes & Gill, 2006; Morecroft et al., 2004). As Lowes & Gill (2006: 594) put it: 'It would appear that providing a non-judgemental and confidential environment, where participants can talk about their experiences in an open and unhurried manner with someone who is genuinely interested in what they have to say, can be of mutual benefit to researchers and participants'.

CHAPTER 3 RESPONDENT PROFILES

RESPONDENT PROFILES

This chapter provides an overview of both the quantitative and qualitative samples on which this research report is based. Demographic details of those who participated in in-depth interviews are provided first, followed by an overview of the respondent profile of online survey participants, based on data gathered during a three month period spanning November 2007 through January of 2008.

IN-DEPTH INTERVIEW SAMPLE

A total of 40 individuals took part in in-depth interviews. These participants ranged in age from 16 to 62 years, with an average age of 31 years. Forty percent of the sample (n = 16) were aged 25 years or under. Young people therefore were well represented in the qualitative sample.

Half of the qualitative sample were male (n = 20), all of whom identified as gay. Just over two fifths of the interviewees (n =16) identified as female, the vast majority of whom (n = 14) self-identified as lesbian, and two of whom identified as bisexual. Transgender participants constituted ten percent of the sample (n = 4), one of whom identified as 'female-to-male' and three as 'male-to-female' transgender. Two transgender participants identified as heterosexual, one as lesbian, and one did not identify with any of these commonly ascribed categories of sexual orientation.

Urban participants made up three quarters of the overall qualitative sample (n = 30), while the remainder were living in rural (n = 9) or semi-rural settings (n = 1). A higher proportion of the sample however (40%), had grown up in a rural setting. Ethnic minorities made up over 12% of the sample (n = 5). Sixty percent of the sample (n = 24) were in full-time employment, one was employed part-time, four were enrolled in school, five were enrolled in third level education, five were unemployed, and one was in receipt of a disability allowance at the time of taking part in the research.

ONLINE SURVEY SAMPLE

Findings from the online survey are derived from a large, community-based sample of self-identified LGBT people living in Ireland, or who had previously done so. A total of 1,110 completed surveys were included in the final data set, representing a completion rate of over 80 percent.[1] While it is not possible to determine a response rate, in light of the nature of the online recruitment strategy, it can be said that this constitutes a very large sample of LGBT people, enabling an expansive view of the lives of LGBT people in Ireland. Nevertheless, it is not possible to determine the representativeness or otherwise of the sample, given the lack of census data on the LGBT population in Ireland. The fact that participation in the survey was limited to those with internet access, and that participants were recruited primarily through LGBT venues, web-sites and groups, means that the perspectives of those who experience same-sex attraction but who don't identify as LGBT for example, or those who do not have internet access, or do not attend LGBT venues are, in all likelihood, underrepresented. These limitations are addressed more fully in the conclusion to this chapter and in Chapter 8.

Age

Online survey respondents ranged in age from 14 to 73 years with a mean (average) age of 30.5 years and a standard deviation (hereafter s.d.) of 9.93. Eleven percent of participants were under the age of 20 at the time of completing the survey; 43% were in their 20s, 27% were in their thirties, 14% were in their forties, four percent were in their fifties, and less than one percent were in their 60s/70s (see Table 3.1 below). Thirty five percent of the overall sample were 25 years of age or younger. Those over the age of fifty, and particularly those 60 or older were underrepresented in the survey. Furthermore, while young people in general are well-represented in the survey sample, only 6% of the overall sample was 18 yearsof age or under, which means that the number of participants of school-going age was limited.

1 Surveys were deemed invalid and excluded from the final dataset if they were incomplete, replicated, or if the respondent indicated that they had never lived in Ireland.

Table 3.1: Respondents' age: survey sample

Age	n	%
Under 20 years	124	11
20 – 29 yrs	477	43
30 – 39 yrs	300	27
40 – 49 yrs	152	14
50 – 59 yrs	44	4
60 yrs and above	13	1
Total	1110	100

Residence

Over ninety percent of survey respondents (n = 1011) were resident in the Republic of Ireland at the time of completing the survey. A far smaller proportion (4%, n = 50) were living in Northern Ireland, and a similarly small percentage (all of whom had previously lived in Ireland) were living abroad at the time of completing the survey.[2] Over half of the sample (n = 595) lived in Dublin, while a significant proportion lived in some of the other more densely populated counties of Cork (9%, n = 101), Galway (6%, n = 64), Limerick (3.2%, n = 35), Kildare (2.7%, n = 30) and Wicklow (2%, n = 23). LGBT people from all counties on the island of Ireland, with the exception of Monaghan, were represented in the study, albeit to varying degrees. Those living in rural areas made up just under a fifth of the overall sample (n = 196). Almost three quarters of all respondents were living in urban or suburban settings, with just over half of all respondents (n = 578) indicating that they lived in large cities. Almost 13% (n = 142) lived in towns with 5000 people or more, while a further 11% lived in small towns (n = 42) or villages (n = 80).

Nationality

The vast majority of respondents (86%, n = 958) indicated that their primary nationality was Irish. A further 5% (n = 60) stated that they were British. Table 3.2 provides a more complete breakdown of the sample by primary nationality.

2 The under-representation of participants from Northern Ireland is most likely due to the fact that promotional efforts were confined to the Republic of Ireland, as this was the focus and remit of the study

Table 3.2: Respondents' primary nationality: survey sample

Nationality	n	%
Ireland	958	86.3
Britain/United Kingdom	60	5.4
Northern Ireland	9	0.8
France	9	0.8
United States/America	8	0.7
Germany	7	0.6
Poland	4	0.4
Spain	4	0.4
Australia	3	0.3
New Zealand	3	0.3
Holland	2	0.2
Portugal	2	0.2
Sweden	2	0.2
Finland	2	0.2
Israel	2	0.2
Other	12	1.1
Not specified	23	2.1
Total	1110	100

Gender identity

Women were underrepresented in the survey sample relative to men. Almost two thirds of the sample (64%, n= 707) were male, while 34% (n = 377) were female. The remaining two percent identified as 'something else', primarily as 'Transgender' or 'Gender Queer.'

Four percent of the overall sample identified as Transgender (n = 46), a majority of whom (n = 24) described themselves as 'male-to-female.' A small number of Transgender respondents (n = 5) described themselves as 'female-to-male.' The gender-related categories, or terms with which the remainder of transgender respondents identified (n = 16), are presented in Table 3.2 below.

Table 3.3: Transgender identifications: survey sample

Transgender Identification	n	%
Male-to-Female	24	52.2
Female-to-Male	5	10.8
Something Else (see below)	17	37
Total	46	100
Self-identifications...	n	
Androgynous	2	
Bi-Gender	3	
Gender queer	3	
Differently gendered	1	
In-between	1	
Male and female	1	
Female-to-male if boxed	1	
Myself	1	
Post-Op	1	
Something else	2	
Somewhere between male and female	1	
Total	17	

The relationship between sexual identity, attraction and experience is complex (Hillier et al, 2005). Public health research in particular has highlighted the extent to which not all men and women who have sex with people of the same gender self-identify as gay or lesbian; hence the common usage of terms such as "men who have sex with men" and "women who have sex with women" in public health discourse (ibid). The current survey used a number of indicators of sexual minority identification including: sexual behaviour/experience, sexual attraction and self-identification as LGB.

Sexual orientation

Just over four fifths of the overall sample self-identified as gay or lesbian (see Table 3.4). Just over one tenth indicated that they were bisexual. Three percent of respondents indicated that they were questioning or unsure of their sexual orientation, while less than one percent of the sample identified as heterosexual. The remaining four percent, many of whom also identified as transgender, used a range of other terms to describe their sexual orientation, including: 'pansexual' 'polysexual; 'dyke' 'queer,' 'sexual,' and 'bisexual transvestite,' while others indicated that they preferred not to use, or be identified, with labels.

Table 3.4: Respondent profile by sexual orientation: survey sample

Sexual Orientation	n	%
Gay/Lesbian	902	81.3
Bisexual	124	11.2
Questioning/Not Sure	35	3.2
Heterosexual	9	.8
Something else	40	3.6
Total	1110	100

A fifth of all female respondents (n = 74) identified as bisexual compared with just 6 percent of male respondents (n = 45). In all, 71% of female respondents (n = 270), compared with 88% of men (n = 625), identified with the labels 'gay or lesbian.'

Just over a fifth of those who identified as transgender reported a gay or lesbian sexual identification (See Table 3.5). A higher proportion (37%) identified as bisexual while a small number identified as heterosexual or as questioning. As noted above, a significant minority of transgender individuals (30%) identified with labels other than these commonly ascribed labels of sexual orientation.

Table 3.5: Sexual orientation of transgender respondents: survey sample

Sexual Orientation	n	%
Gay/Lesbian	10	21.7
Bisexual	17	37
Questioning/Not Sure	2	4.3
Heterosexual	3	6.5
Something Else	14	30.4
Total	46	100

Sexual attraction

The pattern of self-reported sexual attraction was also gendered, with women being more likely than men to report being sexually attracted to both sexes. Twenty six percent of females (n = 72), compared with fewer than 9% of males (n = 44), indicated that they were sexually attracted to both males and females. Similarly, women reported that they were less likely to be exclusively attracted to the same sex (71% of females as compared with 90% of males). Thus, there was a high degree of consistency between self-reported sexual orientation and attraction.

Sexual experience

The patterns of sexual experience broadly follow those of sexual attraction and sexual orientation. [3] The vast majority of women who identified as gay or lesbian had previous sexual experiences with women (95%, n = 255); similarly, amongst self-identified gay men, the percentage reporting prior sexual experience with men was 96% (n = 603). Almost 80% of women (n = 57), and a similar proportion of men (n = 36) who identified as bisexual had had prior sexual experiences with both men and women.

LGBT awareness and disclosure

The overwhelming majority of respondents (96%, n = 1063) were 'out' to at least one other person in their lives. The average age at which participants first became aware of their sexual orientation and/or transgender identity was 14.34 years (s.d. = 5.6), with most respondents indicating that they were 12 when they first became aware of their LGBT identity. The average age at which respondents first disclosed their LGBT identification was 21 years (s.d.= 7.09).

Comfort with sexual orientation/transgender identity

Over four fifths of survey participants (81%, n = 904) indicated t hat they were either 'comfortable' (n = 335) or 'very comfortable' (n = 569) with their sexual orientation, with less than 7% expressing discomfort in relation to their sexuality. The remaining 11% (n = 125) indicated that they were 'neither comfortable nor uncomfortable' with it.

Sixty one percent (n = 28) of those identifying as Transgender reported feeling either 'very comfortable'

3 S exual experience was defined as having "given and/or received oral, anal or vaginal sex".

or 'comfortable' with their transgender identity, whereas 17% (n = 8) reported feeling 'uncomfortable' or 'very uncomfortable' about their transgender identification. The remaining 23% (n = 10) indicated that they felt 'neither comfortable nor uncomfortable' about their transgender identity.

Living arrangements

Participants in the survey were asked to describe their living arrangements and reported a diverse range of home situations (see Table 3.6). Almost a quarter of respondents were living with parents/guardians. Just over a quarter of respondents were living with a partner when they took part in the survey, in most cases, without children. Just under a quarter were living with friends or in a house share arrangement. Almost a fifth were living by themselves. A small proportion of respondents (1.8%) were living alone, as single parents, with children.

The vast majority of respondents (over 90%) did not have children. Almost 8% of the sample was biological parents, and a further one percent was non-biological parents. Less than one percent of the sample was adoptive or foster parents.
A small proportion (2.4%) of survey respondents were 'co-parents'. [4]

Table 3.6: Living arrangements: survey sample

Living Arrangement	n	%
With friend(s) or house share	296	26.7
With parent(s)/guardians	258	23.2
With partner (without children)	252	22.7
Alone (without children)	198	17.8
With partner (with children)	45	4.0
Alone (with children)	20	1.8
Something else	41	3.7
Total	1110	100

Relationship status

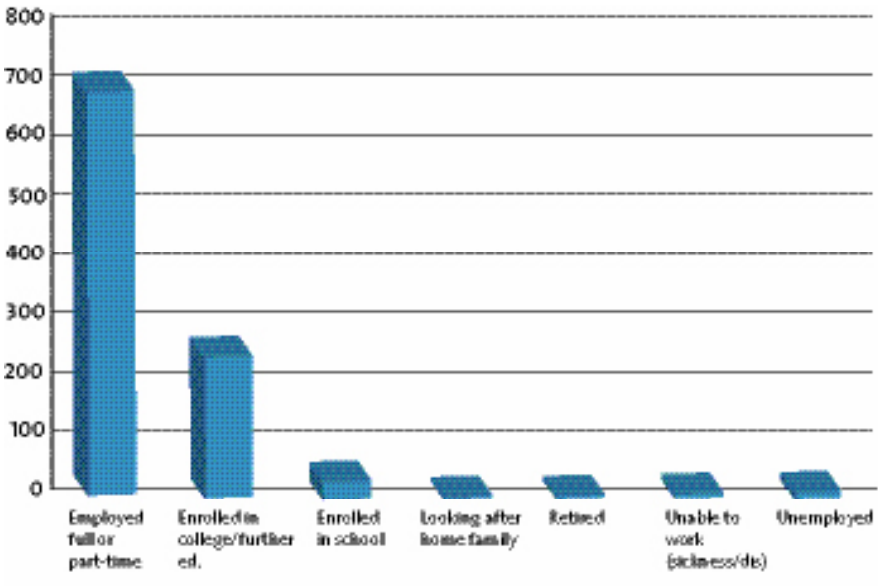
Just under 40% of the sample (n = 439) were in a steady or committed relationship at the time of completing the survey. A further 17% (n = 192) stated that they were seeing someone but did not consider the relationship to be serious, (or were dating different people), while a further 38% (n = 419) indicated that they were single and not dating or seeing anyone at the time.[5]

Educational attainment

As shown in Figure 3.1, less than one percent of the sample had been educated to primary level or below. Twenty-seven percent of the sample had been educated to secondary level; the remaining 70% had completed their education with a third level qualification, three quarters of whom had obtained at least a primary degree, suggesting that educational attainment levels for the sample as a whole is very high.

4 The online survey defined co-parenting as an arrangement involving teaming up with other(s) to share parenting responsibilities outside of a romantic or sexual relationship.
5 The remainder of respondents described a range of additional relationship scenarios, such as being in a long term, committed and open relationship, being in a heterosexual marriage but seeing a same-sex lover, being in a same-sex marriage or civil partnership, or being engaged to one's same-sex partner.

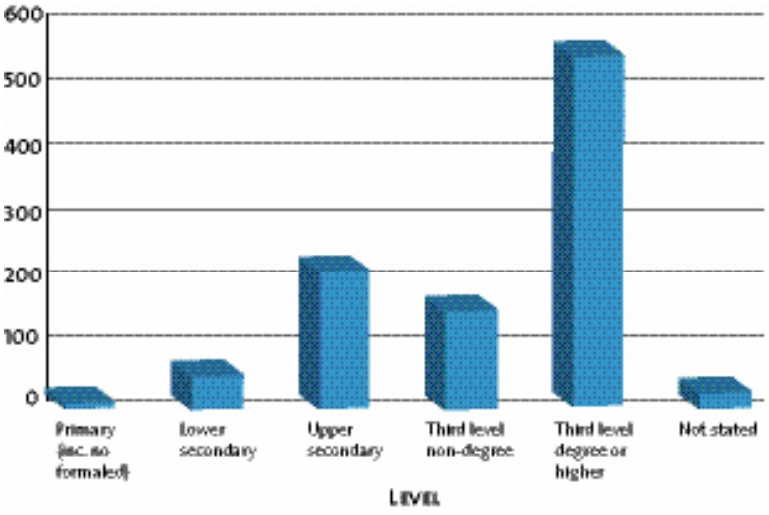
Figure 3.1: Highest educational level attained: survey sample



Principal status

Figure 3.2, which presents the employment/principal status of respondents, indicates that almost two thirds of participants (n = 720) were employed at the time of completing the survey, the vast majority of whom (n = 683) were employed in a full-time capacity. Almost a quarter of respondents were enrolled in college or university (n = 247), and a further 1.4% (n = 15) were enrolled in further education. Fewer than 5% of the sample were enrolled in school (n = 51), reflecting an under-representation of 14-18 year olds in the sample.[6] Just under one percent of the sample (n = 10) were retired, reflecting the under-representation of over 65s in the sample. Five individuals indicated that they were looking after home/family as their primary responsibility and just over 1% indicated that they were unable to work due to sickness/disability. The remainder did not state their principal status or indicated a range of other gainful activities in which they were involved.

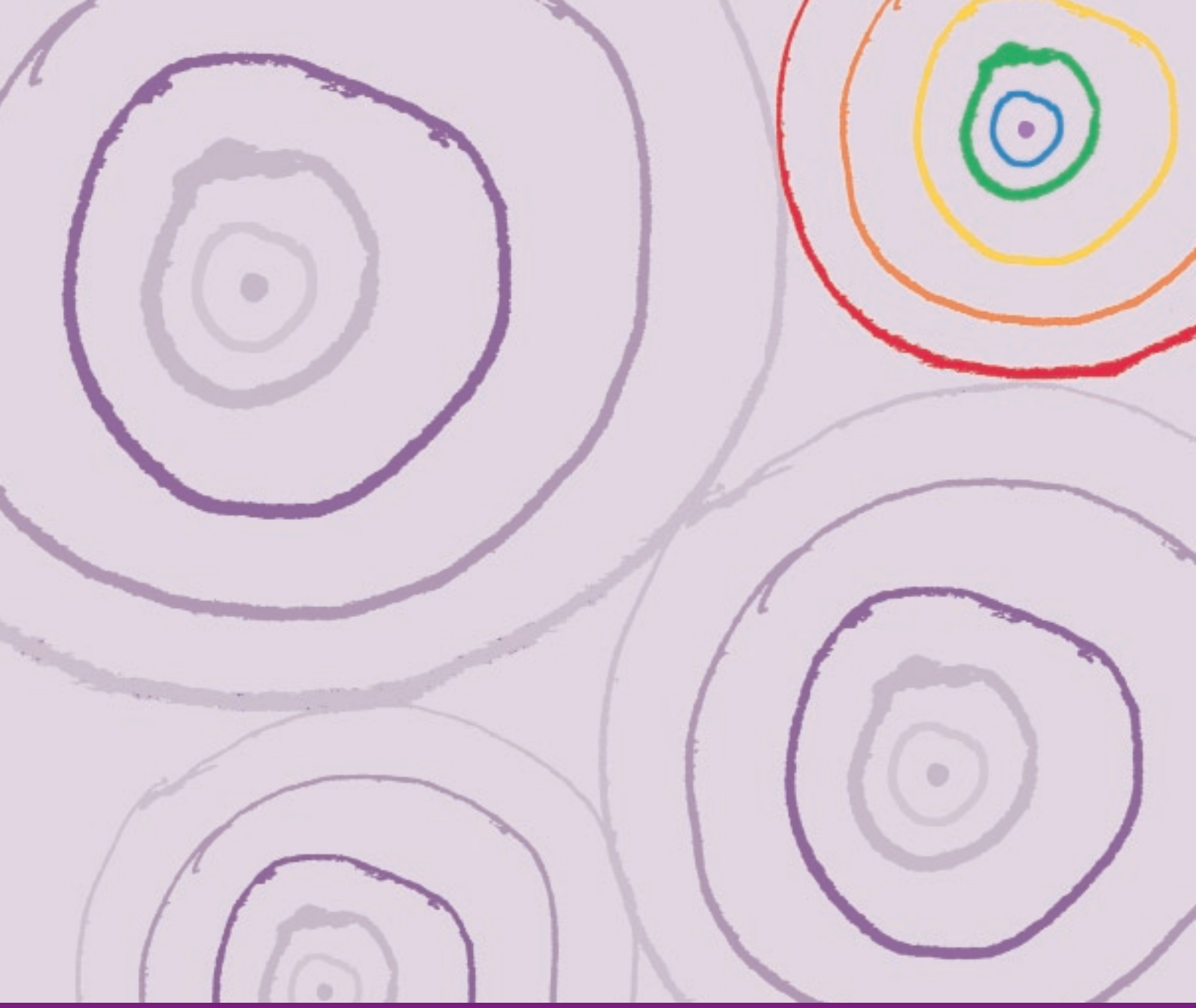
Figure 3.2: Principal status of respondents: survey sample



6 For reasons relating to ethical guidelines on informed consent, only those aged 14 and above were permitted to complete the survey.

CONCLUSION

This chapter has provided an overview of demographics for both the quantitative and qualitative samples in the study. Both samples were broadly similar along a range of indicators, including age, the representation of young people, and the proportion of respondents living in rural versus urban settings. Because internet surveys are prone to sampling bias and reduced researcher control over the participant recruitment and response process, and because the size of the LGBT population in Ireland is unknown, it is not possible to determine how representative the survey sample is. It must also be acknowledged that the survey under-represents women, seniors, school-goers, and also in all likelihood persons with low literacy levels, as well as persons whose first language is not English. Furthermore, due to the nature of the promotional and recruitment efforts, the sample is likely to be skewed towards more openly LGBT people. Despite these limitations, the sample is sufficiently large to enable us to generate an adequately detailed overview of the lives of LGBT people in Ireland. Collectively, the qualitative and quantitative findings from the online survey, as well as data gathered in the context of the in-depth interviews, enable us to capture and better understand the diversity and complexity of experiences of LGBT people living in Ireland.



CHAPTER 4 MINORITY STRESS

MINORITY STRESS

The literature review identified the concept of minority stress as a useful framework for understanding the external and internal stressors that are uniquely experienced by LGBT people, including direct and indirect forms of LGBT discrimination and victimisation, internalised homophobia, and the stress associated with concealing and/or disclosing one's identity as LGBT. This chapter seeks to provide a deeper understanding of some of the major stressors associated with being LGBT in contexts where it is assumed that heterosexuality and dominant male/female gender identities are 'the "normal", right and only way to be' (Blaise, 2005: 22). The chapter first provides a descriptive overview of participants' experiences of coming out, a process which has been consistently identified in the literature as particularly stressful for LGBT people (Meyer, 1995; Troiden, 1989). It then provides an overview of the prevalence and nature of victimisation experienced by LGBT people, before focusing more specifically on two settings within which LGBT people experience their everyday lives, namely school and work. The focus on unique stressors in the lives of LGBT people that are directly related to their sexual orientation and/or transgender identity provides an important backdrop to a later examination of indicators of their mental health and well-being (see Chapter 5).

COMING OUT

> *Coming out is probably one of the most extreme and difficult things you can do. Before you come out you have to deal with it all yourself and it took me six years to. And I couldn't be myself for those six years and it is, again, it's called in the closet because you are in the closet. No one can see you; they see this door because no one's ever opened up the closet to look inside (Gay, Male, 17).*

The term 'coming out' is widely understood to refer to a public acknowledgement of a person's lesbian, gay or bisexual identity. In the context of the present study, it is also used to refer to the process of publicly disclosing one's identity as transgender. An overwhelming majority of survey participants (96%), and all in-depth interview participants, were out to at least one other person in their lives.

Table 4.1 presents the individuals to whom, or settings within which, online survey participants had disclosed that they were LGBT. Whereas over two thirds of respondents were out to all immediate family members (parents and siblings), and friends, less than half of all respondents were out to all those in other social contexts, such as the workplace, at school or college, or in youth group or other organisational settings. Almost a quarter of the sample had not disclosed that they were LGBT to either of their parents, and almost a fifth was not out to siblings. A similar proportion was not out to work colleagues or school/college friends.

Table 4.1: Disclosure of LGBT identification: survey sample[1]

	None		Some		All		Valid n
Are you out to...	n	%	n	%	n	%	n
Friends	44	4.0	314	28.7	736	67.3	1094
Parents	239	23.2	99	9.6	694	67.2	1032
Siblings	186	18.0	144	14.0	702	68.0	1032
Family (other than parents/siblings)	307	29.2	376	35.7	369	35.1	1052
Work colleagues	199	20.2	363	36.9	423	42.9	985
At school/college	121	20.0	183	30.3	300	49.7	604
At youth/other organisation(s)	132	25.2	140	26.8	251	48.0	523

1 Figures are based on valid percentages, and exclude those for whom these questions were not applicable.

While we did explore the coming out process in some detail, particularly in the in-depth interviews, a thorough analysis of participants' experiences in this regard is beyond the scope of the present report. Rather, this chapter is limited to a consideration of experiences of coming out to friends and family members. The following chapter focuses on the environmental risk factors associated with psychological and suicidal distress which some LGBT people experience. It examines in more detail the feelings of anxiety and depression that are often associated with disclosing or not disclosing one's true sexual orientation or gender identity, or indeed having one's true identity revealed.

The period between initial awareness of, and coming to terms with, one's own sexual orientation or transgender identity, and coming out, was generally experienced as difficult, daunting, and traumatic by most participants. For many, coming out was associated with a process of self-acceptance, which was often coupled with an awareness of the stigma associated with assuming an 'alternative life script' in social contexts where heterosexuality and gender conformity are presumed and where heterosexism, homophobia, and transphobia exist (Wichstrom & Hegna, 2003).

> *When I came out it wasn't, I didn't get any hardship from people, but actually realising, it was kind of hard. Even though I always knew that there was something different about me, and after I had the relationship with the girl I pretty much knew that I like women, but once the full realisation of that kind of dawned on me it was very daunting... (Lesbian, Female, 20).*

> *...my family were asking me – 'What's wrong? You have a good life and a good marriage and why have you left?' I was struggling to come to terms with being gay myself never mind telling anybody (Gay, Male, 46).*

> *You know people have, they think they know who I am, do you know what I mean? And for me to go and change that now, I think it would...that's the difficulty for me (Lesbian, Female, 32).*

> *I still had to deal with it in my head that even though I had never dreamt of wedding dresses and getting married and having children and all the rest of it just that I would be an outsider in society. At the same time it was very exciting to me. Incredibly exciting.(Lesbian, Female, 54).*

For a large number, coming to terms with one's own minority sexuality and/or gender identity was often compounded by fears that they would be rejected by their family and friends because of their LGBT identification. First disclosures were particularly memorable in terms of the extent to which revelations about one's gender identity or sexual orientation resulted in denial, acceptance, positive affirmation, invalidation or rejection on the part of family members or friends.

Coming out to friends

A majority of in-depth interview participants chose to come out to a friend or other trusted individual prior to coming out to their family. In those instances where the news was positively received, the experience, while stressful, was also often associated with initial feelings of relief that the act of revealing one's true identity had 'worked well,' or at least had not resulted in rejection.

> *[Telling] one of my close friends ... even though it was stressful doing it, it was still brilliant like. Nearly getting the words out were nearly, do you know what I mean, it was just a relief and because that worked well for me, that's when I would have discussed it then with other close friends (Lesbian, Female, 32).*

Other participants' accounts of telling close friends were far less positive; in a small, but significant number of cases, coming out to friends was deeply traumatic, and as one in-depth interview participant described, evoked an extreme and physically violent reaction.

> *... I think I was 18, and I told my best friend I was gay and I was coming out of the pub and I was walking up the street and he tripped me up and I fell on my back and I saw him, you know, standing*

up and I suppose really, it happened very quickly but it was very frightening. He started kicking me, you know, on the ground and he broke my nose and my jaw and I got my skull fractured and I was kind of crying out for help and 'please stop'. And I ended up in hospital and this kind of happened at the stage when, you know, when you're keeping something inside and all the anger builds up. And I told someone I was gay, my best friend at the time, and just the way he reacted I thought you know, like I have to go away so I went to London (Gay, Male, 24).

Coming out to family

Coming out to family was a critical juncture in the life stories of in-depth interview participants, and was typically associated with considerable stress and fear of rejection or lack of acceptance by parents and/or siblings. The need for parental acceptance, affirmation and validation were central features of the narratives. Reports ranged from outright rejection and/or denial, to bare acceptance or mere tolerance, to a wholehearted embrace of their child's LGBT identification.

So I told them both I was gay and my father straight away stood up and went over to me, pulled me off my seat, gave me hug and said, do you know what, that doesn't matter one bit, and he was great, and my mother was like, em, they still love me, d'you know, it doesn't matter (Lesbian, Female, 31).

Basically what they said was that they wouldn't be happy but they wouldn't kick me out of the house type thing over it. But that doesn't seem to me very accepting of it. Oh we'll tolerate you but we don't really like you, as if it was some kind of personal choice (Gay, Male, 20).

Accounts of coming out to family were often suggestive of a reluctance on the part of parents to acknowledge, accept or embrace the 'alternative' LGBT life script. In some instances, this was perceived as a failure by parents to discuss, and hence validate, their child's LGBT identity within the family context.

It was great, it was a relief to tell them, but again it's never mentioned in the house since, and I knew that would be the case, you know I mean once I said it, it would never be mentioned again, so you know. But they know, that's all that matters (Lesbian, Female, 39).

He [father] didn't actually speak to me for a week. They didn't actually broach the subject and it was just left (Lesbian, Female, 51).

For others, the response was one of outright denial and rejection of their children's identification as LGBT, in some cases resulting in the child being asked to leave the family home.

... my mother doesn't get my body yet and she was, she was very shocked at first, then she tried to convince herself that it was just a phase and then she was trying to tell me like that there are some women who are feeling masculine but they are fine with it and I'm, even again when I told her I maybe going on to, like actually going through the hormone therapy, she was like, 'If you're doing that then you're not living here anymore' (Female-to-Male Trans, 20).

When I told my Mum she said that she's sure that I can't be bi-sexual because bi-sexual people don't exist (Bisexual, Female, 18).

Some parents' reactions to the news about their child's sexual orientation and/or gender identity were based on a concern about the difficulties associated with being LGBT in society.

'No, you can't be gay, it's too hard a lifestyle to live in, just be straight, it's a lot easier, you're just going through a phase'. I said, 'Listen, this phase is after lasting for 3 or 4 years at this stage'... I says like, 'There's something not quite right', and he was like, 'Oh god no, it's too hard to live with, you can't go doing it (Gay, Male, 18).

They were going to be worried because it's not an ideal situation; I'm a minority or whatever (Lesbian, Female, 20).

In other cases, parents reacted with disappointment that their children would not fulfil heteronormative expectations, such as getting married and having children.

My mam did say to me that she was afraid that I was going to catch something or that she was never going to have grand children. Or she was never going to see me getting married (Gay, Male, 21).

The next chapter explores in more detail the relationship between perceived or actual lack of acceptance or rejection by family and friends, and the consequent negative mental health outcomes for LGBT people. It emphasises the impact of such responses on the psychological well-being of LGBT people, particularly as it relates to feelings of depression, self-harm and suicidality. Conversely, Chapter 7 focuses on the theme of LGBT resilience. It offers a detailed account of the positive impact which acceptance by others has on LGBT people's sense of self and well-being. In particular, this chapter highlights the crucial significance of parental acceptance, especially at the time of coming out.

LGBT DISCRIMINATION AND VICTIMISATION

The previous section revealed that while disclosing one's LGBT identity can in some cases and settings be met with acceptance and affirmation, in others the revelation or realisation that one is LGBT can be met with extremely homophobic or transphobic responses. Meyer (1995) has identified living with homophobia as a key factor in minority stress. This section seeks to explore LGBT people's experiences of homophobia and transphobia in more detail, with reference to both subtle and more extreme manifestations of LGBT victimisation. It begins with an overview of the prevalence of LGBT victimisation, based on figures reported in the online survey, and then offers an account of the nature of LGBT victimisation provided in the in-depth interviews.

The online survey assessed LGBT harassment and victimisation by asking respondents to report the number of verbal insults, threats of physical violence, actual physical assaults (with and without a weapon or object), and sexual assaults that they had experienced on the basis of their known or perceived LGBT identification. As outlined in Table 4.2, four fifths of survey respondents indicated that they had been verbally insulted on the basis of their LGBT identification, almost half of whom reported that this had happened to them 'six times or more' in their life.

Table 4.2: Frequency of experiences of LGBT victimisation: survey sample

	Ever		Once		Twice		Three-FiveTimes		Six Times or more		Valid n
	n	%	n	%	n	%	n	%	n	%	
Verbally insulted	882	80.4	102	9.3	108	9.8	266	24.2	406	37.0	1097
Threatened with physical violence	465	42.5	144	13.2	95	8.7	129	11.8	97	8.9	1093
Punched, kicked or beaten	266	24.4	120	11.0	68	6.2	49	4.5	29	2.7	1089
Attacked with implement/ weapon	86	7.9	50	4.6	20	1.8	8	0.7	8	0.7	1089
Attacked sexually	97	8.9	72	6.6	14	1.3	5	0.5	6	0.6	1090
Someone threatened to 'out' you	374	34.2	183	16.8	93	8.5	61	5.6	37	3.4	1092

Two fifths of respondents had been threatened with physical violence because they were, or were thought to be LGBT, with a quarter of respondents reporting having been punched, kicked or beaten as a result of their LGBT identification. Almost 8% reported being attacked with a weapon or implement (such as a knife, gun, bottle, or stick) on at least one occasion. Similarly, nine percent reported that they had been attacked sexually as a consequence of being LGBT on at least one occasion. The fact that the vast majority of those who took part in the online survey had experienced verbal insults, with a quarter of all respondents reporting having experienced physical violence as a consequence of their LGBT identification, is indicative of the hostile and homo/transphobic climate within which LGBT people experience their everyday lives.

Accounts of victimisation provided in the in-depth interviews ranged from indirect discrimination to overt verbal attacks and physical assaults, including two reported incidents that resulted in hospitalisation. Many in-depth interview participants described routine experiences of verbal harassment encountered in everyday settings, such as walking down the street, or at school.

> *It can be very stressful, because you have to go out everyday and try and walk along the street, you have to put up with other people. You have to put up with the looks and the comments, all that sort of thing ... (Male-to-Female Trans, Heterosexual, 37).*

> *I'm sure people knew I was gay you know, I did walk up through (rural village) and people would be calling faggot and stuff like that. It did kill me a lot hearing you know the words and stuff and I was afraid as well, I felt very alone inside and the drink was my best friend (Gay, male, 24).*

RESPONDENT: Like, on the street, like, if I'm walking down the road with my boyfriend and we kiss or something, there's always someone who'll be like laughing or shouting or something.
INTERVIEWER: And typically, what would they shout?
RESPONDENT: Queers, or faggots, or they'd just laugh out loud or something (Gay, male, 16).

Although far less common than verbal insults, a small number of interview participants recounted incidences of physical assault. The following in-depth interview participant, for example, recalls how she was physically assaulted and 'left for dead' on her way home one night by a 'guy who tried to take advantage' of her, when he discovered her transgender identity:

> *...obviously he put his hand for my boobs because there's nothing there and this is the last memory I have and I woke up in the hospital again. And my cheek bone had been fractured in four places. I'd been left for dead basically .... I woke up and I was lying on a hospital bed. ...I was all swollen and I cried and I think my mom came over and came to the ward and she had to be taken out of the ward because she broke down. Basically I must have looked like elephant man or something; my face was that fucking destroyed. ...and then I had plastic surgery on my face. I got a plate there and three plates there. My cheek bone had to be reconstructed basically...I was terrified to tell the story of what happened so I just said I couldn't remember. (Male-to-Female Trans, Heterosexual, 27).*

This section has sought to highlight some of the unique stressors experienced by LGBT people that are directly related to their sexual orientation and/or transgender identity, with a particular focus on the stressors associated with the coming out process, and experiences of harassment and victimisation. The remainder of this chapter focuses on the school and work-based experiences of LGBT people in an Irish context.

SCHOOL AND WORK EXPERIENCES

This section combines key findings from both the quantitative and qualitative dimensions of the study as they relate to the school and work-related experiences of study partipants. Quantitative data fromthe online survey are provided to give a broad overview of various aspects of the social experiences of survey participants at school and work. Qualitative findings from both the online survey and in-depth interviews are presented alongside these figures, with a view to providing a deeper understanding of the

LGBT people's experiences in these settings.[2]

SCHOOL EXPERIENCES

As highlighted in the literature review, there is a wealth of evidence to suggest that many LGBT people in other geographical contexts experience schooling as heterosexist, hostile and homophobic. Schools, as with other social institutions, operate according to the assumption that heterosexuality and gender conformity are the norm. Indeed, schools are one of the key settings in which these social norms are learned, both formally and informally, from an early age (Plummer, 1989). Compulsory heterosexuality—the notion that all students are expected and presumed to be heterosexual—is embedded in school policies and practices, including, for example, the failure to address homosexuality in school curricula, and the sanctioning of heterosexual-only events, such as male-female school dances (Adams, Shea, Liston & Deever, 2006).

The online survey investigated participants' perceptions of their school's environment with respect to the treatment of LGBT people and issues, including their sense of belonging or connection to the school community, their comfort levels in terms of being open about their LGBT identities and/or LGBT issues at school, as well as the prevalence, and personal experiences of, bullying and victimisation at school. All of those who had attended formal schooling were asked to respond to these questions, about three quarters of whom had left school since 1990. It should be noted that as a broad-based survey of LGBT people's experiences in an Irish context, the overall proportion of respondents who were enrolled in school at the time of completing the survey was very small (less than 5% of the overall sample). The present study, therefore, cannot offer a comprehensive or representative understanding of the present-day experiences of LGBT youth in schools in the Irish context, nor does it permit us to draw direct comparisons with previous cohorts of school-goers. Additionally, the lack of comparable data for individuals who do not identify as LGBT means that we are unable to draw conclusions about LGBT young people's experiences at school, relative to their non-LGBT peers. These study limitations are addressed more fully in Chapter 8 of this report. Despite these limitations, a combination of quantitative and qualitative data gathered from both online survey and in-depth interview participants of current school-goers are reported, where appropriate, to generate a more complete understanding of what it is like to be an LGBT student attending school in Ireland today.

School belonging

In order to examine participants' sense of belonging to their school community, survey participants were given a series of statements about feeling part of their school, and asked to indicate their level of agreement or disagreement with each statement. Table 4.3 shows the percentage of respondents who agreed or disagreeed with each statement (those reporting "agree" or "strongly" agree and "disagree" or "strongly disagree" respectively). [3]

2 School and work are by no means static institutions, and there is likely to be some degree of variation between, as well as within, different school and workplace settings in terms of the treatment of LGBT people. Moreover, school and workplace cultures change over time to reflect broader societal trends and attitudes towards LGBT people. Nonetheless, data are reported in the aggregate here, where appropriate, to provide a broad overview of the work and school-based experiences of the survey sample as a whole.
3 These survey items were adapted from the GLSE's National School Climate Survey, which assesses the prevalence of homophobia in U.S. schools. Survey items are derived from the Psychological Sense of School Membership Scale (Goodenow, 1993).

Table 4.3: Perceived school belonging: survey sample

School belonging items	Agree/ Strongly Agree		Disagree/Strongly Disagree		Valid n
	n	%	n	%	n
I feel/felt like a real part of my school.	548	52.9	487	47.1	1035
It is/was hard for people like me to be accepted at my school.	666	69.3	295	30.7	961
People at my school are/were friendly to me.	786	77.0	235	23.0	1021
I am/was treated with as much respect as other students.	639	63.6	365	36.4	1004
I can/could really be myself at school.	282	27.6	741	72.4	1023
There is/was at least one teacher/other adult in school I could talk to.	405	40.3	600	59.7	1005
Other students at my school liked me that way I am/was.	609	62.5	365	37.5	974
I feel/felt proud to belong to my school.	528	52.6	475	47.4	1003

While a majority of survey respondents (77%) agreed that people were friendly towards them in school and that they were liked by other students (62%), almost 70% of respondents felt that it was hard for them to be accepted at school, whereas less than one third felt that they could really be themselves at school. These seemingly contradictory findings may in part reflect the fact that many respondents were not out while in school. As one survey participant who left school in 2000 put it:

> *I was never identified as being gay and had a group of friends that I hung around with and was respected within, I felt extremely isolated in school due to my own awareness of my sexual orientation and a negative attitude toward/about homosexuality amongst my peers and teachers. There was very much a general attitude of intolerance and poor example setting from those in authority. I used to miss school frequently due to my feelings of isolation and eventually changed schools (Gay, Male, 26, Survey Participant).*

Negative emotions and experiences are not limited therefore to those LGBT young people who are out in school contexts. Indeed, a number of other respondents who had not disclosed their sexual orientation or transgender identity in school pointed to feelings of isolation and/or psychological distress which they experienced as a consequence of being LGBT within heteronormative and homophobic school environments, even though they had not directly experienced homophobic or transphobic harassment or victimisation themselves.

The proportion of those indicating that it was hard to fit in as an LGBT person in school was not quite as high amongst current school goers, relative to the overall survey sample. However, almost two thirds of those enrolled in school at the time of completing the survey still felt that it was hard for people like them to be accepted at their school, and over fifty percent did not feel that they could really be themselves at school, which suggests a failure to embrace or accept sexual or gender diversity as facets of school and social life. Again, these issues are taken up in more detail below in relation to official school responses to homophobic bullying and the willingness to address LGBT issues in schools.

Comfort with expression of LGBT identity/issues

Table 4.4 provides the breakdown of responses to a series of statements assessing comfort with a range of scenarios related to the expression of LGBT identities and issues likely to affect one's sense of belonging to their school. That at least three quarters of all survey respondents would have felt uncomfortable talking to their teachers or their school principal about LGBT issues, raising or responding to LGBT issues in class, taking a date of the same sex to a school event such as the 'Debs', or setting up of being part of a club addressing LGBT issues suggests that schools were perceived and/or experienced as

unsupportive and hostile places for those who identify as LGBT.

Table 4.4: Comfort expressing LGBT identity/issues in school: survey sample

How comfortable would you have been...	Comfortable/ Very Comfortable		Neither/Nor		Uncomforable / Very Uncomfortable		Valid n
	n	%	n	%	n	%	n
Talking to your teacher(s), one-on-one, about LGBT issues	118	11.4	130	12.5	791	76.1	1039
Talking to your school principal about LGBT issues	60	5.8	92	8.9	883	85.3	1035
Taking a date of the same sex to a school event	96	9.3	69	6.7	870	84.1	1035
Raising or responding to LGBT issues in your classes	155	14.9	120	11.6	762	73.5	1037
Setting up or being part of LGBT club or group	109	10.5	126	12.1	804	77.4	1039

On the whole, respondents who were enrolled in school at the time of completing the survey also expressed high levels of discomfort around LGBT self-expression in school contexts. Just over a quarter (n = 14) said that they would feel comfortable or very comfortable talking with their teachers on a one-to-one basis, about LGBT issues, whereas less than a fifth (n = 9) said they would feel comfortable talking to their principal about such matters. Just under a third said they would feel comfortable bringing a date of the same sex to a school event, such as a 'Debs' or school dance, while two fifths (n = 21) admitted to being comfortable raising or responding to LGBT issues in class. A third said that they would feel comfortable setting up or being part of a club or group that addresses LGBT issues.

Silencing of LGBT identities and expression in school

Gauging how comfortable LGBT students are in terms of expressing themselves in various ways as LGBT persons in school settings is one indicator of acknowledgement or acceptance of minority sexualities and/or gender identities in schools. Yet LGBT students' ability to openly express their LGBT identities, or to promote discussion of LGBT issues in the classroom, can be actively discouraged and/or prevented by school authorities, or other school personnel, irrespective of LGBT students' own comfort levels and efforts in this regard. Forty percent of those who were in school (n = 20) at the time of completing the survey reported a failure or refusal to address LGBT issues/concerns in class, and almost a third reported negative discussion of LGBT issues in class (See Table 4.5).

One young online survey participant, who was enrolled in school at the time taking part in the research, described her reluctance to come out as bisexual in a school setting which actively discourages the visibility or expression of LGBT concerns, issues or identities because of its religious ethos.

> *... Although the majority of teachers in my school would be extremely LGBT friendly, because my school is a [religious school], the principal and all the older teachers all tend to be [religious], they discourage promotion of LGBT events etc. I'm fairly certain that I am the only LGBT person in my school, and I am not out in school because I do not want to cause hassle with the older teachers because I do love my school. I remember one of my friends brought in one of the [LGBT] leaflets that were out last year, we put it up in the classroom, we were told to take it... down as she (my teacher) didn't want the first years to see it. That really angered me (Bisexual, Female, 17, Survey Participant).*[4]

Another online survey participant who had recently left school relayed how school-based codes of compulsory heterosexuality fail to meet the needs of, or validate, the identities of LGBT youth in schools, by sanctioning heterosexual-only identities and suppressing LGBT issues, and by failing to take appropriate action against homophobic bullying.

4 A fifth of online survey participants who had been enrolled in school during the 2006-2007 academic year were aware of "Stop Homophobic Bullying" posters being displayed in their schools.

> *In relation to school events, we were banned from taking someone of the same sex to the debs, and a group attempted to run a LGBT sexual health class one year but couldn't get around the "Catholic ethos" of the school....A gay male friend of mine in a similar boys' school was unaware that STIs could be transmitted by oral sex. Schools don't do enough as they don't want to seem controversial to parents....I lost a close friend to suicide earlier this year as he couldn't face coming out and the jeering he was getting for being suspected of being gay. Yet the school he was in did NOTHING in the way of policy afterwards so it could potentially and probably will be repeated. I was also sent to a councillor in the hope it would "talk me out of being bisexual" and got a warning that if I dated girls in college or had gay friends my parents will not pay for my education (Bisexual, Female, 18, Survey Participant).*

LGBT issues and the formal curriculum

Participants reported that sex education was limited or, more often, nonexistent in terms of its relevance to them. This meant that LGBT issues were for the most part invisible in the formal education. Less than 5% of the overall survey sample, and less than 8% of current school-goers, were aware of coverage of LGBT-specific content in the relationships and sexuality education (RSE) curriculum. One online survey participant, who was also a primary school teacher, criticised the failure to address minority sexual orientations or gender identities and LGBT people's existence in the curriculum more generally as follows:

> *LGBT is NEVER mentioned in the RSE programmes in school and was NEVER addressed in [teacher] training college. I have serious issues with this. Children know about LGBT from TV, friends, relatives etc., yet primary schools ignore our existence. I was brought up to believe that I would live a 'normal' life, fall in love with a member of the opposite sex, marry and have children. Surely it should be presented in schools that this is not always going to be the case. Surely in our efforts to prepare children for life and society we need to address LGBT (Gay, Male, 23, Survey Participant).*

Another survey participant, who left school in 2001, pointed out that to the extent that sexual diversity was addressed in school, it was presented as 'deviant' and 'unnatural.'

> *There was little or no sex education and particularly no reference to homosexuality. (Although one science teacher used an experiment with magnets to point out that homosexuals were unnatural -'opposites attract, like repels like'. When I was 12, I asked a sex [education] teacher (anonymously) who visited my primary school at what age one knows one is gay (as I was becoming very much aware of my sexual attraction to males) and she advised that one does not know one is gay until one reaches the age of 17. I felt like a sexual deviant after this response and I didn't attempt to communicate my sexual orientation to anyone again until I was 17 in a suicide note. (Gay, Male, 26, Survey Participant).*

Another described how the silence pervading LGBT issues in the curriculum at school meant that he lacked the knowledge and vocabulary with which to understand, express or explore his evolving sense of his sexual orientation as a young gay man.

> *I think I have answered the (survey) questions honestly but they seem more positive answers than would accurately reflect the reality of the years in secondary school, where my sexual identity was hidden even from myself because I did not have a language to describe my experience. It may even be that the lack of language and openness also protected me from direct discrimination in school as it was not something talked about. However the lack of knowledge and understanding did cause me a lot of wasted time and difficulties in the years after leaving school and I was lucky that this did not cause me too much suffering or pain (Gay, Male, 39, Survey Participant).*

Collectively, the foregoing accounts are indicative of a failure on the part of schools to address or embrace minority sexuality and gender identities, or at least not in any meaningful or substantive way. This renders LGBT youth effectively invisible and invalidated in classrooms and at school events, and

hence fearful, or at least constrained, in terms of the extent to which they can express themselves as LGBT in schools. Further evidence to suggest that contemporary school environments can be experienced as hostile for those who are—or who are believed to be—LGBT in an Irish context is presented in the context of a consideration of homophobic bullying below.

SCHOOL SAFETY: ACHIEVING IN UNSAFE PLACES?

Homophobic bullying

Fifty eight percent of the overall survey sample, and half of all current school goers reported the existence of homophobic bullying on the part of students in their schools. Over half of all online survey respondents (n = 593) reported having been called hurtful names related to their sexual orientation or gender identity by fellow students, while eight percent (n = 88) admitted to having experienced name-calling by staff while in school. A significant minority of online survey respondents (40%, n = 435) indicated that they had been verbally threatened by fellow students because they were, or were thought to be LGBT, while 4% of the sample had been verbally threatened by staff. A quarter of the overall sample (n = 282) had been physically threatened by their peers, whereas just over one percent (n = 14) had been physically threatened by staff.

Awareness of the prevalence of homophobic bullying and 'gay humour' at school meant that coming out or being out in school was simply not an option for some participants. As one in-depth interview participant put it, coming out in school was simply not something he would have 'dared to do,' in light of the homophobic culture that pervaded his school.

Interviewer: In the school, was there evidence of homophobic bullying or?

> *Respondent: Homophobic bullying in the sense of what a lot of teenage boys do to kind of knock each other down by using gay jokes, gay humour, you know, that kind of thing. You knew the attitudes that underlay the joking. And you knew damn well where it could lead if you disclosed what you really were. You didn't dare do it (Gay, Male, 40).*

Teacher responses

Many of the foregoing narrative accounts of school-based experiences describe direct efforts on the part of certain school authorities or personnel to prevent, 'silence' or render invisible, LGBT expression in schools. It is perhaps unsurprising, therefore, that teacher responses to homophobic behaviour towards LGBT students were rare. Although almost a tenth of all survey participants indicated the presence of teachers and other staff members who were supportive of LGBT students/issues, most of the narrative commentary on official school responses to homophobic bullying characterised it as non-existent, ineffective, or complicit with a culture of hostility towards LGBT students.

> *There was a fella that started in our school when we were in 6th year... and I think he was bullied, and he was very effeminate and he was kind of small... and a kind of a real outsider... I was told to look after him and mind him.. and I felt as if it was a kind of a joke, let the gay lads mind the gay lads... and it was put to me in a kind of bullying way by the teachers, like – the year head at the time (Gay, Male, 26).*

> *Well, they [primary teachers] were giving out to them for doing it, but ... they didn't really get anything bad [as punishment]. And, when I got beaten up in the schoolyard, they didn't send me home or anything, they just kept me in school for the rest of the day, they didn't ring my mam or anything (Gay, Male, 16).*

Existing research suggests that teachers in an Irish context often view themselves as powerless to address the homophobic bullying that takes place in schools (Norman et al 2006). These authors argue

that in some cases, this may be attributable to the pervasiveness of homophobia in schools as well as the restrictions imposed by the religious ethos of their schools where sexuality is concerned. Yet, as Murdock & Bolch (2005: 170) point out, 'simple steps (e.g., posting an LGB sticker or book, openly reprimanding derogatory comments about gay individuals, and/or integrating LGB-specific issues into class curriculum or discussion) can send messages of acceptance to often "invisible" youth'.

Missing school and dropping out

The online survey asked participants if they had ever missed or skipped school because of the treatment that they received because of their LGBT identification. A fifth of the overall sample (n = 228) admitted to having missed or skipped school because they felt threatened, or were afraid of getting hurt at school, based on their real or perceived LGBT identity. A similar proportion of survey respondents (n = 214) had considered leaving school owing to the negative treatment they had received at school due to their LGBT identity, while a further five percent (n = 55) did actually leave school early because of how they were treated as a consequence of their LGBT identification in school. Furthermore, a small but significant number of in-depth interview participants had to forgo their education due to the homophobic bullying they had experienced in school. This suggests that school-based harassment of, and hostility towards, LGBT people can interfere with LGBT students' ability to learn, and to perform academically in the formal educational domain. The following young man describes why he left school without completing his junior certificate:

> *I left school because of the hurt and suffering I got in school, and the teachers didn't care, as I think it was a case of 'well they call him gay and he probably is gay, so why should we step in, cos they are not saying anything wrong' attitude towards gay people... even though I wasn't out at school. I was forced to leave at my junior cert, due to the abuse I got when leaving the exam room etc., jumped on, called puff, queer etc. (Gay, Male, 23, Survey Participant).*

Similarly, a 17 year old in-depth interview participant who had come out at the end of Third Year described how she had dropped out of school before sitting her Leaving Certificate because of the stress associated with being bullied at school.

> *The stress of the Leaving and all that kind of stuff? Grand. But then the stress of actually being in school because I was kind of bullied a bit in school. I didn't have interest in the hassle of it... If anything it's getting worse... they are just going to stereotype. They're all pretty much scumbags. If you're not scum, or into that kind of thing, then you're slagged for being different. Then coming out being gay. It's just kind of worse again (Lesbian, Female, 17).*

While a necessarily selective account, the foregoing analysis highlights the ways in which unwritten codes of compulsory heterosexuality govern schools in an Irish context, and the negative impact this has on LGBT students. This can result in a silencing and invalidation of LGBT identity and self-expression. It also sought to provide an understanding of the prevalence, nature and effects of—as well as official school responses to—homophobic bullying. It would be inaccurate to suggest, however, that schooling was experienced in a uniformly or exclusively negative way by participants. Space considerations, as well as the focus on some of the more negative dimensions of school life for LGBT youth, have not permitted an exploration of some of the more positive dimensions of schooling to which participants alluded, such as friends, interesting teachers and subjects, school activities, and so on. The following section on workplace experience is similarly focussed on experiences of discrimination in these settings.

Table 4.5: Presence of LGBT issues/experiences at school: survey sample

At your school, is/was there...	All Respondents (N = 1110)		Currently enrolled in school (n = 51)	
	N	%	N	%
A written policy to protect LGBT students from homophobic bullying/other forms of discrimination	42	3.8	9	17.6
Other LGBT students you could look up to or who could act as a role model	41	3.7	5	9.8
Teachers or other school staff members supportive of LGBT students	108	9.7	16	31.4
Parent's Council supportive of LGBT students/issues	4	0.4	0	0.0
Teachers or other school staff members open about being LGBT	37	3.3	5	9.8
A club or support group for LGBT students	5	0.5	1	2.0
Positive imagery (posters, books etc.) representing LGBT issues/ people	23	2.1	10	19.6
Positive discussion of LGBT issues in class	96	8.6	9	17.6
Negative discussion of LGBT issues in class	335	30.2	16	31.4
Open discussion about LGBT issues in anti-bullying seminars	45	4.1	6	11.8
Homophobic bullying by students	641	57.7	26	51.0
Failure or refusal to address LGBT issues/concerns in class	506	45.6	20	39.2
Homophobic comments by teachers/other staff members	381	34.3	11	21.6
Access to information about LGBT support/youth groups	18	1.6	4	7.8
Relationships and sexuality education including LGBT specific information	53	4.8	4	7.8
Workshops for students addressing LGBT issues	9	0.8	2	3.9
Workshops for teachers about how to address and understand LGBT issues	3	0.3	2	3.9

EXPERIENCES IN THE WORKPLACE

Discrimination in the workplace

Four fifths of the online survey sample was employed at the time of completing the survey, a majority of whom were in full-time employment. Over 70% of the online survey sample was out to at least some of their work colleagues.

As outlined in Table 4.6, just over a quarter of those who had ever been employed admitted to ever having been called hurtful names related to their sexual orientation or gender identity by work colleagues. Fifteen percent of those who had ever been employed admitted to having experienced verbal threats because they were, or were believed to be, LGBT. Almost seven percent admitted to having been physically threatened by a work colleague, while almost ten percent admitted to having missed work because they were afraid of being hurt or felt threatened because of their LGBT identity.

Table 4.6: Experiences of victimisation in the workplace: survey sample

	Ever		Current job	
	n	%	n	%
Verbally threatened by work colleagues	155	14.7	28	3.2
Physically threatened by work colleagues	71	6.7	11	1.3
Called hurtful names by work colleagues	282	26.8	78	8.9
Missed work to avoid any of the above	98	9.3	17	1.9

Reports of overt forms of physical and verbal harassment in respondents' present places of employment were lower, although 9% of those who were employed at the time of taking part in the survey did admit to having been called hurtful names related to their transgender identity or sexual orientation in the workplace. While overt forms of harassment and victimisation were generally low in current workplace settings, many online and in-depth interview participants described direct and indirect forms of discrimination that impacted their lives at work, or beyond the workplace. Some pointed to a failure to provide the same benefit entitlements available to heterosexual spouses. Others called for stronger condemnation of, and disciplinary procedures in relation to, homophobic behaviour and remarks, pointing to the failure of anti-discrimination policies to prevent discrimination in practice. One online survey participant, for example, criticised the university setting where she worked for its failure to effectively tackle instances of bullying.

> *The university where I work does not have a positive attitude towards LGBT people. For all the 'equality' and 'diversity' legislation and workplace policies in existence, few practical steps are ever taken to deal with bullying. It is more likely that the complainant will be pressurised to leave the workplace (Lesbian, Female, 32, Survey Participant).*

Others expressed frustration at a range of work-place policies and practices which they experienced as marginalising, isolating, or discriminatory. As the following survey participant's story suggests, in some workplace settings at least, same-sex partnerships are not accorded the same respect or recognition as heterosexual partnerships.

> *My partner was very ill last year and had to be rushed to hospital on several occasions. On two such occasions I asked to leave work early (on the 2nd occasion 10 mins early, she has a severe form of asthma and minutes matter). I was not allowed to do so. I was asked if her 'family' could not go instead. There was a sense of tolerance of my sexual orientation in that job, but no sense that my relationship with my partner of eleven years deserved parity of esteem with my two bosses' heterosexual marriages. My partner was referred to repeatedly as my 'friend', despite my repeated correction of the term. This was not bullying per se, but it was blatant inequality. I don't know precisely how it can be addressed (Female, Lesbian, 35, Survey Participant).*

Equality legislation and discrimination against LGBT people

Other respondents made direct reference to the negative impact that current employment equality legislation exemptions can have for those who are LGBT. While not directed specifically at LGBT individuals, Section 37 of the Employment Equality Act (which permits certain medical, educational and religious organisations to discriminate in order to protect their religious ethos), can have a range of implications for LGBT people, including, losing or be forced out of their jobs, rendering them invisible in certain workplace settings, or at least making it difficult for them to be open about their sexuality (Walsh et al., 2007).

One commentator described how she had been forced out of her career as a teacher, having been 'outed' at work to the Principal.

> *As someone who has worked in Education and was bullied out of my part time teaching post due to anonymous letters to the Principal that I was gay, it is a disgrace that [the Employment Equality Act] still allows discrimination in the teaching workplace to occur with the ethos opt out of the legislation that still is in place. Mental ill health for lesbians and gays can be caused by the perception that society thinks it's OK to discriminate against gay people. Thanks to my friends and my own resourcefulness at the time I changed careers. It could have affected me very badly if I had not been able to cope and have the support I had (Lesbian, Female, 48, Survey Participant).*

As the foregoing comments reveal, legislation exemptions of this nature can have the effect of forcing LGBT persons out of employment in certain sectors, to avoid seeking employment in these sectors, or to take up employment in conditions where they are compelled to conceal their sexuality (Walsh et al., 2007). Yet even in those work settings and instances where such equality exemptions do not apply, the

routine stressors associated with being LGBT can affect some LGBT people's ability to hold down a job, or can influence their decision about where to work.

The following young man described how the combined effects of depression and coming to terms with his sexual orientation caused him to call in sick from work, affecting his ability to hold down a job in his early working life.

> *I used to ring in sick... at the time when I was just starting to come out I wasn't lasting in jobs because I kind of didn't, trying to find myself you know, where I was going. Even though my social life is great, like I had a great partner. When it came to work, I was still a bit, I wasn't sure what I wanted to do (Gay, Male, 26).*

For others, the perception that being LGBT was not acceptable or 'normal' forced them to conceal their true identity and aspects of their personal life in the workplace. As the following vignette reveals, for some participants, this impacted on the decision to seek employment elsewhere, occasionally resulting in a more supportive working environment.

> *Previously when I worked for (workplace name), I was with them for 25 years and one of the reasons I decided to change jobs, well one was for the promotion and the other was that again I was fed up of pussyfooting around with people and not saying that I was with my partner. There were children involved and because of the whole PC thing...some people didn't see it as being a normal lifestyle... The new job, I'm there two years and I sat down today at lunchtime and I was able to talk about Primetime last night and gay marriage and actually get support from the people I work with (Lesbian, Female, 47).*

Others who were not out in the workplace described how the additional stress associated with coming out at work, and/or fear of discrimination influenced their decision not to disclose their identity in these settings.

> *I would consider it [coming out] definitely, but at this present moment in time it would be too much added stress, I feel for me to come out when I don't necessarily need to... if I did, how will I put it, come out, it would be the focal point of who I was, whereas now, I'm me for different reasons (Lesbian, Female, 32).*

People know I'm lesbian most of the time. But I kind of feel like I'll get less flak if I don't say it than if I say it. Because if they're not 100% sure, then they can't 100% discriminate...I obviously wouldn't intentionally choose to live in fear if I didn't think there was some grounds for it. It's not a fear that I feel all the time but it's something that is there all the time that I'm aware of it (Lesbian, Female, 54).

CONCLUSION

> *I believe ignorant attitudes toward homosexuality and sexuality generally need to be tackled head on in our education system to avoid causing unnecessary harm to young people through ignorance and intolerance (Gay, Male, 26, Survey Participant).*

The minority stress model, which is a conceptual framework for understanding the negative impact on health and well-being caused by a stigmatising social context (Brooks, 1981; Meyer, 1995, 2003), has provided a useful lens through which to better understand LGBT people's lives. The foregoing analysis demonstrates that the stress associated with being a person of minority sexual orientation or gender identity is a routine occurrence for many who identify as LGBT, in both work and school settings. Moreover, LGBT youth in particular are vulnerable to distressing experiences and emotions, with stress especially evident in their narratives of coming out.

The findings on the school-based experiences of LGBT people closely parallel assertions made elsewhere that the school years are often marred by routine harassment and victimisation for some LGBT youth. In addition to more overt manifestations and expressions of LGBT-related harassment, such as homophobic

bullying and taunting, more subtle aspects of victimisation, discrimination, and social exclusion are also prevalent in schools. Collectively, the findings underscore the need for school personnel to advocate for LGBT youth in contexts characterised by homophobic bullying, taunting by peers and school climates which invalidate LGBT lives or render them invisible. Existing research suggests that teachers in an Irish context often view themselves as unable to address the homophobic bullying that takes place in schools, which may be related to the ubiquity of homophobia in schools and the religious ethos which characterises most schools in an Irish context (Norman et al, 2006). Yet, the importance of openly reprimanding derogatory comments about LGBT people and/or integrating LGBT-specific issues into class curriculum or discussion must not be underestimated. Such actions send messages of acceptance to otherwise 'invisible' or stigmatised youth.

While overt forms of harrassment and victimisation were generally low in current workplace settings, many particpants described direct and indirect forms of discrimination that impacted on their lives, even beyond the workplace. Indirect discrimination and heteronormativity, common in workplace settings, limit the ability of LGBT people to discuss or construct their own identities at work. More direct forms of institutional discrimination, including equality legislation exemptions, can force LGBT people out of employment in certain sectors, or cause them to avoid seeking employment in these sectors in the first instance, or to take up employment in contexts where they are compelled to conceal their sexuality. Even in those work settings where such equality exemptions did not apply, the routine stressors associated with being LGBT affected some participants' ability to hold down a job, or influenced their decision about where to work. The following chapter seeks to further underscore the effect that social contexts such as school and work can have on LGBT lives, with a particular emphasis on the impact of minority stress on the mental health and well-being of LGBT people.

CHAPTER 5 MENTAL HEALTH RISKS

MENTAL HEALTH RISKS

The previous chapter identified some of the unique stressors associated with being a sexual minority and/or transgender in an Irish context, and examined two specific social contexts, namely school climate and workplace cultures, within which LGBT people experience their everyday lives. Collectively, these findings suggest that many who identify as LGBT experience work—and school cultures in particular—as hostile and discriminatory. This chapter seeks to further underscore the impact that social contexts have on LGBT lives with a particular emphasis on indicators of mental health and well-being among LGBT people. Taken together, these chapters seek to provide a detailed understanding of the environmental risk factors, including aspects of discrimination and homophobia, that may be linked to psychological and suicidal distress among some LGBT people (McDaniel, Purcell & Augelli, 2001). In so doing, we pay particular attention to the direct and indirect impact of institutionalised and everyday practices of discrimination on LGBT mental health, in particular as they relate to depression, self-harm, and suicidal distress.

The chapter is organised as follows: Initially, we examine the prevalence and nature of depression, alcohol use, and self-harm. Here we attempt to contextualise these experiences, and to locate them within respondents' everyday lives. This is achieved through the analysis of survey data alongside everyday accounts of situations, events and experiences (past and present) depicted by respondents as sources of distress. Following this, we focus more exclusively on respondents' experiences of suicidality. This section first presents key findings from the online survey related to the prevalence of suicidal ideation and attempts amongst members of the LGBT community in Ireland. It then offers a more nuanced qualitative understanding of how being LGBT informs some people's experiences of suicidality, an understanding which the quantitative data alone cannot provide.

DEPRESSION

As outlined in Table 5.1, the vast majority of online survey participants (86%) indicated that they had felt down or depressed at some point in their lifetime. [1] Two thirds of respondents to the online survey reported having felt down or depressed in the past 12 months, and over two fifths felt depressed in the previous 30 days. Almost a quarter of the sample had taken medication prescribed by a doctor for the treatment of anxiety or depression during their lifetime, and 8% were currently taking such medications. The proportion of male and female respondents reporting depression was similar.[2] Nor were there significant differences by LGBT self-identification, although a slightly higher percentage of bisexual respondents reported having ever felt down or depressed than those who identified as gay or lesbian, or transgender (86% and 87% of gay, lesbian and transgender participants respectively, compared with 92% of bisexuals). [3]

1 It should be noted that no standardised measures were used to assess depression in either the online survey or in-depth interviews. These figures are based on self-reports, based on the following question: "Almost everyone becomes sad, down or depressed at times. Have you ever had a spell of feeling sad, down or depressed in your lifetime? In the past 12 months? In the past 30 days?"
2 It should be borne in mind that women are underrepresented in the sample, making up just a third of survey participants. Similarly, the number of respondents who did not identify as male or female is very small and should be interpreted with caution.
3 Data are disaggregated by LGBT identification in this chapter for analytic purposes, although it should be borne in mind that these categories are not necessarily mutually exclusive. As outlined in Chapter 3, a majority (n = 28) of transgender respondents also identified with commonly ascribed labels denoting a minority sexual orientation (i.e., lesbian, gay, bisexual).

Table 5.1: Prevalence of self-reported depression by gender: survey sample

	All Respondents (N=1110)		Female (N=377)		Male (N=707)		Something Else [4] (N=22)	
DEPRESSION	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Lifetime	958	86.3	325	86.2	612	86.6	17	77.3
Past Year	730	65.8	249	66	461	65.2	17	77.3
Past 30 Days	483	43.5	181	48	285	40.3	16	72.7
Taken medication for depression (ever)	259	23.3	102	27	150	21.2	6	27.2
Currently taking medication for depression	92	8.3	28	7.4	64	9.1	0	0

Reports of feeling 'down', 'low' or depressed were widespread across the sample of interview respondents with all but four of the forty interviewees (90%) reporting that they had experienced these feelings at some time. As might be expected, the severity and duration of depressed feelings varied. This study's qualitative exploration of depression was concerned with allowing respondents to elaborate, where appropriate, on the experience of depression. A se ries of open-ended questions permitted them to share their ideas about the origins of depression and their understanding of the impact of depression on their lives. In general,

respondents spoke candidly about feeling down or 'low,' and their accounts provide important insights into the 'place' of depression in the lives of LGBT people.

Twenty five respondents, or over 60% (comprising 14 gay men, 7 lesbian women, 1 bisexual woman and 3 transgender people), attributed the experience of depression directly to sexual or gender identity issues. The following are examples of respondents who made this explicit connection:

> *I hate using the world depressed but I was really down for about two years over just different things. The underlying issue was I was gay and stuff and I didn't happen to know it (Gay, Male, 20).*
>
> *I started getting very anxious and depressed but I could never identify or speak to anyone about it because to be gay was like [pause], it's harsh coming out and it was a huge thing for me (Gay, Male, 21).*
>
> *It's [depression] an issue for lots of people. People I work with that aren't gay are suffering from depression but I think it's made even more difficult if you're gay because I think your sexuality is part of your make-up. To struggle with that is like struggling without a kidney. I think your sexuality is a very important part of your life and if you're not comfortable with it you can struggle with it all your life (Gay, Male, 46).*

It was possible to identify a number of themes underpinning respondents' stories of depression from the diverse accounts received, including: feelings of inadequacy and isolation; perceived 'outsider' status; and the denial and concealment of self. These, and the relationship between depression and LGBT identification, are explored below.

Feelings of inadequacy and isolation

As highlighted in the previous chapter, the process of coming out was challenging for the majority. When respondents talked about the struggle of coming to terms with their sexual orientation or transgender identity, they frequently talked about feelings of fear and inadequacy leading to low self-worth. These interviewees sometimes depicted themselves as feeling out of kilter with the mainstream world, particularly during their teenage years. Indeed, the teenage and young adult years were almost consistently portrayed as a period when they confronted multiple emotional challenges and a time when depressed feelings were particularly intense. A bisexual woman, aged 20, made direct reference to

4 Respondents were asked whether they self-identified as 'male', 'female' or 'something else.'

feeling 'inadequate' as she reflected on her emotional state during the period prior to coming out to her parents:

> *I felt that I was inadequate, worthless, I didn't think I had a place in the world. I felt like I was an alien and I didn't belong anywhere at all (Bisexual, Female, 20).*

Irrespective of age, respondents consistently identified the period prior to coming out as one when they were susceptible to depressed feelings linked to anxiety and stress. During adolescence in particular, many struggled to feel connected with, anchored or guided by, important people in their lives and some indicated that depression continued unabated during their teenage years. A gay man, aged 43, had vivid memories of this period.

> *... it was kind of like I had to come out because I was very, very depressed at the time and, you know, I had years of knots in my stomach and I hadn't discussed it with anyone and I couldn't even come to terms with it myself ... I mean I never slept any night during my teenage years ... I spent four or five years in that state (Gay, Male, 43).*

Another gay man, aged 40, similarly identified the period spanning from his teens to his mid-twenties as particularly difficult.

> *I think those years [school] were not very good, you know. There was a lot going on and I was confused and in a lot of turmoil. All the hormonal urges a lot of teenagers have and no way of articulating them or expressing them. That's very destructive. And you know the distress carried on into my early twenties. And to be honest, for a couple of years, about 23, 24, a lot of it was just being masked by alcohol abuse ... That was not a pleasant time, you know (Gay, Male, 40).*

A number of younger respondents who had recently come out to friends or family members indicated that this step endowed them with a personal sense of achievement as well as temporary respite from feelings of anxiety and depression. This relief was most often short-lived however, and for the majority coming out (to friends and/or family) generated new anxieties and fears. A young gay man who had disclosed his sexual identity to friends and family just four months prior to his interview explained.

> **RESPONDENT:** *I just felt very low and like my life isn't going to be good, like, and almost like as in not suicidal but like very, very, low.*
> **INTERVIEWER:** *Was this after you came out?*
> *Respondent: Yeah. Just like a realisation that like [pause], 'cause I never thought about actually being gay, I just had thoughts in my head, you know, of liking men but I never actually thought about what it was going to be like. And after I came out then it kind of hit me like and I just felt very low about what my life was going to be. How I'd never get married or anything like that.*
> **INTERVIEWER:** *Can you tell me some more about what that felt like?*
> *Respondent: It's kind of like, sometimes I felt like I couldn't breathe. It was like, just feeling very pressured, or just distressed really. Like, nothing would make me feel better, like there was nothing I could do. I didn't care about anything really (Gay, Male, 16).*

Preoccupied by the need to disclose his true sexual orientation to others, the respondent above appeared only to begin considering his personal feelings after negotiating the challenges he experienced while coming out. This is consistent with Savin-Williams' (1998: 141) suggestion that sexual minority youth often feel "most vulnerable and out of control" when they come out or have their sexual orientation discovered by others. Misunderstandings or deteriorating relationships with peers during the months subsequent to coming out sometimes compounded these difficulties and a preoccupation with the views and judgements of others was a strong feature of these narratives. The following account illustrates one young man's struggle for self-acceptance and acceptance by others.

> *I was having problems with some of my friends there just for different reasons and it just got really shit and crap and I still didn't really like myself. That was it really ... I was so focused on everyone else's opinion of me (Gay, Male, 20).*

Irrespective of age, many articulated a sense of disconnection from others, experienced as a kind of loneliness or aloneness. Although most had one person in whom to confide, an overwhelming sense of dislocation permeated many accounts everyday life. In addition, some appeared not to have a legitimate means of expressing or articulating this sense of detachment, as suggested in the following account.

> *It got to a very extreme stage where there was almost no feeling at all, whatever was going on in my life I wasn't reacting to it at all. I was just utterly detached from what was going on (Gay, Male, 28).*

Some who lived in rural locations related their sense of isolation to the physical and symbolic make up of their social environments. A lesbian woman, aged 39, described life in rural Ireland.

> **INTERVIEWER:** *Can I just ask if you have any experience of feeling down?*
> **RESPONDENT:** *Try living in [rural area]! [laughs] I would, yeah. And being gay would be a lot of it and the other part is the weather [laughs] and living in the countryside on my own and not being able to get out ... I think it's the isolation. It's just because there's no community around here, you know (Lesbian, Female, 39).*

There were numerous other accounts of social isolation from lesbian, gay, bisexual and transgender people of all ages.

> *I was feeling very isolated and felt that [my sexual orientation] kind of had to be hidden (Gay, Male, 21).*

> *At the end of fifth year I said, 'That's it I need to leave, I cannot take it anymore'. I felt so alone and so isolated on my own (Bisexual, Female, 20).*

> *If there was a big group I just felt isolated and I wasn't really there almost (Gay, Male, 21).*

It is well established that isolation and hopelessness increase depression and suicide risk on an individual level for people of all sexual orientations (Beck et al., 1985). The stigma associated with LGBT identification can compromise or erode people's ties to friends and family, resulting in a reduction of perceived social support. Lack of social support is a negative experience and constitutes a significant risk factor for poor emotional adjustment of sexual minority youth, in particular (Safren & Heimberg, 1999).

Perceived 'outsider' status

Depressed feeling were often linked to a sense of disconnection from, or lack of relationship with, peers, family members and others in their immediate social environment. This sense of 'separateness' was also related by a considerable number to the broader culture of heterosexism. For example, several of the study's older respondents recalled feeling like an 'outsider' as young people. One gay man, aged 50, felt like 'a completely unwanted person in society' during his teenage years. He elaborated on this 'outsider' status with reference to the homophobic attitudes that dominated his everyday experience.

> *Feeling an emotional outsider, the butt of jokes and being as sensitive as I was, too sensitive for my own good. No role models, not having any mentors (Gay, Male, 50).*

While most respondents acknowledged that Irish society had become more tolerant and accepting of LGBT identities, this acceptance was often portrayed as superficial, tenuous and context-dependent. For a number, including younger participants, the messages embodied in this persistent culture of homophobia and heterosexism dictated that being gay was morally inferior.

> *Well society tells you that being gay is wrong and that it's a sin and everything. When there's people around you telling you that, it makes you feel more down ... In the local community and stuff you grow up being told and hearing it from other people's that it's wrong (Gay, Male, 21).*

From this understanding of heterosexism and homophobia in society it is possible to grasp the context in which LGBT men and women find themselves struggling to create a positive identity and sense of

belonging to society. A lesbian woman, aged 54, framed her 'outsider' status with reference to the risk of being labelled.

I have felt very unsafe most of my life. If I was just to walk around with a label 'lesbian' on me, I would be judged harshly in this society so I don't ... and even though I never dreamt of wedding dresses and getting married and having children, just that feeling that I was an outsider in society (Lesbian, Female, 54).

Living and coping with heterosexual definitions of the 'norm', whether in the context of intimate, peer or family relationships, emerged as a significant source of stress. A number of lesbian women and gay men specifically referenced their struggle with the fear that they might not be able to live and enjoy a 'normal' life when it came to marriage and/or having children, in particular.

> *That baby thing was really niggling me ... I wasn't getting the support whereas had I had a heterosexual relationship it would have been just normal to go and get pregnant (Lesbian, Female, 50).*

> *Not being able to have kids and stuff in the normal way ... made life just not worth living (Gay, Male, 20).*

LGBT individuals may internalise significant aspects of the censure and prejudice they experience within a heterosexist society. As well as generating doubt about one's ability to live a heterosexually constructed 'normal' life, the internalisation of societal expectations and norms can also lead to the kind self-blame and loathing often referred to as internalised homophobia (Meyer & Dean, 1998).

Denial and concealment of self

As the sexual aspect of the self emerges and becomes increasingly more central to identity, questions of non-heterosexuality become a predominant focus as individuals begin to question their sexual orientation and/or gender identity, particularly during adolescence. The realisation that one is gay, lesbian, bisexual or transgender is most often accompanied by fear of disclosing one's true identity to family, friends, and others. This fear is strongly embedded within societal expectations that privilege heterosexuality and view it as the 'acceptable' norm. As highlighted in the previous section, dominant messages include representations of homosexuality as wrong, immoral and/or unacceptable. As well as generating anxiety and distress, these messages prolong the 'coming out' process and contribute to mental health risks. Many LGBT individuals also internalise significant aspects of the prejudice they experience within a heterosexist society, leading to denial and the concealment of self (Plummer, 1995).

A considerable number of this study's interviewees talked about their struggle with self-acceptance and their consequent denial, sometimes over prolonged periods, of their LGBT identity. A gay man of 21 years explained that his denial found expression in the hope that his questioning of his sexual orientation was simply a phase.

> *There was a huge sense of self-denial within myself ... I was deluding myself to a certain extent that it was just a phase, it would pass. I started to get anxious and depressed (Gay, Male, 21).*

This young man went on to explain the negative impact of this self-denial. His account also highlights his limited access to guidance and support.

> *I then started getting like, feeling very isolated then, and felt that this [sexual orientation] had to be kind of hidden, I had to hide, like you know, and there was a huge sense of self-denial within myself ... I had no guidance. I had this huge thing, I didn't understand it, I didn't know how to express myself. I was just a complete and utter total mess (Gay, Male, 21).*

For a number, this discomfort with self seemed to sometimes coincide with an awareness of oneself as being watched or critically observed by others.

> *You have to put up with looks and comments. You know at this stage I'm not pushed ... I'm used to people looking (Male-to-Female Trans, Heterosexual, 37).*

Denial and concealment of self of the kind articulated in the accounts above also led to feelings of self-loathing, as the following narratives suggest.

> *I hate the way I look. I hate everything about myself really (Male-to-Female Trans, Lesbian, 30).*
> *[one day when attending psychiatric service] ... I sort of said, 'I hate being a queer'. And I do, I think deep down I never wanted to be and think that was half the problem and the whole thing. Like the way we were in those days, particularly in school, and I'm not blame gaming, but like just part of the reality of our lives, the obsession of the brothers with the fact that this [homosexuality] was evil and the worst possible thing in the world. And my father kind of believed in the death penalty for queers so [laughs] ... there was a huge depth of self-hatred (Gay, Male, 62).*

These narratives largely confirm that the stigma that surrounds minority sexual orientation and transgender identity can lead to an extremely negative experience of being LGBT. Fear, feelings of shame, and secrecy all emerge as significant ramifications of this experience. In this context, denial can pervade people's consciousness (Plummer, 1995) and may also become a major source of distress.

The relationship between LGBT identification and depression

Previous sections demonstrate the extent to which depression, and other manifestations of distress, are linked to the minority status of LGBT people. Minority stress therefore arises from the totality of the minority person's experience in dominant society (Meyer, 2003), including the stigma that LGBT people experience, their lack of integration with the community, their social isolation and problems of self-acceptance. For LGBT people, minority stress also results from external stressors such as discrimination, homophobia and hate crime (DiPlacido, 1998; Meyer, 2003). For many in this study, homophobia and anti-gay or anti-transgender violence, whether physical or verbal, featured as deeply distressing experiences.

> *I'd be walking up through [local town] and people would call me faggot and stuff. It did kill me a lot hearing those words (Gay, Male, 24).*

> *When I was nineteen and badly beaten up I would have been down (Male-to-Female Trans, Heterosexual, 27).*

> *I was very, very emotionally unstable both a mixture from the drugs and the fact that I was consistently getting abuse (Gay, Male, 21).*

Participants who experienced homophobic bullying or other forms of victimisation were particularly susceptible to depression, arising in large part from their vulnerability within potentially hostile environments. A ubiquitous tolerance of homophobic and heterosexist attitudes among peers, teachers and community members increased the sense of isolation and depression. When they experienced homophobic bullying, or were verbally or physically attacked, many in this study did not feel adequately protected, nor was their victimisation recognised or challenged by people or institutions with responsibility for their development or protection.

Other experiences associated with a depressed mood included specific personal challenges or events such as illness, the death of a loved-one, or the loss of an intimate relationship. Indeed, several who reported such experiences remarked that people, irrespective of their sexual orientation, may find themselves dealing with these issues and challenges. However, a number of respondents specifically mentioned the emotional and physical loss they experienced following the break down of an intimate relationship.

> *After the break up of the last relationship, I just saw a big black hole appearing again. I just thought, 'No' (Lesbian, Female, 39).*

> *In my teens I was very depressed, it was because of the break up with the girl I had been going out with, so mentally I was very fragile (Lesbian, Female, 25).*

Younger participants in particular talked about stressful home situations, including strained relationships with their parents or siblings. Others talked about the impact of their parents' deteriorating or difficult relationships.

> *The whole thing at home, my Mum and Dad constantly fighting (Bisexual, Female, 20).*

> *I don't know how, I just got really down ... my parents separated ... her relationship with my Dad kind of broke down, she doesn't like him very much. They still live together, which is, as you can imagine, quite difficult to go home to (Lesbian, Female, 17).*

Some respondents were in fact keen to point out that their sadness or depression was not necessarily nor exclusively, related to their LGBT identification. Nonetheless, as earlier analyses suggest, there was strong evidence of an association between depressed feelings and everyday experiences of homophobia, transphobia, prejudice or fear. The majority of accounts are also suggestive of low social support and limited access to formal or informal mechanisms that might help to alleviate fear, trauma or distress. In the following account, a gay man in his forties told of his ongoing struggle with depression, which was compounded by his HIV-positive status.

> **INTERVIEWER:** *How would you describe your mood, say in the past month?*
> **RESPONDENT:** *Unhappy. Unhappy. I have been unhappy for quite a while now, probably a couple of years. I get times where I can be happier and I'm able to go about my life. But then there's time where I just [pause] ... I might be coming in the gate and I'd get to the front door and I'd just burst out crying ...*
> **INTERVIEWER:** *And is there anything that you'd describe as good or makes you happy?*
> **RESPONDENT:** *No, 'cause I've struggled for the past couple of years, especially with the HIV and feeling so unwell at times and wondering where my life was going ... I'm unhappy about all aspects of my life. And I don't have a lot of friends. I'm probably very much a loner (Gay, Male, 46).*

All people can face certain stresses in their lives which may lead to mental health problems such as loss of family and friends, family discord, illness, bullying and discrimination. However, the level and degree of victimisation faced by LGBT people, along with a lack of social support, can be particularly harrowing (Warwick et al., 2001). The longer-term effects can include depression and anxiety, guilt and shame and feelings of social isolation (Elliot & Kilpatrick, 1994).

ALCOHOL USE

The online survey assessed current alcohol consumption patterns amongst the sample using two standardised measures, the CAGE (Ewing, 1984), and the short version of the Alcohol Use Disorders Identification test (AUDIT-C)[5]. Responses to AUDIT-C questionnaire items, measuring frequency and quantity of current alcohol consumption, are shown in Table 5.2.

Ninety-two percent were current drinkers, about half of whom consumed alcohol on a weekly basis. A roughly equal proportion drank less frequently (two-to-four times a month or less). On a standard drinking occasion, just over one fifth limited their intake to one or two drinks, with a higher proportion reporting that they consumed between three and four drinks (32%) or five and six drinks (27.2%) on a typical night out. About a fifth reported drinking seven or more drinks during a standard drinking occasion.

5 The CAGE is a four-question survey instrument used to identify potential alcohol dependence. CAGE is an acronym for the four areas identified (Felt need to Cut back, Annoyance by critics, Guilt about drinking, and Eye-opening morning drinking). The AUDIT-C is an abbreviated Alcohol Use Disorders Identification Test that assesses quantity and frequency of alcohol consumption (Bush et al., 1998; Gordon et al., 2001; Rumpf et al., 2002; Dawson et al., 2005).

Table 5.2: Frequency and quantity of alcohol consumption based on the AUDIT-C: survey sample

Frequency of taking a drink	n N=1110	% [6]
Never	85	7.7
Once a month or less	136	12.3
Two to four times per month	360	32.6
Two to three times per week	378	34.2
Four or more times per week	146	13.2
Valid n	1,105	100
Amongst drinkers: number of drinks on a standard day	**N=1025**	
1 or 2	218	21.4
3 or 4	327	32.0
5 or 6	278	27.2
7 to 9	137	13.4
10 or more	61	6.0
Valid n	1,021	100
Amongst drinkers: frequency of 6 drinks or more on one occasion	**N=1025**	
Never	165	16.3
Less than once a month	351	34.6
Monthly	308	30.4
Two or three times per week	173	17.1
Four or more times a week	16	1.6
Valid n	1,013	100

The in-depth interviews with young people in particular indicated that alcohol consumption was strongly associated with socialising and 'going out.' Alcohol was often depicted by respondents as helping them to unwind or relax or as a way to boost confidence and socialise more easily, especially during the early hours of a night out. Socialising in pubs and clubs sometimes led to drinking to intoxication, as indicated in the following account.

> *Well it starts off with pints and then go to vodkas and they go to double vodkas and a couple of shots in there too. So normally I spend, if I'm going out with my mates, on a good night I'll easily spend eighty euro on drink, if not more. And I'll remind you, I'm not working. So it's kind of, 'Dad, I need money'. So you skip the dinner part and just use the money for drink which isn't a good idea either. I know I'm doing stuff wrong, I just can't stop myself (Lesbian, Female, 17).*

There was also evidence of young people using alcohol to help them to 'feel good' at times when they felt frustrated, angry or upset.

> *I know myself if I'm really mad at myself and I go drinking I drink a load and just get sick and the next day I don't feel good about myself. If I was in a really bad mood and I was going out with a group of friends I'd be relaxed drinking. I wouldn't be angry. I wouldn't get drunk to drown my sorrows, just to relax and take a break from it I guess (Gay, Male, 20).*

This young man went on to explain that he had, in the past, consumed alcohol to help him deal with pressure or stress. He also alluded to the negative consequences of using alcohol in this way.

6 Figures reported are valid percentages.

I used to go drinking when I told people I was out and that. It was just basically, I was drunk and when you know there's something going on in your head, you're just kind of all over the shop and you're needy and you're really kind of like drunk and falling on the floor and having fights with people over nothing. It just wasn't nice (Gay, Male, 20).

As part of the AUDIT-C, online survey participants indicated the frequency with which they consumed six drinks or more on one occasion, an amount often categorised as 'binge drinking'.[7] Eighty-four percent of all drinkers (n = 860) engaged in binge drinking, with almost a fifth doing so at least twice a week. Age was associated with drinking, with younger respondents reporting higher levels of alcohol consumption during a typical drinking session (r = -.278, p <.01) as well as a greater tendency to binge drink (r = -.197, p <.01).

These findings appear to mirror drinking patterns in the general population in Ireland and among young people. Alongside evidence of a dramatic increase in alcohol consumption over the past 10-15 years (Hope, 2007), research also suggests significant changes in drinking patterns and, in particular, a rise in 'binge' or heavy episodic drinking. This trend has been noted in relation to teenagers and young people (Hibell et al., 1997; 2000; 2004; Kelleher et al., 2003; Nic Gabhainn, 2007), college students (Hope et al., 2005a), and among men and women of all ages (Hope et al., 2005b; Ramstedt and Hope, 2005; SLAN, 2003).

Problem drinking

The CAGE instrument was used to determine perceived problem drinking amongst the survey sample. Table 5.3 shows the percentage of respondents who answered 'yes' to individual items on this measure.

Table 5.3: Perceived problem drinking as measured by the CAGE alcohol use scale: percentage of survey sample answering 'yes' to each item on the scale

Cage Item	n	%	Valid n
Have you ever felt you should cut down on your drinking?	593	58.2	1019
Have people annoyed you by criticizing your drinking?	230	22.9	1003
Have you ever felt bad or guilty about your drinking?	438	43.1	1017
Have you ever had a drink first thing in the morning (as an "eye-opener") to steady your nerves or get rid of a hangover?	103	10.2	1005

Almost two fifths of the overall survey sample (38%, n = 424) and 41% of current drinkers had CAGE scores of two or more, the 'cut off point' signaling problem drinking.[8] Thirty eight percent of women (n = 145) and a similar proportion of male respondents (n = 267) had CAGE scores that signaled probable alcohol misuse.[9] In the AUDIT-C assessment, a majority of respondents scored at or above the threshold for potentially hazardous drinking, (i.e., drinking above recommended limits)[10], with 18% of respondents (n = 209) obtaining a total AUDIT-C score of 8 or higher, the score that generally indicates harmful drinking behaviour or potential alcohol dependence.

7 Although there is widespread consensus amongst researchers about the potentially problematic nature of 'binge drinking' and its distinctiveness from moderate drinking, there is generally no agreed definition of the term. For example, Nadeau et al. (1998) use eight standard drinks per day to define binge drinking, while Reilly et al. (1998) define different levels of binge drinking in terms of risk. In the Irish context, an analysis of drinking culture and 'binge' drinking estimated the frequency of drinking larger amounts of alcohol (i.e. binge drinking) by asking respondents to state how many times during the past 12 months they had consumed "at least one bottle of wine, 25 centilitres of spirits or 4 pints of beer, or more, during one drinking occasion" (Ramstedt & Hope, 2004: 2). Irrespective of variations in definition, there is considerable agreement that binge drinking is a public health matter of considerable concern.
8 A point is scored for each positive answer on the CAGE, with a score of two or more indicating probable alcohol misuse.
9 The lack of a comparison group limits our ability to determine the significance and severity, or otherwise, of these findings. As such, these data should be treated with caution. See Chapter 8 of this report for a discussion of study limitations.
10 The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. A positive scores means that an individual is at increased risk for hazardous drinking or alcohol dependence. Hazardous drinking does not necessarily equate with alcohol dependence

A number of interview respondents also reported heavy or problematic drinking patterns, either currently or in the past. These accounts provide insight into the nature and origin of these drinking patterns and also help to contextualise the survey findings which indicate that alcohol consumption among a significant proportion of participants exceeds the threshold for hazardous drinking.

There was strong evidence of people using alcohol during periods of particular stress. A number of participants identified the onset of their patterns of heavy drinking as coinciding with the process of coming out.

> *It was a very difficult time. Like I never knew, I thought I was the only person who was ever attracted to men, it might sound silly but because I never, I never heard it. Like I would hear the words faggot, queer and stuff like that but I never actually thought, you know, like I thought I was the only person and when I was about 14 years of age I was drinking at that stage (Gay, Male, 24).*

This respondent subsequently moved to another country and depicted his alcohol use as associated with his need to 'run away from myself' at this particular juncture.

> *I went to [name of city] for a year and all I was wanting was drink to kind of, I don't know, suppress feelings or something like that ... I was kind of saying, 'What am I doing?' or 'Am I doing right?'. Like I didn't tell anyone where I was, you know none of my family or anything like that. I just wanted to go, just kind of run away from myself (Gay, Male, 24).*

Another gay male, now aged 40, recalled his abuse of alcohol during his twenties which he attributed to his need to 'blot out' or 'mask' the emotional distress associated with coming to terms with his sexual orientation.

There was a lot going on and I was confused and in a lot of turmoil. You've all the hormonal urges a lot of teenagers have with no way of articulating them or expressing them. That's very destructive. And you know the distress carried on into my early twenties. And to be honest, for a couple of years, about 23, 24, a lot of it was just being masked by alcohol abuse. So a lot of people though it was just student high jinx whereas I was blotting out how I actually felt. That was not a pleasant time, you know (Gay, Male, 40).

Similarly, others described a period of heavy drinking which they depicted as helping them to cope with difficult experiences or distressing emotional states.

> *I would say I drank excessively to be able to cope with going into straight environments, pretending to be something I wasn't. That for me was very hard and I suppose with misuse of alcohol you're able to cope, it takes the edge off. I suppose most weekends I probably would have drank too much. But again like that, it dulls the senses and just gets you through what ordinarily would have been a very difficult time (Lesbian, Female, 47).*

> *It was not a nice scenario. I went into a phase when the stress was not good. I drank too much at times. And god I didn't have the money to be doing that but hell, Wednesday and Saturday nights I used to go and get wasted. To be honest it helped me to cope (Gay, Male, 40).*

Some of the narratives also suggested that heavy alcohol use overlapped with depression.

> *I was actually very depressed in college as well. I don't know, I think the amount of alcohol that I was kind of drinking as well at the time kind of didn't do me any favours, but it was a combination. When I came out it wasn't, I didn't get any hardship from people but actually realising it was kind of hard ... once the full realisation of it kind of dawned on me it was very daunting, and I did get very depressed 'cause I thought to myself, you know, there's so many miserable aspects to this, you know, I mean you can get people hating you from everywhere and discrimination and all that kind of crap. So it was more like the weight of all these dreadful things that could happen just kind of hit me (Lesbian, Female, 25).*

A gay man who had experienced depression for many years explained that he used alcohol to help him to cope with psychological distress.

> *Anger and depression and so on ... I'd say I had it all my life but I disguised it with alcohol but I don't drink anymore so that makes things, well it makes things harder in one way but it makes things easier too ... I suppose I regret my own inability to deal with my sexuality when I was younger. I regret it very much now that I'm out ... And I think deep down that I never wanted to be [gay] and I think that was half the problem and the whole thing ... I masked it with drinking, I medicated myself with drink. It's very hard to separate out [alcohol and depression] so it's like which came first, the chicken or the egg, you know? (Gay, Male, 62).*

While drinking patterns varied, almost half of all survey participants consumed alcohol on a regular basis (i.e., they drank at least twice weekly), with qualitative data suggesting that drinking plays a significant role in the socialising routines of a majority of LGBT people. A vast majority of survey respondents who drank also reported that they engaged in heavy episodic or 'binge' drinking either intermittently or regularly, a fifth of whom did so at least twice a week. While the survey data do not enable us to draw direct comparisons between the drinking patterns of LGBT people and those who do not identify as such, the fact that a significant minority of respondents (43.1%) reported that their alcohol consumption made them 'feel bad or guilty' and that almost 60% indicated that they have felt they should reduce their intake of alcohol suggests that alcohol consumption patterns are subjectively viewed as problematic by a significant number. Furthermore, responses to both standardised measures of alcohol use suggest that the alcohol consumption patterns of a significant minority could be characterised as problematic, as they exceeded the threshold for hazardous drinking or probable alcohol misuse. Collectively, the study's qualitative data suggest that motives for regular or heavy alcohol consumption can be strongly associated with a felt need to 'mask' distressing emotional states. In other words, some clearly used alcohol as a coping mechanism or as a form of self-medication. A number of these narratives also suggest that heavy alcohol use overlapped with depression, while analysis of quantitative findings indicated a statistically significant correlation between alcohol use and suicidality, where higher CAGE and AUDIT-C scores were associated with a greater likelihood of having thought seriously about taking one's own life in the previous twelve months ($r = .155$, $p < .01$ and $r = .086$, $p < .01$ respectively).[11] LGBT people's experiences of suicidality are explored in more detail below, following an account of the prevalence, nature, and factors related to self-harm amongst participants.

SELF-HARM

The term self-harm includes a wide range of behaviours ranging from highly lethal, to less lethal, to superficial self injury.[12] This section is concerned with those respondents who reported self-injurious behaviour that was typically not framed as a suicide attempt, although many also reported suicidal thoughts and/or a separate suicide attempt. Over half of all online survey participants who had self-harmed, for example, also reported having 'sometimes' or 'often' given serious consideration to ending their own lives (52%, n = 159), and a very significant minority of self-harmers also reported having attempted suicide on at least one occasion (46%, n = 140).

11 Spearman Rho (rank order) correlations were performed for ordinal level data indicating frequency with which respondents had contemplated taking their own life during the previous 12 months. ('never'; 'rarely', 'sometimes' 'often'). 1998; Gordon et al., 2001; Rumpf et al., 2002; Dawson et al., 2005).

12 Terms such as self-injury and attempted suicide pose problems of definition. Individuals may self-injure either with or without any intention to kill themselves. Kreitman & Philips (1969) proposed the term 'parasuicide' to describe behaviour displayed by an individual to parody suicide but with no intention of killing themselves. What is referred to here as self-harm is elsewhere known as parasuicide (Kreitman, 1977), self-mutilation (Clarke & Whittaker, 1998), or self-injury (Deiter et al., 2000; Soloman & Farrand, 1996).

People who engage in self-harm are a diverse group and caution is therefore needed when making generalised comments about self-harm. As Skegg (2005: 1473) points out, '[t]he complexity and mix of intentions behind any act of self-harm should always be kept in mind.' This section of the analysis is primarily concerned with exploring respondents' stories of self-injury. Quantitative findings from the online survey are presented at the outset to provide a sense of the prevalence and nature of self-harm amongst members of the population who identify as LGBT in Ireland. This is followed by an exploration of the experiences of those in-depth interview participants who reported self-injurious behaviour, in an effort to provide a more nuanced understanding of self-harm. The circumstances surrounding self-harm are explored, as are the motivations for self-harming, and the meanings that those who self-harmed attached to this behaviour.

Prevalence of self-harm

The online survey assessed lifetime prevalence of self-injurious behaviour by asking respondents if they had ever harmed themselves in a way that was deliberate and not intended as a means to take their own life. As reported in Table 5.4, over a quarter of all survey respondents (27%) indicated that they had self-harmed at least once in their life. For the vast majority who reported self-injurious behaviour, it was not a one time event, with over four fifths of those who had self-harmed reporting at least two self-injurious acts (85%) and close to half reporting six or more acts of self-harm. Indeed, as will be explored in more detail below in the in-depth interview narratives, for a considerable number of those who self-harmed, the behaviour was a regular and prominent feature of their lives, with some describing it as 'addictive.'

Amongst those who no longer self-harmed, the average length of time that respondents had self-harmed for was just over four and half years. Indeed, the proportion of the overall survey sample that had harmed themselves intentionally in the recent past was relatively low. Six percent admitted to having harmed themselves intentionally within the previous 12 months, while 3% had self-harmed within the last thirty days.

Table 5.4: Prevalence of self-reported self-harm by gender: survey sample

	Total (N = 1110)		Female (n =377)		Male (n =707)		Something else (n = 22)	
Prevalence of self-harm	n	%	n	%	n	%	n	%
Lifetime	304	27.4	147	39.0	142	20.1	12	54.5
Past 12 months	69	6.2	37	9.8	29	4.1	3	13.6
Past 6 months	42	3.8	29	7.7	11	1.6	2	9.1
Past 30 days	33	3.0	24	6.4	8	1.1	1	4.5

Types of self-injurious behaviour

Online survey participants were asked to select from a list all the forms of self-harm behaviour they had engaged in. As is evident in Table 5.5 below, self-injury in the form of cutting, scratching and hitting was the most prominent means by which individuals self-harmed (81.6%), while excessive use of prescription medication was reported by almost a third of respondents who self-harmed. About a fifth of respondents who self-harmed reported having ingested drugs or alcohol with the intention of causing harm to themselves, while a very small proportion (2%) reported having ingested a non-ingestible substance or object. Other self-injurious acts identified by respondents included: punching walls and/or oneself, burning oneself, and binge-eating or starving oneself.

Table 5.5: Type(s) of self-harm behaviour: survey sample

Type(s) of self-harm behaviour	n (n = 304)	%[13]
Self-injury such as cutting, scratching, self-hitting	248	81.6
Ingesting a substance in excess of prescribed dose	97	31.9
Ingesting a recreational or illicit drug/alcohol as a means to harm yourself	63	20.7
Ingesting a non-ingestible substance or object	7	2.3
Other	33	10.8

Gender

A Chi-square test of independence revealed that the relationship between gender and self-harm was statistically significant ($X2 = 46.6$, $p < .001$). Female respondents were almost twice as likely to have self-harmed as males, with almost 40 percent of female respondents admitting to having self-harmed in their lifetime compared with 20% of males (See Table 5.4).

Age

The average reported age of onset was 16 years, which corresponds closely with the sample from the qualitative dimension of the research, indicating that respondents typically began to self harm during the mid-teenage years. Reasons for the onset of self-harm during adolescence are discussed in more detail below in the context of the qualitative findings on self-harm. Those who had harmed themselves within the recent past (12 months) ranged in age from 14 to 41, with a modal age of 21 years and an average age of 23 years. For those who no longer engaged in acts of self-harm, the average age of cessation was 20 years.

Sexual orientation

A quarter of all respondents who identified as gay or lesbian had self-harmed during their lifetime. A greater proportion of bisexual respondents reported that they had self-harmed, with over two fifths having self-harmed at some point. Over a third of those who were 'questioning' or 'not sure' about their sexual orientation had self-harmed, whereas two fifths of those who did not identify with these commonly ascribed categories of sexual orientation had self-harmed (See Table 5.6).

Table 5.6: Self-harm by sexual orientation: survey sample

LGBT Identification	All respondents (n = 1110)		Gay/Lesbian (n = 902)		Bisexual (n = 124)		Questioning/ Not sure (n = 35)		Heterosexual (n = 9)		Something else (n = 40)	
Prevalence of self-harm	n	%	n	%	n	%	n	%	n	%	n	%
Lifetime	304	27.4	223	24.7	51	41.1	12	34.3	2	22.2	16	40
Past 12 months	69	6.2	44	4.9	17	13.7	3	8.6	0	0	5	12.5
Past 6 months	42	3.8	24	2.7	8	6.5	5	14.3	0	0	5	12.5
Past 30 days	33	3.0	22	2.4	5	4	3	8.6	0	0	3	7.5

13 These figures are based on a 'check all that apply' response format, and hence do not add to 100%.

Self-harm amongst transgender participants

Figures for transgender survey participants who self-harmed are reported here as a separate category for analytical purposes. A significant minority (44%) of transgender participants had self-harmed at some point in their lives, and 11% had self-harmed in the previous twelve months.

Table 5.7: Self-harm amongst transgender participants: survey sample

Prevalence of self-harm	Transgender respondents (N=46)	
	n	%
Lifetime	20	43.5
Past 12 months	5	10.9
Past 6 months	4	8.7
Past 30 days	3	6.5

Help-seeking

Half of those who self-harmed sought some form of help for their self-harm behaviour, through a combination of formal and informal channels. Table 5.8 below presents the breakdown of supports utilised by those who sought help for their self-harm behaviour.

Table 5.8: Sources of support for self-harm behaviour: survey sample

Source of help/support	n (n = 151)	%[14]
	%	
Psychiatrist/Psychologist	96	63.8
Friends	85	56.3
Family	53	35.1
Other mental health professional	40	26.5
Other medical professionals	29	17.2
Other helpline (besides LGBT-specific)	23	15.2
LGBT group/organisation	15	9.9
LGBT helpline	8	5.3
Something else	21	13.9

QUALITATIVE FINDINGS ON SELF-HARM

Of the 40 individuals interviewed, 11 (just over 25%) reported at least one episode of self-harm. This included 6 gay, 4 lesbian and 1 bisexual respondents. The vast majority (9 of the 11) were 25 years or under at the time of interview. It is notable, therefore, that accounts of self-harm did not generally feature in the narratives of those over the age of 30. All who reported self-harm engaged in cutting or scratching and a smaller number stated that they had also hit or punched themselves. The onset of the behaviour was almost always during the mid-teenage years, although one stated that her first episode occurred in her early 20s and another at age 11. Two respondents self-harmed on one or two occasions only while others described the behaviour as occurring intermittently. However, a considerable number (6 respondents) reported multiple episodes of self-harm over a period of two or more years. In general, the onset coincided with a period of particular difficulty during adolescence. While self-harm was portrayed as intermittent initially, for a number, cutting appeared to gradually become a more persistent and enduring behaviour.

14 These figures are based on a 'check all that apply' response format, and hence do not add to 100%.

I don't think kids know what self-harm means when they're young but then I did it when I was that young [age 11] and I don't understand when I heard about it. I don't know how I got into it. But then it started off grand, it would have been once in a blue moon that I did it then. As I got older it just got more and more frequent and it just got worse (Lesbian, Female, 17).

It [cutting] was every couple of weeks at the start and then it became every few days and then in the really intense period it was every day (Lesbian, Female, 20).

One young man explained that, as time passed, self-harming grew progressively more frequent and intense, culminating in a daily routine of cutting during the final year of his formal schooling:

So I don't know how it started but I started cutting in maybe November of 4th Year. Just kind of gave myself minimum grazing type thing. It got worse then. At the time I was still depressed about the fact that I was gay, I just didn't want to think about it. There were stresses at school that were getting to me ... The cutting kept getting worse and I couldn't stop cutting. So the Leaving Cert was coming up and pressure and all that. It was just getting worse and bad and shitty and all that and I didn't really know what was going on in my head. I felt crappy and depressed the whole time ... I'd go to class and go home and I'd cut and I'd do my homework and that was kind of my routine for three or four months in the middle of Leaving Cert (Gay, Male, 20).

Some who reported more prolonged engagement in self-harm indicated that, over time, they had become more 'attached' to the act of cutting, describing their behaviour as somewhat compulsive. The accounts below suggest that respondents retrospectively perceived the sense of relief they attained from self-harm as 'addictive':

Then it came to the stage where I was kind of looking for any excuse just to cut. It was my only relief (Gay, Male, 20).

The problem was that the release, it was addictive (Gay, Male, 17).

But other times it's like I'd kind of think I'd want to do it [self-harm]. Then it would be in my head the whole day. Then I'd be like, I really want to do it. Then it's like, I'm not going to do it. It's like you have two people fighting in your head, 'I want to do it, no I'm not going to'. It just gets more and more, then gets to the stage where, fuck it, I've just done it. It's sometimes like an addiction almost (Lesbian, Female, 17).

The majority of respondents did not seek medical attention following episodes of self-harm. Although a small number indicated that they confided in a close friend or romantic partner, most invested considerable energy in concealing the behaviour from family members, peers and teachers.

I cut my arms before as a stress relief you know that kind of way ... I always hid them [cuts, scars], you know, and I was kind of scared for myself, hiding the fact that I was harming myself (Gay, Male, 21).

It was mainly my arms, pent up energy so I cut there. Then when it was say summertime or whatever I wouldn't be able to cut my arms because people would see it and stuff and I'd use my legs (Gay, Male, 20).

Despite such efforts to conceal their injuries, four respondents stated that one or both parents had inadvertently discovered that they were self-harming. A visit to the local GP almost always followed this discovery and these young people invariably depicted this experience in negative terms. The weight of criticism fell on the response of the health care professional they encountered at this juncture. The following account of a 20-year-old gay man, who was not out to his parents at the time, demonstrates his frustration with the intervention of his GP.

It was fairly negative. He [GP] wasn't really understanding. He was kind of talking about his own son. He was trying to understand but he just wasn't. I was sitting there and it was just not a comfortable feeling ... Then he talked about the whole thing that if his son was gay, not that he wouldn't accept him, but

> *he wouldn't be happy about it and stuff like that. And I'm just thinking, no tact, kind of thing. Then the fact that there was the whole thing of Dad going talking to him and the doctor gave him a little bit of feedback and was almost implying, or did more than imply, basically told him that I was gay and I didn't want that (Gay, Male, 20).*

Breaches of confidentiality of this kind described above are likely to engender strong distrust in young people who are trying to come to terms with their sexual orientation. Another account of intervention following multiple episodes of self-harm also suggests that the health care professionals this young woman encountered did not grasp or, indeed, fully investigate the difficulties she was experiencing at the time she attended these services.

> *She [teacher] called my parents and I'd been cutting myself as well for a few months so they found out about all that and they brought me to the GP that evening. The GP was a bit useless and tactless but she sent me to the A&E ward in the hospital and I spoke to one of the psychiatric nurses there. He put me in touch with the counsellor and was like, 'Oh, you'll be grand, it's just college work, etc.' Of course it wasn't that (Lesbian, Female, 20).*

This 20-year old lesbian woman did, however, subsequently attend counselling and indicated that she had benefited from this experience.

> *As soon as I started getting help and someone was listening to me, people recognising there was a problem and people started trying, I just stopped, just stopped (Lesbian, Female, 20).*

Feeling alone and different

A consistent theme permeating accounts of self-harm was the notion of feeling alone. Respondents portrayed a picture of spending extended periods in their bedrooms away from others in the household. Possibly to avoid rejection and subsequent invalidation, they engaged in social isolation through actively distancing or removing themselves from the company of others. One bisexual young woman depicted a home situation where there were few supports available, leading to feelings of non-acceptance and isolation.

> *At the time I started cutting myself, around when I was 17, I was still in secondary school. The whole seclusion thing, I didn't feel accepted, I felt isolated. My mum and dad constantly fighting, my sister, she was very wild, very unstable and so my mum had a lot of problems to deal with so I didn't really express myself to her like, my emotions (Bisexual, Female, 20).*

Social settings such as the school environment were also places where they felt lonely and socially isolated. Feeling surrounded by people who had no knowledge or understanding of their situation provided little consolation and, as demonstrated elsewhere in this report, school was a challenging and threatening social environment for many. However, in their descriptions of self-harm, the weight of attention often fell on the sense of isolation respondents experienced in their own homes.

> *I just felt shit and crap and just my parents never accepted me and that (Gay, Male, 20).*

> *I was so angry that nobody could see when I started doing it [self-harming] that I was obviously hurting. There was such a big problem, even if you couldn't see me cutting myself there was obviously something. Teachers were picking up on it, friends were picking up on it. Why the fuck weren't my parents offering me help or whatever? (Lesbian, Female, 20).*

These accounts suggest that young people craved legitimacy through their acceptance as gay or lesbian by family members and by their parents in particular. Many appeared to judge themselves harshly in this context, fearing that their 'non-conformity' might possibly be tolerated but never fully embraced, understood and accepted. In this sense, there was evidence to suggest that self-harm was connected with respondents' desire to be considered legitimate people of worth.

Feeling attacked, silenced and angry

As highlighted in the previous chapter, a very considerable number of participants struggled with their school and, to a lesser extent, with their work environments. School is a context dominated by heteronormative expectations, thus alienating individuals who do not conform to this standard. One respondent likened the pejorative use of the word 'gay', whether directed randomly or explicitly at gay youth, to a form of "metaphorical" stone-throwing.

> *There's all this pressure [at school] and then the word gay being used as an insult for someone that's in school. You hear it and it's almost attacking you. It's attacking you I guess even without them even knowing and you just feel that you can't be yourself because if people know that you're gay they'll just attack you and throw stones at you, metaphorical stones at you, and you'll be kind of the centre ... (Gay, Male, 20).*

These kinds of experiences were sources of considerable distress and sometimes generated anger linked to feelings of invisibility. This lack of recognition and respect led one respondent to feel "angry and silenced".

> *Why did I do that [self-harm]? It wasn't life threatening. I can't actually remember why. I suppose I just felt so horrible, but I didn't want to die, you know, or didn't feel suicidal. Just angry and silenced (Lesbian, Female, 29).*

Expressions of anger by other respondents were attributed to the absence of communication with their parents and their parents' failure to recognise their identity struggles. For one 20-year-old lesbian woman, the solution to this impasse was self-harm.

> **INTERVIEWER:** *Before doing it [cutting], how might you feel, from your memory?*
> **RESPONDENT:** *Really, really angry. Usually something happened to make me really angry and frustrated and I felt like I'd no other way. There was very little communication with my parents ... It was just complete deadlock and I just couldn't feel any other way, there was nothing else. Or I felt like there was no other way (Lesbian, Female, 20).*

Feelings of self-loathing

Linked to feelings of non-acceptance and rejection, a number talked about their fear of the thoughts and perceptions of others. These respondents often stated explicitly that they feared the disparaging thoughts of others (homonegativity) and stated that these experiences also engendered feelings of self-loathing.

> *I know personally that it [self-harm] was to do with my sexuality because there were times when, you know when I came out, I'd been out maybe a year and I still had a problem with it even though no one else had a problem with it. So I hurt myself through myself. Then there was the whole problem of internalised homophobia. I'd beat myself up over issues (Gay, Male, 21).*

On the one hand, the young man below felt proud to be gay but this positive sense of self was invalidated by self-doubt.

> *I was being afraid of everyone else and what they thought of me and I didn't like myself. I was, you know, shit and this and that. It was just basically self-loathing, I didn't like myself ... I was my own worst enemy. Then there was part of me that was proud, I was different being gay. I wasn't like everyone else in that respect but I probably didn't like that either. Like I shouldn't be feeling proud about it because it's crap basically. So that's why I cut and covered it up, to justify myself, I guess (Gay, Male, 20).*

Feeling relief

Respondents, as demonstrated above, explained self-harm with reference to the difficult emotions they

confronted, particularly during their teenage years. In general, these struggles were related directly to the process of coming to terms with their sexual orientation and/or coming out in contexts of uncertainty and fear. Feelings of alienation, anger and the stress were almost always articulated. Above all else, cutting or other forms of self-harm provided a sense of relief and, therefore, release from intense emotional distress and pain.

> *It was a release I guess. You'd feel like a pent up ball and you'd cut and it's a release, kind of relaxation sort of thing. The pain then, it's just blank I guess. You're not thinking about what's pissing you off or annoying you or of what's shit at the time ... when I was cutting always I felt depressed and shit the whole time. There was rarely any occasions when I felt good (Gay, Male, 20).*

> *It's a release, like. Like when you hold your breath and you hold it for ages, a big release, that's what it's like sometimes (Lesbian, Female, 27).*

> *It [cutting] gave the same kind of relief but more intense that hitting a punching bag or something. It's a sense of release but also like an adrenalin rush as well. It became addictive and still, times when I get really stressed out I do still feel like doing it (Lesbian, Female, 20).*

One woman who engaged in self-harm in the past depicted the behaviour as a "physical manifestation of emotional turmoil".

> *It's [self harm] kind of like a physical representation of emotional turmoil or something. I doubt that I would have put it so articulately at the time but I suppose that's what it's supposed to represent or whatever ... it did actually make me feel peripherally better. I suppose at the time it was more like symbolic. It was the act of doing it or whatever ... (Lesbian, Female, 25).*

The accounts of the majority suggest that they felt particularly isolated, with few or no trusted adults or peers in whom to confide, during the period when they self-harmed. In this sense, self-harming was a form of 'expression' which simultaneously provided relief from emotional pain.

> *I didn't really express myself, my emotions. I used to lock them inside and I think that's kind of what happened, that I kept them locked inside and they built up and I needed to release the stress and get rid of it. And I used to feel that cutting myself was a release, like just took the pain away, made me feel numb, you know (Bisexual, Female, 20).*

It is suggested that self-destructive behaviour stems from a disregard for one's own self-interest due to low self-esteem or anger (Hammersley & Pearl, 1996), that it may relieve feelings of anger or tension (Richardson & Joughin, 2000) and/or that self-harming may help a young person to feel in control. Solomon & Ferrand (1996) claim that for the young women they interviewed, self-injury transformed emotional pain into more manageable physical hurt or damage. There is certainly evidence to suggest that young people in this study engaged in self-harm as a way of coping with intense emotional distress and pain.[16] [17]

Feeling regret

While the vast majority of those who self-harmed were clear that they derived momentary or short-term benefits from cutting or other forms of self-injury, a number also talked about feeling regret or remorse after these episodes.

> *But immediately afterwards I'd feel very bad, I mean after the euphoria of being alive or whatever I'd think to myself, just this isn't right; that was always the thing that used to stick out in my mind, this isn't right (Lesbian, Female, 25).*

One young woman indicated that a mounting conflict between feelings of relief and regret led her to question her motives for self-harming:

> **INTERVIEWER:** *Why or how did the self-harm stop?*
> **RESPONDENT:** *I don't know. I just stopped, I saw what I was doing to myself. I still have scars now and I just really don't see the point. I don't like what it was doing to me. Like I'd wake up in the morning after doing it and I would look at my arms or my legs and say what did I do to myself? I felt I needed to get back to normality, you know. So I think I just stopped because I'm not doing this anymore, I need to find something else to replace the need to do that, you know (Bisexual, Female, 20).*

She explained later that she now felt more 'stable' than at the time when she was harming herself.

> *No I'm more stable now. It could be because of my relationship at the moment or it could be from my own experiences. I know it's [cutting] not good to do that, I don't want to go to that place again, you know. It could be my own strength that I am able to cope with more now that I was then ... But I know myself that cutting myself is not a normal thing to do. I shouldn't have been doing that, depression led me to doing that (Bisexual, Female, 20).*

The only respondent who indicated that self-harm remained part of her life was aged 17 years. Although she continued to experience the desire to self-harm as difficult to resist, she also expressed regret about this behaviour:

> *It's not as bad or as much as it used to be so it's getting better but I wish I didn't do it though ... When something happens that upsets me or gets me down, you know, I'd turn back to it no problem. But yeah, I regret doing it as well (Lesbian, Female, 17).*

These accounts suggest an uneasy tension between the benefits and costs of self-harm and that, over time, individuals who reported self-harm began to reflect on their behaviour.

Understanding self-harm

Research suggests that men and women with gay, lesbian, or bisexual orientation are more likely to self-harm than are heterosexuals (Skegg et al., 2003; Jorm et al., 2002). In a longitudinal study of Norwegian youth, gay, lesbian, or bisexual attraction, identity, and behaviour were associated with self-harm, with most episodes occurring after or around the time that participants realised that they were not exclusively heterosexual (Wichstrom & Hegna, 2003). For a large number in the current study who self-harmed, the onset of the behaviour coincided with particularly difficult or painful periods linked to struggle of coming to terms with their sexual orientation. These young people depicted their emotional states during this period as anxiety-ridden. Many feared rejection – by parents, peers and others – and they appeared to feel unable to cope with the pressure of these anxieties.

Alexander & Clare's (2004) qualitative study of the subjective experience and meaning of self-injury among 16 lesbian and bisexual women characterised self-harm as a coping response arising within a social context characterised by abuses, invalidation, and the experience of being regarded as different or in some way unacceptable. Our data suggests self-injurious behaviour was similarly located within periods of particular anxiety and emotional stress. Young people appeared to understand that harming themselves did not provide a positive 'solution' to their difficulties in the long term; rather, it promised a momentary or short-term release from emotional turmoil. Although some talked to peers about their behaviour, self-harm was predominately a private activity characterised by concealment. In this sense, self-harm was depicted as a 'cry of pain' rather than a 'cry for help' (Williams & Pollock, 2000). For young people interviewed, self-injury was certainly a communication of pain but 'to an unresponsive or absent audience' (Solomon & Ferrand, 1996: 116).

The cessation of self-harm was sometimes linked to a positive turnabout or life event (e.g., a new relationship, the transition out of school) but was also strongly linked to young people's efforts to self-manage their emotions and, hence, their responses to emotional turmoil or pain. The majority of in-depth interview participants who self-injured had not been referred to, or indeed sought the help or advice of, health professionals in relation to self-harm. The small number who had attended a health care service on the insistence of their parents appeared not to have faith in the treatment or assistance they received.

Health professionals dealing with self-inflicted injury have been found to be more sympathetic if the behaviour is viewed as an attempt to end one's life than when they believe the person is engaging in self-harm for some other reasons (Ramon, 1980).

SUICIDALITY

This section focuses specifically on the issue of suicidality (i.e., suicidal thoughts, plans, and attempts) amongst LGBT people in an Irish context. Previous chapters have pointed to a wealth of research carried out in other geographical contexts which suggest that gay, lesbian and bisexual youth in particular are at greater risk for suicidal ideation and attempts than their non-LGB peers. It is important to reiterate here that the research findings are equivocal in this regard, largely as a consequence of the methodological and conceptual difficulties that have characterised many of the studies exploring the relationship between suicidality and LGB identification (e.g., Remafedi, 1999). The general conceptual and methodological issues in the measurement of LGBT suicide and suicidality are beyond the scope of this report and have been discussed elsewhere (e.g., McDaniel, Purcell & D'Augelli, 2001; Savin-Williams & Ream, 2003). Nevertheless, it is important to point out in the context of the present study that methodological constraints do not enable us to draw conclusions about the probability of LGBT people (or youth in particular) attempting suicide in comparison with the probability of non-LGBT people doing so (e.g. Russell & Joyner, 2001).

In addition to providing a quantitative overview of the prevalence of suicidality amongst the online survey sample, this section presents a qualitative understanding of the ways in which suicidal distress is experienced and perceived by members of the LGBT community in Ireland. These subjective experiences and insights are important in terms of generating a deeper understanding of the personal, social and contextual factors that contribute to the development of suicidality amongst some LGBT people, as well as the important mediating effect of protective factors in suicidality among LGB youth (Eisenberg & Resnick, 2006). As with the previous sections on depression, alcohol use and self-harm, the focus is largely on the meanings that those who had contemplated and/or attempted suicide ascribe to their ideation and/or actions. In particular, it seeks to examine the extent to which those who reported suicidal ideation or suicide attempts relate their suicidality to their sexual orientation or gender identity.

Prevalence of suicidality

The study assessed suicidality using multiple self-report indicators, including suicidal thoughts, intent, plans, and attempts. The number and severity of suicide attempts was also examined. As one might expect, findings from the quantitative and qualitative aspects of the research indicate that there is significant variation in the extent to which participants had ever thought about, or attempted suicide. Findings from the online survey revealed that a majority of respondents (n = 820) had rarely (32%) or never (42%) seriously contemplated suicide, which lends support to the view that sexual orientation or transgender identity per se are not risk factors for suicidality, and that consequently, it would be inappropriate to characterise the entire LGBT population as being 'at risk' for suicidality (Savin-Williams & Ream, 2003).

Almost a fifth of online survey respondents (17.7%), did however, report having attempted suicide, just under two thirds of whom had tried to take their lives on more than one occasion. Almost two thirds of first attempts, as well as most recent suicide attempts resulted in injury or poisoning that had required medical treatment, indicating that a majority of these attempts could be characterised as 'life-threatening' (Savin-Williams, 2001b). Three quarters of those whose attempts required medical treatment were offered an assessment following their first suicide attempt, a majority of whom (83%) took part in the assessment.

Fourteen percent of the overall survey sample had sometimes (n = 114) or often (n = 43) given serious consideration to the idea of ending their own life within the previous year, and a similar proportion (13%, n = 142) had actually made a suicide plan during the previous twelve months, almost a fifth of whom had gone on to attempt suicide.

Gender

A Chi-square test of independence revealed that the relationship between gender and suicidality was statistically significant (X2 = 12.83, p <.001). A quarter of all female survey participants (n = 89), compared with 15% of male participants (n = 105) had attempted suicide at least once in their lifetime (See Table 5.9).

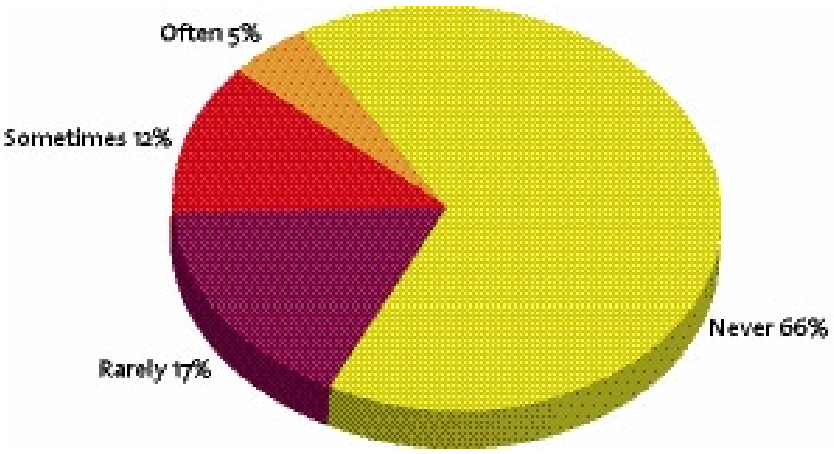
Table 5.9: Self-reported suicide attempt(s) by gender: survey sample

	Total (n = 1110)		Female (n = 377)		Male (n = 707)		Something else (n=22)	
Suicide	n	%	n	%	n	%	n	%
Lifetime	197	17.7	89	23.6	105	14.9	3	13.6
Past 12 months	25	2.3	14	3.7	11	1.6	0	0
Past 6 months	16	1.4	9	2.4	7	1.0	0	0
Past 30 days	6	.54	3	.79	3	.42	0	0

Age

The average age at first attempted suicide was seventeen and a half years (with an age range of 8 to 42 years), which supports existing evidence that it is LGBT young people who are most at risk of suicidality. Age was correlated with suicidal ideation (as measured by thoughts about taking one's own life during the previous 12 months), such that younger respondents were more likely to have thought seriously about ending their lives within the last year (r = -.113, p <.01). Over half of those aged 25 or younger at the time of completing the survey reported having given serious consideration to ending their own lives, while just under a fifth (n = 72) reported having attempted suicide. Of those aged 25 or under, over a third (n = 134) had thought seriously ('rarely,' 'sometimes,' or 'often') about ending their lives in the past year (see Figure 5.1 below), while just under five percent (n = 18) had actually attempted suicide within the previous 12 months. These findings suggest that, while it would be inappropriate to characterise all LGBT youth as being in danger of taking their lives, a significant sub-group of LGBT young people are nevertheless at risk for suicidality.

Figure 5.1: Frequency of suicidal thoughts amongst those 25 and under within the previous year: survey sample [15]



15 These figures are based on the question: "Within the last year, how often have you ever seriously thought about ending your own life"?

Sexual orientation

Seventeen percent of those who identified as gay or lesbian reported ever having attempted suicide (see Table 5.10 below). A higher proportion of those identifying as bisexual (25%) had attempted suicide than those who identified as gay or lesbian, which partially mirrors research carried out in other geographical contexts which has suggested that bisexual and questioning youth may be at higher risk for suicidal behavior than self-identified lesbian or gay youth (D'Augelli & Hershberger, 1993; D'Augelli, Hershberger, & Pilkington, 1998; Rotheram-Borus, Piacentini, Miller, Graae, & Castro-Blanco, 1994).

Table 5.10: Suicide attempt(s) by sexual orientation: survey sample

Sexual Orientation	All respondents (n = 1110)		Gay/Lesbian (n = 902)		Bisexual (n = 124)		Questioning/ Not sure (n = 35)		Heterosexual (n = 9)		Something (n = 40)	
Prevalence	n	%	n	%	n	%	n	%	n	%	n	%
Lifetime	197	17.7	152	16.9	31	25.0	6	17.1	1	11.1	7	17.5
Past 12 months	25	2.3	17	1.9	3	2.4	3	8.6	0	0	2	5.0
Past 6 months	16	1.4	10	1.1	3	2.4	2	5.7	0	0	1	2.5
Past 30 days	6	0.5	5	0.6	1	0.8	0	0.0	0	0	0	0.0

Suicide attempts among transgender participants

Over a quarter of those who identified as transgender indicated that they had attempted suicide at least once, most of whom (n = 10) had tried to take their lives on more than one occasion (see Table 5.11).

Table 5.11: Suicide attempt(s) among transgender respondents: survey sample

	Transgender (n = 46)	
Prevalence	n	%
Lifetime	12	26.1
Past 12 months	3	6.5
Past 6 months	3	6.5
Past 30 days	0	0

Relationship between experiences of victimisation and suicidality

Spearman rho (rank order) correlations were used to examine the relationship between experiences of victimisation and suicidality. Statistically significant associations were found between lifetime suicidal ideation (having ever seriously thought of ending one's life) and having been verbally insulted ($r = .163$, $p < .01$); physically threatened ($r = .205$, $p < .01$); physically attacked (i.e., punched kicked or beaten) ($r = .176$, $p < .01$), or sexually assaulted ($r = .19$, $p < .01$), such that the more frequently one had experienced these forms of victimisation, the more likely they were to have ever thought about ending their own life.

Relationship between self-esteem, life satisfaction and suicidality

Higher levels of self-esteem, as measured using the Rosenberg Self-Esteem Scale (RSES) were associated with fewer thoughts about ending one's life within the past 12 months, such that those with higher levels of self-esteem were less likely to have thought about ending their lives within the past year ($r = -.533$, $p < .001$). [16]

16 Self-esteem amongst online survey participants was assessed using Rosenberg's Self Esteem Scale (RSES), a ten item, four point global measure of esteem with total scores ranging from 0-30, where higher scores are indicative of higher self-esteem.

As one might expect, measures of subjective happiness and satisfaction were also negatively associated with suicidal ideation, such that those who reported higher levels of happiness and life-satisfaction were less likely to have had thought seriously about ending their own lives in the past year ($r = -.42$, $p < .01$ and $r = -.38$, $p < .01$ respectively). [17]

QUALITATIVE FINDINGS ON SUICIDALITY

Of the qualitative sample, over half of all participants (n = 22) expressed that at some point in their lives they felt that life was not worth living and/or admitted to having had suicidal thoughts, whereas almost a third (n = 13) had attempted suicide at least once. Collectively these findings suggest that, while LGBT people are not a homogenous 'at risk' group for suicidality, the numbers reporting suicidality are significant enough to warrant attention and support. The following section, based on qualitative narratives from the study as a whole, provides a more in-depth analysis how LGBT people make sense of their experiences of suicidal distress, including the extent to which self-reported suicidality is perceived to be related to one's sexual orientation or gender identity.

Suicidality scenarios

The qualitative narratives help to shed light on the kinds of thoughts, feelings and behaviours that LGBT people have experienced in relation to suicidality. The sample can be broadly classified according to one or more discrete points along a suicidal continuum, from those who never experienced thoughts that life is not worth living, or who never reported feeling suicidal, to those who made multiple life-threatening suicide attempts.

At one end of the spectrum, sixteen of those (40%) who participated in in-depth interviews could be described as never having felt that life was not worth living, or never having experienced thoughts of suicide, which lends further support to the view that it would be inappropriate to identify LGBT people as a homogenous 'at risk' group for suicide. Those falling within this category made clear statements to the effect that, 'I've never thought along those lines,' 'I haven't done it [tried to take my life] nor will I do it,' 'Thanks be to God I haven't felt like that [suicidal], and hopefully I never will.' Others expressed a range of thoughts about death and suicidality, including those who had experienced a passive wish to die, those who had experienced fleeting or more persistent thoughts of suicide, in some cases formulating suicide plans, to those who had actually attempted suicide, in some instances making multiple life-threatening suicide attempts.

Passive wish to die

A small number of interview participants, although not having felt suicidal as such, did recount experiencing a more passive wish to die on at least one occasion, as distinguishable from a more active and intentional desire to take one's own life. These participants expressed this wish to die as follows:

> *And it was just, generally speaking I would have been, you know, growing up it would have been tough anyway, but the gay thing just kind of threw it over the edge. Now I was never suicidal or anything during that period of time, but I wished I was dead all right, but I wasn't going to do anything about it, or never intended to do anything about it (Gay, Male, 43).*

> *But you do come to a point when you think, it's not worth it, you know, there has to be something more, you kind of pray for death. You wish yourself that you were dead, that's the only way to describe it. You can't be bothered going on living; you just want it to end (Male-to-Female Trans, Heterosexual, 37).*

17 The survey contained two questions measuring subjective happiness and life-satisfaction. For each question, respondents were asked to place themselves on an 11 point scale running from 0 to 10, were 0 was 'extremely dissatisfied/unhappy' and 10 was 'extremely satisfied/happy'. This standard survey scale has been widely used in research into subjective well-being and based on questions used in the European Social Survey (ESS).

Another participant who was 40 at the time of interview and had come very close to attempting suicide in his mid twenties, also drew a distinction between 'suicidal thoughts' or thoughts that were 'bordering on suicidal', which he had encountered at different times in his life, and a desire to die, which he experienced at other points.

> *I have to confess that I do have very, very dark thoughts. Now they never go to the point of you actually doing something to inflict harm on yourself, apart from that one incident [when I was about to jump from a window ledge]. But you do wish you were rather dead sometimes (Gay, Male, 40).*

Suicidal ideation

Fifty five percent of the qualitative sample (n = 22) reported having experienced suicidal thoughts at some point in their lives. For a small number of these individuals, these thoughts were fleeting or short-lived, and/or largely a feature of their past lives, relating to difficulties they had encountered at that time. Those who had experienced brief or random suicidal thoughts typically reported that that they could not, or would not, have acted on these thoughts.

> *Two or three times I just got thoughts into my head about doing it and then they just went (Gay, Male, 17).*

> *I actually thought of killing myself. I would never have done it, I just thought of it (Bisexual, Female, 18).*

> *It's a fleeting thought exactly and I'd say at some stage everybody has had, if you go into a hard patch and you think, God you know it would be easier to check out altogether (Lesbian, Female, 34).*

I would have thought of it [driving off a bridge] for a while, maybe just for a few minutes or something but I never cut myself or took an overdose or anything like that. I would never do anything like that and to be honest with you I really enjoy life, there are so many things that I love. Friends, people whose company I enjoy, music, travelling. I've got a lot to live for (Lesbian, Female, 54).

Others spoke of more persistent thoughts of suicide which they had experienced during a specific period of their lives, but again referred to being somehow 'held back' from ever acting on these thoughts. For example, one young lesbian woman who was 25 at the time of interview described having experienced 'constant' thoughts of suicide between the ages of 12 and 16, during a period when she felt extremely isolated.

> *I don't know, I was [pauses] ... unusual to try and explain but I suppose as a child, I mean I knew, even though thoughts of suicide or whatever were constantly on my mind, like not every minute of every day but frequently enough ... I mean, even though I was thinking about it I never actually thought I was in danger of doing anything like that, really. Like at the back of my mind I always knew that there would be a better reason to not do it, to just hold off (Lesbian, Female, 25).*

A small number of non-attempters recounted episodic, recurring and recent suicidal thoughts. One respondent, for example, now in his mid forties, recounted how he had first planned his own suicide in his late twenties, following what he described as a 'nervous breakdown', and also alluded to more recent thoughts of suicide.

> **RESPONDENT:** *No I couldn't [explain to my wife that I was gay]. I actually wanted to commit suicide without telling anybody and I picked a spot and I timed the trains and I picked a spot where I was going to go through the hedge and I picked the spot of the track that I was going to lie on. But when the morning came to do it I couldn't do it. So I told [my wife] that I wanted to commit suicide. So she rang a doctor immediately 'cause I was in such a state.*
> **INTERVIEWER:***Have you had a similar mind set since that?*
> **RESPONDENT:** *Several times I've thought about drowning myself. I have a terrible fear of the water and I can't do it. Several times, even recently I've thought about taking an overdose. I've a bag of drugs*

there and I'm sure if I took half of them even it would kill me. But I'm too frightened. I'm too frightened to do it (Gay, Male, 46).

Another gay male participant, now 62 years of age, had experienced recurring suicidal thoughts, including during the Christmas holidays shortly before taking part in the study. He characterised this ideation as an 'urge' that comes into his head from time to time. He spoke of the psychological function that making a suicidal plan served for him.

It is kind of sort of a comfort thing – it would normally hit you like going to sleep at night and you just kind of plan it out like and just and I think it seems to be just kind of comfort thing you know that. I know that sounds very peculiar (Gay, Male, 62).

Significant others as a deterrent

Suicide prevention programmes highlight the central importance of ambivalence as a construct in suicidality and in suicide prevention. Ambivalence refers to the fact that those who experience suicidal thoughts generally experience feelings of being of two minds as to whether they wish to end their lives; part of them wants to die and, at the same time, a part of them wants to live (Schneidman, 1985).

A recurrent theme in the narratives of those who had experienced suicidal thoughts but had never acted upon them was the presence of significant others in their lives, including parents, siblings and/or friends, which prevented them from following through on these thoughts.

INTERVIEWER: *Was there any time that you felt that life was not worth living?*
RESPONDENT: *I did I suppose if I was serious, I did yeah. But I would never have done anything but I just, oh I couldn't do that to anybody. Parents or sisters or whatever, yeah (Lesbian, Female, 50).*

I don't think I'd ever do it though. I know I'm probably going to sound a bit up my own arse again but, I don't know, I wouldn't be able to do it to my Ma and all my friends and all … I do have friends that would miss me, parents and all that. I just don't think I'd be able to do it (Gay, Male, 17).

What would happen with my kids, I couldn't do that to them. I keep hoping that life is going to get better for me (Gay, Male, 46).

One participant relayed how the loss of his long-term partner to suicide was at once a source of his own suicidal distress, as well as something that prevented him from taking action in relation to his own suicidal thoughts.

So again, I have never been to the stage in terms of, I still would keep the rationality of how unfair it would be to my relations and friends. I had a kind of long-term partner who committed suicide there in 2003 and, um, I kind of don't think I would ever like to inflict that on anyone. But then again I reserved the right at the end of the day, if I want to get off the planet it is going to be their problem you know. And I say that just to make sure I have an out but anytime I've really felt down like that, that's what stops me you know (Gay, Male, 62).

Suicide attempters

Thirteen of the qualitative sample had attempted suicide at least once in their lives, six of whom had tried to take their own life once.[18] Seven participants had attempted suicide more than once; of these, four had made two attempts, and one had made five attempts. The remainder referred to having made several or many attempts, with one respondent alluding to as many as 10 or 11 suicide attempts.

18 Another participant described a would-be suicide attempt, in that he came very close to attempting suicide, but was interrupted.

Amongst those who attempted suicide, there was variation across the sample in terms of the severity of the suicide accounts provided. While a small number of attempters did not require or seek medical treatment after their attempt(s), many of the suicidal instances described could be characterised as 'life threatening,' to the extent that they resulted in injury requiring emergency medical attention (Savin-Williams, 2001b).

Understanding suicidality amongst LGBT people

The narratives of those who had contemplated or attempted suicide highlighted a number of ways in which personal, social and contextual factors contributed to the development of suicidal distress. This section seeks to provide a deeper understanding of the range of thoughts, emotions and circumstances that people were experiencing at the time of contemplating and/or attempting suicide. Obviously the circumstances surrounding the various reports of suicidality differed for each individual, as they did for different attempts by the same individual. Those who had contemplated and/or attempted suicide variously described a lack of self-worth, feelings of self-reproach and self-loathing, isolation, and of not belonging in the world. Others reported having experienced feelings that their life had no meaning or was pointless. The following account by a 24 year old gay man who suffers from depression, and who has attempted suicide on multiple occasions, conveys the hopelessness and lack of a sense of direction in one's life that accompanied his desire to end his life.

> *I only had one thing on my mind and that was just to end my life, they [helping professionals] were suggesting things to me ok but I wasn't, I didn't care I had no hope, I had nothing good to cling onto like they say, you know I had no goal (Gay, Male, 24).*

Another young bisexual woman related her suicide attempts to feelings of worthlessness and a sense of not having a place in the world.

> *I felt that I was worthless and that you know I didn't really have any place in this world and there were many times when I actually tried to kill myself. I took pills and drank alcohol and tried to do it but you know it never worked out so I'm still here obviously (Bisexual, Female, 20).*

Two participants who had attempted suicide understood at least some of their attempts retrospectively as a call for help or as an attempt to communicate difficulties they were experiencing in their lives at the time. A young woman who tried to take her own life by taking an overdose of paracetemol in her final year of secondary school described her attempt as a 'massive cry' for help and recognition.

> *And I'm kind of like, I am really, really in a bad way here and even then not getting the help I thought I needed or the recognition. I think that's kind of what drove me to doing that [trying to kill myself]. At the time I didn't see it like that but now I see it as just a massive cry, actually, I'm really, really in a bad way here will somebody please help me, kind of thing (Lesbian, Female, 20).*

The relationship between LGBT identification and suicidality

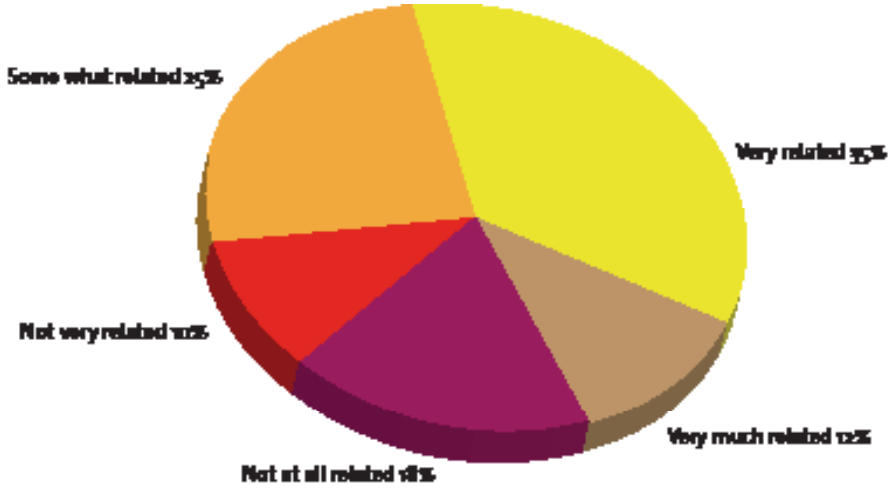
An important dimension of the suicidality findings which warrant exploration, particularly in light of the arguments that have been advanced in the literature that LGBT youth in particular are at elevated risk of suicidality, is the extent to which participants perceive their suicidality as linked to their sexual orientation and/or transgender experiences. Existing research suggests that negative constructions of LGBT lives impact on people's ability to form a positive self-identity within a homophobic and transphobic societal culture. Alongside this, fear of abuse and rejection can result in internalised feelings of low self-worth and shame (Johnson et al., 2007).

The online survey assessed the relationship between LGBT identification and suicidality by asking respondents who had ever attempted suicide to what extent their first and most recent suicide attempt(s) (where applicable) were related to being LGBT. Close to half of those who had attempted suicide (n = 92) saw their first attempt as 'very related' (n = 24), or 'very much related' (n = 68), to their LGBT identification. A quarter (n = 49) saw their first attempt as 'somewhat related' to their LGBT

identification. Less than a fifth of those who had attempted suicide (n = 36) felt that their first suicide attempt was 'not at all related' to their LGBT identification, and a further 10% felt that it was 'not very related' to their experiences as an LGBT person (see Figure 5.2).

Similarly, less than a third of those who attempted suicide more than once viewed their most recent attempt as unrelated or 'not very related' to being LGBT. A majority of those who tried to take their own life on more than one occasion (69%) perceived their most recent suicide attempt as related to the challenges associated with their LGBT identification. Amongst all those who *had ever thought* about taking their own lives (n = 629), close to a third reported that their suicidal thoughts were 'very related' (n = 110) or 'very much related' (n = 90) to their LGBT identification, with a further third reported that these thoughts were 'somewhat related' (n = 200). Less than 20% (n = 124) felt that their suicidal ideation was 'not in any way related' to their LGBT identification.

Figure 5.2: Relationship between LGBT identification and first suicide attempt: survey sample. [19]



While many of in-depth interview participants also attributed their suicidal thoughts and/or behaviours to the challenges associated with their LGBT identification, a small number alluded to a range of other difficult circumstances or events in their lives that had caused them to contemplate or attempt suicide, and did not perceive their suicidality to have been related in any way to their LGBT identity. The following are examples of these kinds of accounts.

> **INTERVIEWER:** *And have you ever had any thoughts about suicide, or wanting to take your own life?*
> **RESPONDENT:** *Definitely, definitely. But again, not in relation, not because I'm gay or any issues surrounding the gay, always because of other issues, you know finding out about my Dad and my sister dying, definitely. When I'm in severe depression I'm like what the fuck am I doing here, what's the point, d'you know? But em, you know, nothing because of being gay, it's always other issues (Lesbian, Female, 31).*

I attempted suicide once when I was 16. It was totally unrelated to being gay. No one knew I did it as it was unsuccessful and I never wanted to try it again after that. In school I knew I was different but I didn't know how/why/what was different about me. I knew if others knew they would bully me so I blended into the background so they never got the chance (Lesbian, Female, 29, Survey Participant).

19 These figures are based on the question: "How much was your first suicide attempt related to your being LGBT?"

In one or two instances, respondents were unable to identify or articulate a specific reason for having attempted to take their own life, but nevertheless believed that it was not related to their LGBT identification.

> *And the second time [I attempted suicide] it was to do, not with my sexuality but it was to do with [pause] ... the second time I never figured out what it was about. I've no idea why I've been depressed for so long and now suddenly I'm out of it. To be honest, I think it was a combination of things, everything built up and I didn't have anywhere for it to go (Gay, Male, 17).*

This respondent did, however, link his first suicide attempt indirectly to his sexual orientation. More specifically, he referred to the fact that he did not have any friends as a consequence of feeling, or being perceived as, 'different from everyone else.' Indeed, the notion of feeling or being perceived as different as a consequence of one's identification as LGBT emerged as a contributory factor in a number of suicide attempts, as evidenced by the following account.

> **INTERVIEWER:** *Do you think then that there were times when you felt that life wasn't worth living?*
> **RESPONDENT:** *Yeah. Just when I first kind of realised, when I was in First year college and I kind of came to the conclusion that yeah, I'm different. I kind of sorted accepted myself more in my head a lot more and built up to telling [friend] that I was [gay] and after I told him then I told a couple of people and I just felt really shit and crap and just my parents never accepted me and that. Not being able to have kids and stuff in the normal way and being viewed as a beast or whatever by ignorant people just really got me down. I figured what's the point in living if you're just going to be looked down upon by everybody as just this? (Gay, Male, 20).*

Several who had contemplated, planned, and/or attempted suicide related their suicidality directly, although typically not exclusively, to their LGBT identification, and a range of challenging experiences or feelings associated with this identity. Indeed, as with similar research conducted elsewhere, people often linked their suicidal thoughts or actions to multiple experiences or issues, rather than understanding them as a response to one particular event, or individualised distress over their identity status (Johnson et al., 2007). Some of these contributing factors included: relationship breakdown, sexual abuse, parental non-acceptance and the stigma associated with LGBT identity more generally, as well as substance use and mental health issues such as depression. For example, one gay man described how he came very close to taking an overdose in his 20s during a period of vulnerability which followed the breakup of a relationship with a girlfriend at the time. He attributed his suicidality to a history of sexual abuse as well as to his sexual orientation.

> *Obviously, [my sexual orientation] would surely have to be part, wouldn't it? I would think, I mean obviously the abuse, sexual abuse that kind of ... being gay ... But no, it was my sexual orientation would have been the suicidal reasons. If I had committed suicide it would have been because of being gay. So that's definitely true, you know (Gay, Male, 46).*

A lesbian woman described how, feeling alone, bereft of support, and trapped in a 'bad marriage,' without the prospect of having a relationship with another woman, caused her to attempt to take her own life.

> *I just felt it wouldn't improve, it was going to be the same. I was never going to feel anything in a sexual way for this man because it just wasn't there and I was never going to know or ever be with a woman because this is my life, this is it. So the time I done it I only existed and sort of my pain only existed. So to stop what I was feeling ... (Lesbian, Female, 51).*

Another young lesbian woman first attempted suicide at age 14 during a self-described 'identity crisis' which she attributed in part to her sexual orientation and her to struggle 'to feel like, get a sense of my place on earth full stop.' She explained how heteronormative expectations, specifically the pressure to marry, had caused her to attempt suicide again while in college.

> *But it was actually my sexuality, certainly a lot closer in [the second attempt] than the last time. And again, you know, I think it was really the pressure of stepping out and not conforming to the*

> *marriage scenario... I really didn't know how to, I really, em, [pause] I suppose I felt [pause], I suppose from a very young age I had been educated and taught, you know, kind of prepared for this marriage for a good 16 years. Taught certainly, from 0 onwards till I was 18, that this is what I was supposed to do, this was where I was, what I was meant to be doing, this was one's purpose in life ... (Lesbian, Female, 29).*

In some instances, thoughts of suicide were compounded by additional mental and/or physical health complications. One respondent, for example, related recent thoughts of suicide to his HIV positive status.

> *If I got to the stage where the hospital told me that they couldn't do anything for me, that the drugs won't work or anything. I don't want to deteriorate and that's all I see when I think about HIV and I think about it. I see this skeleton. And it's terrible (Gay, Male, 46).*

A number of other study participants referred to perceived or actual lack of acceptance or rejection by family and friends, as specific sources of suicidal distress. One online survey participant, for example, named her parents' homophobia and their failure to acknowledge or embrace her lesbian identity or her same-sex relationships, as the primary source of her self-harming and suicidal distress.

> *Most of my self-harming is related to the fact that my family are so disgusted with me for being gay and have shut me out constantly ever since I came out, asked me not to come home for Christmas, not 'advertise' my lesbianness, etc. I knew they were homophobic and that's why I didn't come out to them until I was 27, even though I'd been out to some of my friends since I was 14. While they haven't rejected me completely, they make it very difficult for me to be around them and while they support all the heterosexual relationships of my siblings, they change the subject at any mention of my homosexual relationships. I most want to kill myself when I'm visiting them or after talking to them on the phone. Living away [from home] really helps (Lesbian, Female, 30, Survey Participant).*

Narratives of this nature suggest that there is a direct relationship between homophobia, heterosexism and suicidality for some (although not all) of those LGBT people who experience suicidal thoughts, feelings or acts. The following vignettes convey how, for many participants, suicidal thoughts and feelings are bound up in a range of experiences related to the negative construction of LGBT lives (Johnson et al., 2007). A number of those who related their suicidality to their LGBT identification alluded to specific experiences or events that pre-empted their suicide attempts or caused them to feel suicidal, including homophobic bullying in school and/or in the workplace or in society more generally.

> *... I've been suicidal many times since my breakdown. It's not because I'm a lesbian but because of how I've been treated in my life as a lesbian. School was terrible and then to get bullied badly in work was horrible. (Lesbian, Female, 28, Survey Participant)*

I said when answering this survey that my self-harming and suicide attempt were very strongly related to being gay and this was true when I was 21. But it was not being gay that made me do this to myself and that made me feel suicidal. It was all the bullying, the name-calling, the negative ideas about being gay that I was full of from growing up in a homophobic society, and the fact that I had never heard one person say in all my childhood and adolescence that being gay was okay or even good. Without any basic level of nurturance, encouragement or support around being a gay kid how else could I have turned out. I can see how incredibly vulnerable I was back then but now I am a very happy, well-adjusted gay man. Being gay is part of who I am and I wouldn't want to change this for anything. But the marginalisation of young LGBT people in homes, schools, communities, towns and cities all over Ireland is still happening and young people can still suffer in the same way I did. This is completely wrong in 2007. Work needs to be done to tackle the impact of heterosexism and homophobia on the lives and well-being of Irish LGBT people (Gay, Male, 35, Survey Participant).

Another survey participant highlighted how a constellation of factors, which he attributed directly and indirectly to his sexual orientation, including a history of sexual abuse, homophobic bullying, and fear of rejection by family and friends, eventually 'took their toll' on him, resulting in his attempted suicide and hospitalisation in a psychiatric facility at the age of 21.

When I was 21 I was admitted to a private psychiatric facility and diagnosed with anorexia nervosa and depression. I had tried to kill myself soon after coming out as gay. I was convinced that everybody in my life would reject me because I was gay. This of course was not the case but the trauma of having been sexually abused by a priest who singled me out as a vulnerable gay boy when I was 11, the trauma of being bullied in school because I was gay and the fear I lived with for so long that I would be rejected by family and friends if I came out, all took its toll. When I came out and got a positive response from people it was a shock but also a pleasant surprise. But I was very vulnerable and traumatised from the terrible things I had gone through growing up (Gay, Male, 35, Survey Participant).

Collectively, the narratives linking suicidality to LGBT identification suggest that suicidal distress can be understood as a response to a hostile social context which invalidates and thereby fails to accept, let alone tolerate or embrace, minority sexual orientation or transgender identity (Johnson et al., 2007). Many of those who experienced suicidality drew direct connections between their fears of rejection, or lack of acceptance by family or peers, including a failure to recognise the significance of same-sex relationships, their experience of being regarded as different, and victimisation related to their LGBT status. From this vantage point, suicidal distress can be understood as a response by some LGBT people to institutionalised discriminatory and homophobic beliefs and practices which they encountered in a number of social institutions and settings such as family, education, and the workplace.

Throughout this report we have sought to demonstrate how LGBT people experience unique stressors in their lives that are directly related to their sexual orientation and/or transgender identity (Savin-Williams, 1994). That a majority of study participants had never contemplated, planned or attempted suicide suggests that it would be inappropriate to characterise the entire LGBT community as being at risk for suicidality. As noted elsewhere, LGBT people are not a homogenous 'at risk' group, with many conveying multiple 'resilience factors', including personal traits or characteristics of their social environment that protect them from harm. As Eisenberg & Resnick (2006: 663) comment: '... indeed the majority of GLB adolescents grow up to lead happy, healthy, productive lives'. The personal, family and community protective factors that affect the likelihood of negative outcomes among LGBT people are addressed in the following chapter.

However, the fact that almost a third of the in-depth interview sample, and almost one fifth of the quantitative sample had attempted suicide at least once would seem to suggest that the issue of suicidality and LGBT identification warrants serious attention. While this study does not directly address the claim that LGBT people are at elevated risk for suicidality relative to their non-LGBT peers, the individual narratives of many LGBT people who have experienced suicidal distress, combined with quantitative data suggesting that a majority related their suicide attempts or thoughts to their LGBT identities (to varying degrees), points to a relationship between suicidality and sexual orientation and/or transgender identity. Reports from respondents who attributed their suicidal thoughts and/or suicide attempts directly (at least in part) to their negative treatment by others in a range of settings, including at home, in schools, the workplace, etc. as a consequence of their LGBT identification, is a serious cause for concern, and points to a clear need for intervention in these settings.

CONCLUSION

This chapter has examined indicators of mental health and well-being among LGBT people with specific reference to instances of depression, self-harm, suicidality, and patterns of alcohol consumption. As with previous chapters, the focus was largely on the social contexts and experiences that give meanings, often negative ones, to LGBT identification, highlighting some of the major stressors in the lives of LGBT people that are directly or indirectly related to their sexual orientation and/or transgender identity.

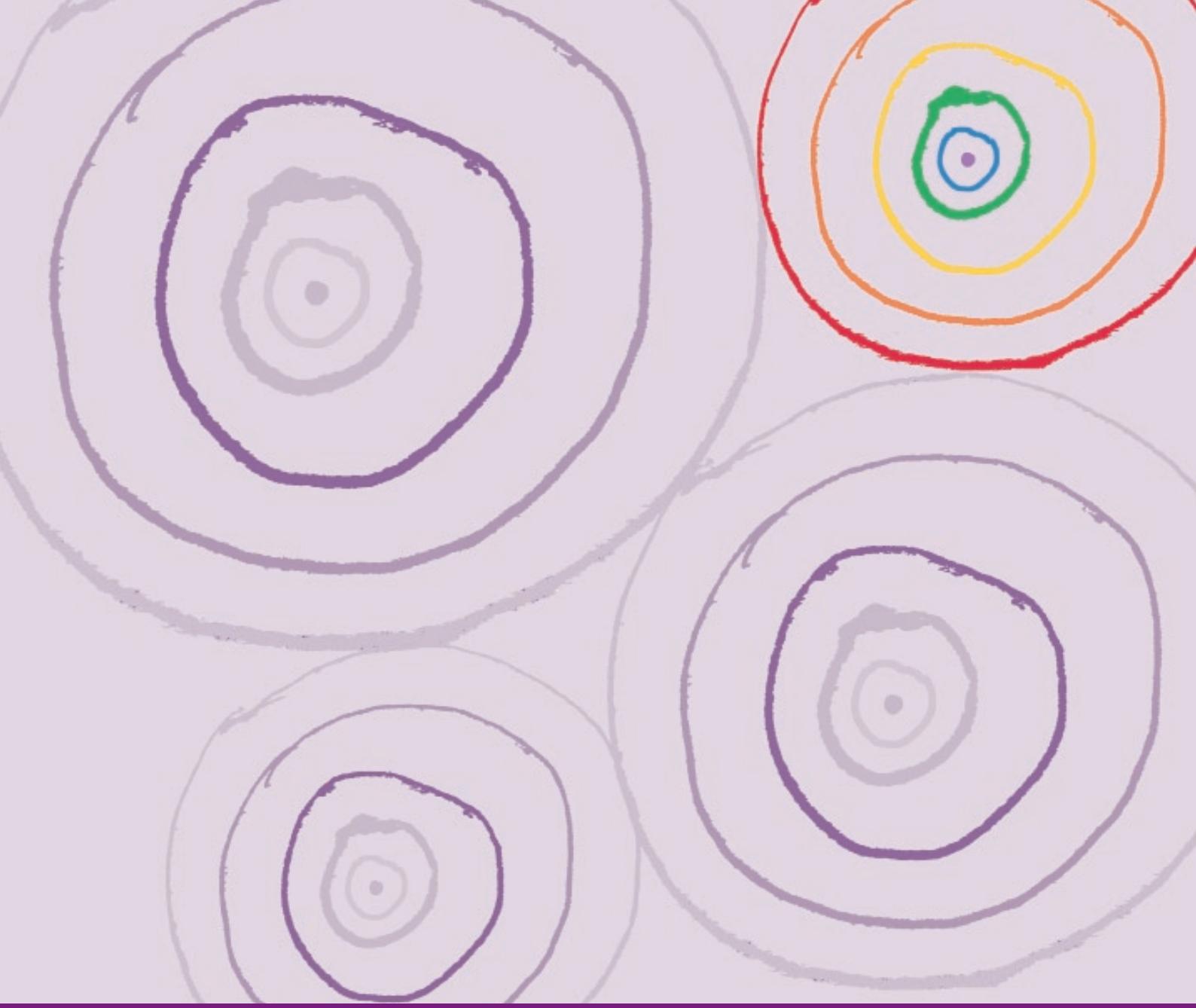
Quantitative findings suggest that a majority of those with LGBT identification in Ireland have experienced low or depressed periods in their lives, and that a significant minority, (almost a quarter of the sample), had been prescribed medication for their psychological distress. Similarly, over a quarter of survey respondents had engaged in self-injurious behaviour at some point in their lives, while almost a fifth had attempted suicide on at least occasion. Almost a third of the in-depth interview sample had attempted suicide at least once, and over a quarter had self-harmed, indicating that the issues of deliberate self-harm and suicidality among LGBT people, and LGBT young people in particular, warrant serious attention.

It is also important to point out that many of the difficulties expressed in the respondent narratives are not unique to those who identify as LGBT. However, although LGBT people obviously share many risk factors with the general population or those with mental health difficulties or who attempt or die by suicide, other factors, such as disclosure of sexual orientation to friends and family are unique to this population (McDaniel, Purcell & D'Augeli, 2001). In the context of the present study, the coming out process, which typically coincided with adolescence, was often identified as an especially difficult, vulnerable and stressful time in the lives of many participants.

Narratives of self-harm, depression and suicidality were often tinged with feelings of disconnectedness from family and peers, social isolation, loneliness or aloneness, compounded by feelings of lack of self-worth and self-loathing. These emotions were often linked to the internalisation of discrimination, victimisation, and/or heteronormative expectations about what constitutes a 'normal' life in society at large. Those who experienced homophobic bullying and/or lack of acceptance by significant others in their lives as a consequence of their LGBT identification were particularly susceptible to depression, self-harm and or suicidality.

Findings from the in-depth interviews suggest that a majority who have experienced depression related this psychological distress directly to the challenges associated with being LGBT. Similarly, many of those who had contemplated, planned, and/or attempted suicide related their suicidality directly (although typically not exclusively) to the negative experiences associated with their LGBT identification. In the case of the online survey, close to half of all suicide attempters viewed their first attempt as 'very related' or 'very much related' to their being LGBT.

Collectively, the findings on mental health indicators suggest that the stigma and discrimination that surround LGBT identification can result in an extremely negative experience of being LGBT. This causes many to experience depression, and a significant minority to engage in self-harming behaviour and to experience and/or act upon, suicidal thoughts. Chapter 7, which focuses on the issue of resilience among LGBT people, attempts to capture the strengths and supports, as well as the struggles that characterise LGBT people's experiences. The next chapter focuses on LGBT people's experiences of healthcare services and related supports and services.



CHAPTER 6 LGBT PEOPLE AND SERVICES

LGBT PEOPLE AND SERVICES

The previous chapter on Mental Health Risks alluded to some LGBT people's encounters with healthcare professionals and settings in the context of their experiences with depression, self-harm and suicidality. This chapter provides a more in-depth analysis of LGBT people's experiences of services with particular attention to general healthcare and mental health services. The findings demonstrate diverse experiences as well as specific barriers to healthcare access, including presumed heterosexuality, homophobia and lack of cultural competence on the part of healthcare providers.

POLICY AND SERVICE CONTEXT

Since the mid-1990s, there has been increased attention to the specific health needs of LGBT people in a range of Irish policy documents and research reports (Collins & Sheehan, 2004; Dillon & Collins, 2004; Gibbons et al., 2007; National Conjoint Child Health Committee, 2001). While these publications indicate growing awareness within both research and policy arenas of the challenges facing LGBT people in accessing appropriate and adequate health care, it is not clear to what extent this has translated into more appropriate service provision. Gibbons et al's (2007) recent study of healthcare access among LGB people in the North West of Ireland has highlighted some of the difficulties that persist, from experiences of overt homophobia within healthcare settings, to lack of sensitivity on the part of heath care providers to the needs of LGB individuals. This report also noted significant variability in respondents' experiences of mental health services.

The Community Assessment phase of the current study involved the conduct of interviews with policy makers from the health and education sectors at government and national levels as well as service providers from LGBT-specific services (see Chapter 2 for a full account of the methodology). This phase of the research uncovered a number of issues that are relevant to LGBT health service provision, including: regional disparity in service provision, differential service experiences, and the diversity of LGBT people's needs.

Regional disparity in LGBT-specific service provision

LGBT-specific services in Ireland are concentrated in the major urban centres. While these services are funded through a variety of sources, they receive their primary funding allocation from the statutory health sector. Most undertake what can broadly be characterised as health-related work, including the provision of personal development courses, advice services and advocacy work. A recent mapping exercise, conducted under the auspices of the Health Service Executive's National Social Exclusion Steering Group (forthcoming), highlights regional variability in service provision as well as the absence of LGBT-specific services in the midlands and in parts of the West of the country. These regional disparities indicate that there are significant differences in the services available to LGBT people and that much of this disparity is related to people's geographical area of residence. This mapping exercise also draws attention to the absence of a specific policy governing the support or funding of LGBT work.

Regional variation and, in particular, the prominent urban/rural divide in relation to LGBT service provision, was an issue consistently highlighted by a large number of this study's Community Assessment respondents. Deficiencies in strategic planning were also identified, as were inadequacies in current service provision and delivery.

> *There are fine examples within LGBT-specific services of these 'islands of excellence' but they don't live together and they're isolated as well (Community Assessment, Interview 9).*

> *There are a lot more groups starting up around the country but there are still real pockets of isolation where there's absolutely nothing (Community Assessment, Interview 6).*

Different experience of services

Given the regional variation in service provision noted above, LGBT people might be expected to have very different experiences of both service access and utilisation. Quality of healthcare provision was another factor considered to impact on LGBT people's service experiences. Reference was repeatedly made to negative or pejorative attitudes and poor training affecting the ability of health care professionals to deal appropriately with LGBT clients.

There are definitely issues around the sensitivity and there aren't appropriate LGBT services. We would see a need for targeted LGBT services around mental health and they mostly don't exist currently (Community Assessment, Interview 3).

Several believed LGBT clients to be largely 'invisible' within most health arenas, claiming that their needs were not being adequately met. Some who worked directly with LGBT people also emphasised that their service users reported highly variable experiences across a range of healthcare settings. This issue is explored in greater detail below.

Diversity of need within the LGBT population

Community Assessment respondents were keen to emphasise the diversity of LGBT people and also to highlight the needs of specific groups.

> *... I think there could be a slight danger in representing the LGBT communities as a homogenous group and I would imagine that there are varying levels of potential 'at risk' statuses (Community Assessment, Interview 12).*

Respondents identified the following categories of need within the LGBT community that warrant specific and targeted service provision, particularly in relation to mental health promotion:

- LGBT young people
- LGBT people living in isolated/rural locations
- Older LGBT people
- Lesbians
- Transgender people

Like the general population, LGBT people differ in terms of their cultural background, ethnic or racial identity, age, education, income, and place of residence. LGBT people's experiences within a whole range of settings and institutions, including the family, school, local and LGBT communities, and the workplace, are also diverse. In relation to mental health specifically, the diversity of LGBT people must be acknowledged, as has been amply demonstrated in Chapter 5. This diversity also has implications for the provision of appropriately tailored services that meet a variety of potential needs.

HEALTHCARE ACCESS AND EXPERIENCE

Research suggests that one of the most significant medical risks for LGBT people includes avoidance of routine health care and dissatisfaction with the healthcare they receive (Bonvicini & Perlin, 2003). This section examines both survey and interview respondents' reports of accessing a range of health care services, as well as their perspectives on their encounters with medical and other health care professionals.

Online survey participants were asked to indicate which services they had accessed, from a list of general health, mental health and LGBT-specific services. Table 6.1 indicates that over a quarter of online survey respondents had accessed mental health counselling services, while a little more than a fifth had accessed an LGBT-specific health service. Almost eleven per cent had attended an HIV and AIDS-related service, while three per cent had accessed substance/abuse/addiction services. Other sources of LGBT-specific support which online survey participants accessed included LGBT support groups (23%) and LGBT youth organisations or youth groups (17%).

Of the 40 individuals interviewed, approximately three-quarters had attended or approached a health care professional (GP, hospital staff, psychologist, psychiatrist, counsellor) or other individual or agency (school personnel, LGBT youth group) with a view to discussing their health needs. While attendance at a health care setting was sometimes imposed on young people (most often by a parent) the majority of interviewees sought advice independently. Across the in-depth interview sample, counselling or psychological services were the services most commonly accessed, followed by General Practitioners (GPs). Six had attended a psychiatric service and, in other instances, respondents reported seeking help or advice at school, LGBT-specific youth services, LGBT help lines, hospitals and STI clinics. In-depth interview respondents indicated that they frequently accessed services during a period of particular difficulty, suggesting that they may have had specific needs at this juncture. There was considerable diversity in their accounts of accessing and interacting with services and health care professionals and, while some gave positive accounts, many others reported negative experiences.

Table 6.1: Use of LGBT and related health services: survey sample

Service(s) used	n	% [1]
Mental health counselling services	301	27.1
LGBT support group (Other than youth group)	253	22.8
A gay or lesbian health service	241	21.7
LGBT youth organisation or LGBT youth group	193	17.4
HIV and AIDS services	121	10.9
Substance abuse/addiction services	35	3.2
Something else	115	10.4

General healthcare experiences

Online survey participants were asked about their experiences with healthcare professionals in general, responses to which are provided in Table 6.2 below. While two thirds of respondents with prior experience of healthcare professionals felt that the health advice they received was generally useful and appropriate, over three quarters were of the opinion that healthcare providers needed to have more knowledge and sensitivity to LGBT issues. A fifth actively sought out LGBT-friendly professionals because of negative experiences they had had in the past, while a similar proportion did not feel respected as an LGBT person by healthcare professionals. Almost a quarter of those who had prior experience with health professionals admitted to hiding the fact that they were LGBT when dealing with these individuals because of how they might react.

The vast majority of online survey participants (94%) indicated that they had a GP or family doctor whom they attended. Most of those who had a GP attended about once or twice a year (61%), whereas about ten percent attended somewhat more frequently - about once a month. About a quarter attended their GP every few years. GPs were only aware of respondents' LGBT identity in 44% of cases.

1 Based on 'tick all that apply' format. Percentages do not add to 100%.

Table 6.2: General experiences with healthcare professionals: survey sample [2]

	Strongly Agree /Agree		Neutral		Strongly Disagree /Disagree		Valid n
	n	%	n	%	n	%	n
I'm generally quite open about being LGBT when I visit a healthcare professional.	528	53.5	186	18.9	272	27.6	986
In my opinion, healthcare professional need to have more knowledge and sensitivity to issues related to being LGBT.	757	76.9	174	17.7	53	5.4	984
I generally try to hide the fact that I am LGBT when dealing with healthcare professionals because of how they react.	220	23.1	184	19.3	547	57.5	951
In general, I feel respected for who I am as an LGBT person by healthcare professionals.	364	40.0	366	40.3	179	19.7	909
In general, the health advice I've received from healthcare professionals has been useful and appropriate.	591	62.5	244	25.8	111	11.7	946
I actively seek out LGBT-friendly healthcare professionals because of bad experiences I've had with providers in the past.	162	19.3	295	35.2	381	45.5	838

Approximately one third of the study's interview participants had attended their GP for routine healthcare treatment, with only a minority describing the encounter in positive terms. It is significant, however, that those respondents who were satisfied with their GP's response almost always referred to feeling comfortable and confident to disclose their sexual identity without the fear of being judged.

> *I'm quite pleased with my doctor. He has never had a problem with my sexuality (Gay, Male, 43).*

> *He (GP) gave me positive feedback which was fantastic (Male-to-Female Trans, Heterosexual, 27).*

The experience of attending GPs was depicted as a negative one by many more respondents, with the weight of negative attention falling on the claim that their GP did not understand LGBT issues. In many cases, respondents felt that most doctors lacked the requisite knowledge or understanding to communicate appropriately with LGBT people.

> *The last doctor, well my current doctor didn't really understand what I was trying to say and I was trying to be discrete about it, not be cause I felt ashamed ... And in the end I had to, you know, just say it very clearly, 'Look my partner is female, you don't seem to be picking up on that. I'm you know, sexually active with another female. And so, you know, he was a bit shocked ... (Lesbian, Female, 29).*

> *When people are trained to be a doctor and treat patients they're not taught how to deal with people. Social workers and youth workers are taught how to do that. Basically there is a lack of training, a lack of understanding (Gay, Male, 20).*

GPs typically presumed that their patients were heterosexual, leading to a reluctance on the part of respondents to disclose their sexual orientation. Several LGB participants did not discuss their sexuality with their GP because they associated disclosure of their sexual orientation with negative reactions. Others felt that disclosure of their sexual orientation to their GP was possibly more trouble that it was worth.

> *Most GPs are heterosexual males or heterosexual females with kids so I won't want to talk to them about that (sexual orientation) (Gay, Male, 27).*

2 Percentages reported are valid percentages. Those who responded 'don't know', or who had 'no experience' of healthcare professionals, were excluded from the analysis.

> *I never told him (work-based GP) that I was lesbian. I'd be afraid they would put it on my file and then it would have an impact on my career (Lesbian, Female, 29).*

> *The doctor was old. She did say, 'If you're gay now is the time to say it'. I was probably that close to saying it but I thought it was too much hassle and stuff (Gay, Male, 28).*

A number of respondents had also attended their GP because of mental health concerns. Indeed for most, the local GP was the first point of professional contact for individuals who sought help or advice in relation to stressful or distressing psychological states. Most of these respondents felt strongly, however, that their GP failed to appreciate the context of their mental health difficulties and a number stated that their circumstances and needs were either trivialised or ignored by their doctor. Young LGBT people experienced particular difficulty and several conveyed a belief that available services did not cater for their needs. A number had been brought to their GP by a parent/guardian because of specific concerns (e.g., because they had become withdrawn, depressed or were self-harming) which these young people typically attributed their struggle to come to terms with their sexuality. Here, one young man described the response of his GP when he disclosed his sexuality and his feelings of depression.

> *But he (GP) said basically to have sex with my best (female) friend who is fifteen, take anti-depressants and I'll be straight by the end of the month (Gay, Male, 17).*

Issues regarding confidentiality also emerged, with young people not wishing to discuss their sexuality with their GP because of concerns that their parents would be subsequently informed. Others feared that the disclosure would be "written on their file" and appeared to have little confidence that this personal information would not be communicated to others without their permission.

More often than not, GPs were the point of entry to primary healthcare services for those who had mental health concerns, with typical accounts suggesting significant problems regarding the adequacy and appropriateness of the care that LGBT people received at this juncture. Healthcare providers routinely assumed that their clientele were heterosexual and did not appear to adequately address issues of sexuality or gender identity. Young people confronted particular challenges and, in the main, did not feel that they could openly discuss issues that were relevant to their health and well being. Whilst acknowledging that concerns regarding the adequacy of healthcare access are not unique to LGBT youth (National Conjoint Child Health Committee, 2001; Aggleton et al, 2000), the findings nonetheless indicate that LGBT young people feel especially vulnerable in the context of seeking general or mental health care. This is of particular concern since negative experiences can lead LGBT youth to avoid services, despite having unmet needs (Ryan, 2003). Moreover, at the same time as LGBT youth are experiencing especially challenging identity issues, they may also be at increased risk for depression, self-harm and suicidality. The following section explores young people's experiences of LGBT-specific youth services, highlighting the role that these services can play in promoting positive mental health.

LGBT-SPECIFIC YOUTH SERVICES

While there are numerous examples of LGBT young people's negative experiences of seeking help from healthcare professionals and other adults, the reports of those who attended LGBT-specific youth services were generally more positive. Almost a fifth of online survey participants had attended a LGBT youth organisation or group at some time and thirteen of those who were interviewed in-depth had accessed LGBT-specific youth services. Accounts were, in the main, very positive, and strongly suggest that these services were important in terms of counteracting experiences of homophobia and promoting positive mental health.

Young people talked about feeling able and free to express themselves, an experience that was often equated with the abandonment of the habitual self-surveillance that characterised their interactions in other contexts. Those who attended LGBT-specific youth services also invariably mentioned the individuals who staffed the project. In contrast to the discomfort they experienced in other contexts where they sought help or advice, young people described making meaningful connections in contexts where they did not feel 'judged' by others. These accounts highlight the importance of the key

competencies, such as listening skills and non-pejorative attitudes, among professionals who staff these projects.

> **RESPONDENT:** *I think it (LGBT youth group) really, really helps. I think it's just one of the best things out there and other things that are getting set up around the country, I think they're brilliant.*
> **INTERVIEWER** *What is good about them?*
> **RESPONDENT:** *Just the people that work there. They must have to go through some rigorous test or something to get the right type of people there. The people are just lovely, they're brilliant (Gay, Male, 17).*

> *He's (youth worker) been really good to me. I can just go and chat to him and let everything out. If I'm really stressed, you wouldn't be able to understand me. I just talk like, go ninety talking, and you wouldn't be able to understand a thing. So he'll sit there and nod and go, 'Yeah, yeah, sounds good'. He's there to listen, he's really class (Lesbian, Female, 17).*

As demonstrated in earlier chapters, LGBT youth can experience chronic stress, particularly in relation to fear about disclosure or exposure of their sexual or transgender identity (see Chapters 4 and 5). According to Ryan (2003: 154), '[p]roviding a supportive, non-judgemental environment is a primary component in signalling that an agency, provider or clinic is a safe place for non-heterosexual youth to seek care'. The accounts of those respondents who had attended LGBT-specific youth services were overwhelmingly positive, demonstrating the importance of 'safe' spaces and environments for LGBT youth. Providers and programmes serving adolescents and their families have only recently begun to consider the needs of LGBT youth (Ryan, 2003). In the Irish context, while there is currently an expansion of LGBT-specific youth services nationally, their coverage remains limited and these services are more or less restricted to larger urban areas with more extensive LGBT communities. This leaves LGBT youth, particularly those living in smaller, less urbanised and rural communities, in the precarious position of having to negotiate challenging personal and social risks with little or no access to support services.

COUNSELLING SERVICES AND OTHER THERAPEUTIC ENVIRONMENTS

As stated earlier, over a quarter of online survey participants had accessed mental health counselling services at some time. A higher proportion of interview respondents (just over 40%) stated that they had attended a counselling or psychological service. Apart from visiting their GPs, counselling/psychological services emerged as the health care settings accessed most frequently by the study's respondents, thus it is useful to explore these experiences. Here, we draw primarily on the accounts of the study's in-depth interview participants.

People accessed counselling or psychological services through a variety of routes: some were referred by their GP or another health professional while other respondents self-referred to a private counselling or psychological service. Young people were often taken to their local GP by a parent and subsequently attended a counselling service through a referral process.

Several interviewees depicted the counselling or other therapeutic settings they attended as providing valuable support. These respondents felt respected and affirmed by their therapist or counsellor and this affirmation appeared to be particularly useful when it came to discussing specific difficulties or challenges. One woman, for example, felt that accessing a supportive counsellor had helped her with the process of 'coming out'.

> *The counselling, yeah, it definitely made me I suppose look at my life and re-evaluate (Lesbian, Female, 47).*

This respondent later explained that having the opportunity to speak openly in the 'safe' space of the counselling session enabled her to identify issues that were personally relevant without the fear of recrimination.

> *It's probably half the battle maybe if somebody almost asks you (about your sexuality). I know that might be difficult but all the person can do is say no. Sometimes you're afraid to say it (Lesbian, Female, 47).*

The importance of freedom to disclose and discuss sexual or transgender identity with a counsellor or therapist was repeatedly raised by respondents who reported positive experiences of counselling. These accounts also strongly suggest that those who benefited from attending such services had accessed an individual counsellor or therapist who adhered to unbiased and sensitive practice. This non-judgemental acceptance of sexual orientation and transgender identity enabled LGBT people to make progress within counselling or therapeutic contexts, as highlighted by a number of respondents.

> *My aunt got me involved with the counsellor who was a friend of hers. So I went to him for counselling and then it all came out. I think he brought it out of me (Male-to-Female Trans, Heterosexual, 27).*

> *I began to feel comfortable with being gay when I was 31 years of age, when I went to a natural healer, and she kind of, she developed that in me (Gay, Male, 46).*

The themes of acceptance and open-mindedness were also prominent in accounts that emphasised the sense of personal re-assurance that counselling provided.

> *She (counsellor) put my nineteen years into one sentence. Oh my god, this stranger, this woman is able to look at my life ... it makes you look at bits of yourself that you didn't want to. She said to me, which I didn't believe at the time, that I was strong. It made me look at things and face up to things (Lesbian, Female, 51).*

It is perhaps noteworthy that the speaker above had a very different story to tell about a marriage guidance counsellor she had previously attended.

> *He (counsellor) gave a ridiculous scenario of a jealous husband who puts down his wife and she ends up going off with someone else. He was deaf to my interventions and reinforced all his (husband's) fantasies (Lesbian, Female, 51).*

When counselling or other therapeutic environments were viewed as constructive and supportive, respondents invariably mentioned the benefits these safe and empathetic settings. These environments gave them opportunities to openly discuss their experiences and challenges. The skills of individual professionals appeared to play a role here. Perhaps the most important element, from the viewpoint of those seeking help, was the confidence that they were understood. The ability to openly articulate anxieties and concerns about their lives, relationships (with family members, peers and intimate partners) and their sexuality or transgender identity played a crucial role in how people related to these therapeutic environments. It is important, in this context, to document reports of counselling that were negative or counterproductive.

> *Personally I have experienced some appalling experiences of counselling services in Ireland and really I think that LGBT issues should be more prominent in training and education for people working in the mental/emotional health sector (Lesbian, Female, 28, Survey Respondent).*

Also noteworthy in this regard is that young people experienced particular difficulty making meaningful connections in these settings. The following are some examples of the negative[3] views expressed about counselling by young people.

> *She was more like a mother with me than a psychologist. I felt different so I stopped going[4] (Bisexual, Female, 18).*

> *My parents shipped me off to counsellors. It actually made me worse. I don't know how many counsellors I've been to (Lesbian, Female, 17).*

School-based counselling services were depicted as particularly unhelpful by those who sought help in this way.

> *The worst experience I had teacher-wise was the guidance counsellor. He was useless to be honest. When the bullying happened he was like, 'You know you couldn't get bullied, you don't look like someone who would get bullied. He had no training. I was the first to come out in the school and he didn't know what to do (Gay, Male, 21).*

> *I couldn't open up to someone who already made his diagnosis before he actually spoke to me and he didn't understand. If I turned around and I told this counsellor I was gay he'd have had a great snigger about it in the staff room (Gay, Male, 21).*

The accounts above may be regarded as unsurprising in light of the school experiences documented in Chapter 4. It should be emphasised that when young people did access affirmative services, marked differences were apparent in both the willingness and ability to engage with counsellors and other professionals charged with serving their needs. Those young people who accessed counselling services through LGBT-specific youth groups were far more positive and a number had clearly benefited from this experience.

> *They are like very good, like they talk to you. It's been a great help to me, to my confidence and self-esteem (Gay, Male, 16).*

> *It was nice. It's good to have an independent party there to talk to (Gay, Male, 17).*

In a general sense, counselling services received a far more positive appraisal from those who had attended them, certainly when compared to GPs and hospital departments. LGBT people clearly benefit from therapeutic environments where their sexual orientation is accepted and where they feel that they and their needs are respected and understood.

PSYCHIATRIC SERVICES

Six people (15%) of interview respondents stated that they had attended psychiatric services at some point in their lives. The majority were gay men who had mainly, though not exclusively, accessed these services when they were older. These services were usually accessed via onward referral from a GP or Accident & Emergency department, typically at a point of acute mental distress, e.g. following a suicide attempt.

> *I went into a deep depression not knowing what it was. All I knew was that I wanted to die (Gay, Male, 50).*

Respondents' experiences of psychiatric services were diverse, ranging from those who reported sensitive and appropriate treatment to others who recounted damaging encounters.

> *We went back to my childhood right up to where I was now and she [hospital-based psychologist] gave me hope and I gave myself some hope as well, you know she was wonderful. I met her on a regular basis and I started talking more about my sexuality (Gay, Male, 24).*

> *The psychiatrist there and they didn't help me at all ... and said no way could I be married and gay, it wouldn't be possible, that he could count on his hands the amount of men that were married and gay and you know, confused. And then he brought my wife in and he confronted me. He picked up the phone and said he was ringing the gay switch board. He done all sorts of strange things to me. I think he was trying to force me into thinking whether I was gay or whether I wasn't. I don't know what he was trying to do to me. I just remember being so upset (Gay, Male, 46).*

However, most who had direct experience of mental health services indicated that they had little confidence in these systems of intervention, with some respondents questioning the quality of care they received in these settings.

> *I would have gone to a public health, public hospital, very unsatisfactory. I was seeing different psychiatrists every time I went back and, you know, five or ten minutes with them. It was of little or no use ... (Gay, Male, 46).*

The following young woman had attended a psychiatric service following what she described as an "emotional breakdown". She had also accessed counselling and therapeutic services. She depicted the process of finding the 'right' service as one of trial and error, noting that she was fortunate to have parents who were in a position to finance this course of action.

> **INTERVIEWER** *You mentioned there about different professionals you've gone to, you have seen GPs, psychologists?*
> **RESPONDENT:** *GPs, clinical psychologists, counsellors, and psychiatrists, the whole lot. I've had a variety of each one.*
> **INTERVIEWER** *Okay, have they helped?*
> *Respondent: The counsellors, I don't know. I've learnt to play the game that is the Irish health system, especially the Irish mental health system, and thankfully my parents have the money to allow me to do it. I've kind of learnt what the difference is between various ones ... but like I'd have a very low opinion of many of the health care professionals I met during that period (Lesbian, Female, 20).*

A number of survey participants described similarly difficult and sometimes distressing experiences of seeking psychiatric help. Much of this commentary centred on the lack of understanding of health care professionals within the psychiatric services of the needs of LGBT people, or of the contexts and experiences that impact on their everyday lives and mental health.

> *When I went into [psychiatric] hospital the staff were generally helpful but completely clueless about the impact growing up gay had had on my mental health. They dismissed the impact homophobic bullying had had on me and did not understand at all how difficult it was for me to come out. They dismissed how homophobia had impacted on my identity as a gay man. They seemed more interested in getting me to take antidepressants than listening to my story. This wasn't unique to me as a young gay man, I know. But they completely missed how society's treatment of gay people and the homophobic world I grew up in had adversely affected my mental health. But worse still, some staff (including my psychiatrist) told me being gay was not normal and that I was choosing to be gay to rebel against my parents. This was a terrible thing to happen to me on top of everything else that had happened. I decided to focus on getting discharged as quickly as possible because I didn't feel safe there [...] How can mental health staff be so clueless in this day and age? But even worse, how can staff behave in a homophobic way towards patients? Don't they get training on working with gay people? The scariest thing that has happened to me in my adult life was the day a psychiatric nurse said to me, "I hate all gay people. They are sick" (Gay, Male, 25, Survey Participant).*

The psychiatrist didn't seem to care that these experiences [school and workplace bullying] had hurt me so much and he told me I shouldn't come out to my family 'cos they'd probably react badly, so that made me more scared. He just gave me medication. I go to my GP now for my antidepressants but I can't really talk to him about what's going on. The only people who I feel really understand what's going on for me is the gay helpline I call from time to time and my friends try to help as well but they are straight and don't really get me any more. I've never met any other lesbian or gay people. That probably sounds weird but I live in a very small town (Lesbian, Female, 28, Survey Participant).

ACCESS TO HEALTH SERVICES FOR TRANSGENDER PEOPLE

Previous research in the Irish context has identified barriers to health service access for transgender people, noting the negative mental health outcomes associated with limited or absent health and support service provision (Collins & Sheehan, 2004). The lack of a coherent, holistic framework for health service delivery

to transgender people in Ireland is clearly a significant problem. Further to this, the expertise available is limited to a very small number of health professionals whose primary responsibility within the healthcare system is not to transgender people. These professionals are Dublin-based and long waiting lists, coupled with significant financial costs, present considerable barriers to transgender people's ability to access appropriate services. A transgender person who decides to access gender re-assignment services must be referred out of the jurisdiction, most often to the UK, having first received a diagnosis of Gender Identity Disorder. [3]

International research strongly suggests that in addition to structural constraints such as cost and service location, fear of service-provider reaction acts as a significant barrier to service access (Goldberg, 2007; Hines, 2007).[4] In the Irish context, research has identified the lack of availability of information, inadequate awareness of the needs of transgender people on the part of healthcare professionals, and the absence of services for families as significant barriers to healthcare among LGBT people (Collins and Sheehan, 2004). Each of the above has particular implications in relation to general healthcare services and more specifically in the context of promoting positive mental health.

The focus of the current study, coupled with the sampling strategy, means that it cannot hope to fully explore the range of issues that may impact on the lives and service utilisation experiences of transgender people in Ireland. Nonetheless, the available data demonstrate the considerable stress associated with the limited medical and support services available to transgender people.

Four transgender people were interviewed in-depth for the purpose of the study and, of these, three identified as male-to-female and one as female-to-male transgender. Three had accessed services initially through their GP and were then referred to a specialist service. As with lesbian, gay and bisexual people, they experienced varied responses from their GPs, with some relating far more positive accounts than others. One participant had not confided in her GP, as yet, about her situation in general or about 'feeling down' because of fears about confidentiality.

> **INTERVIEWER:** *And have you ever spoken to a GP or anybody about feeling down?*
> **RESPONDENT:** *No, I don't speak to anybody really as such, as of yet. But I'm always thinking for the last couple of years about calling into my GP and getting more information and seeing what my next step would be. Going through the support group, they got me the names of doctors, as I said. Eventually I know I'll have to go to meet my GP because I think he or she will have a say in what I do, three or four people will have a big say about whether they will accept me or not.*
> **INTERVIEWER** *And, do you have any worries about going to your GP?*
> **RESPONDENT:** *Well I know my GP is meant to be all confidential like, but something tells me that he or she won't (Male-to-Female Trans, Lesbian, 30).*

Most made reference to the difficulties they experienced obtaining the information they needed to access appropriate services.

> *Some people, they need psychiatric help, but there isn't a whole lot of that going around the country. And there's no real information on how to get it or where to go, there's none of that, so it's a constant struggle for people that aren't as lucky as me ... it can be very stressful because you have to go out everyday and try and walk along the street, you have to put up with other people. You have to put up with the looks and the comments, all that sort of thing ... (Male-to-Female Trans, Heterosexual, 37).*

3 The term 'Gender Identity Disorder' is a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (4th Ed.) (DSM-IV) (American Psychiatric Association, 1994) and is classified in the International Classification of Diseases, Tenth Revision (ICD-10, F64.2, World Health Organisation, 1992). It is worth noting, however, that what has been referred to as the 'medical construction' of transgender people (Hines, 2007: 10) has been subject to critique. For an overview of recent debates in this area see Hines (2007).
4 Particular issues are also evident in relation to healthcare services for transgender people under the age of 18 (Di Ceglie, 2000; Collins and Sheehan, 2004).

In addition to the stress of undergoing a highly significant life changing event such as gender re-assignment, a number identified procedural and financial pressures that impacted on their sense of health and well-being. These included issues such as name changes, medical card provision, and waiting lists for services.

> *... what I did first was I went to the GP and I asked him, I told him the way I was and what I was feeling and all that, and he said 'Right well I will try and make appointments for you to see people'. He wrote to I think a guy in (psychiatric hospital) and he said, 'No I can't take anymore patients, I am fully booked'. And he was the only one in the country, so like I was screwed there straight off. There was nobody to go to so I went off to the UK (Male-to-Female Trans, Heterosexual, 37).*

Most noted the significant costs incurred as a result of having to travel to another jurisdiction to avail of gender re-assignment services; this journey was depicted as a lonely one by practically all transgender respondents who had either begun or completed the process.

BARRIERS TO ACCESS AND ENGAGEMENT WITH SERVICES

Earlier sections have highlighted some of the challenges that LGBT people face in accessing a range of health care services. This final section highlights specific barriers to service access and engagement among LGBT people in general.

Distance and economic factors sometimes prevented LGBT people from engaging with services. The geographical spread of services was an issue frequently raised by those in provincial towns or villages who had to travel long distances to connect with LGBT-specific supports and services. A young man who had regularly attended a LGBT youth group in a provincial city explained that distance deterred many LGBT young people from attending.

> **RESPONDENT:** *There's no support group or anything that I know of closer than (provincial city) ... I mean we discussed it in one of the (LGBT youth) meetings, if we could have the group move around, you could have every third evening in (other provincial town) to make it more accessible for people.*
> **INTERVIEWER:** *And do you think that might be possible in the future?*
> **RESPONDENT:** *I suppose if there was more advertising and stuff and people actually knew about it they would turn up. Then trying to get it advertised is a problem. I know we sent our posters to all the schools but not many of them put them up or anything (Gay, Male, 21).*

The issue of accessibility was emphasised by others, including a number of survey participants who included commentary on their experiences.

> *Just try to make services more accessible and stuff. It's an hour's drive to get there and an hour's drive home again for two hours here (youth service). I'm as long travelling as I am here. So if there was something a bit closer to home it would be a lot easier (Gay, Male, 21).*

> *I am from Dublin but I live in (provincial city). And I feel the LGBT community outside Dublin sucks. I think services in Ireland as a whole are very, very restricting (Gay, Male, 29, Survey Respondent).*

Financial considerations were more likely to be mentioned by people who had attended counselling at some time and there was a strong perception, particularly among LGBT adults, that 'good' counselling was costly.

> *I wish I wasn't gay ... and is there anyone I can go to talk to for professional help for free? (Lesbian, Female, 22, Survey Participant).*

Above all, the data indicate that help-seeking processes, and people's willingness to engage with services, were influenced by the lack of affirmative services available to LGBT people. In terms of health services specifically, the data presented earlier in this chapter demonstrate that many in this study felt that health care professionals lacked the competencies or experience to assist LGBT people. One gay man relayed a

particularly distressing experience of seeking help.

I went to this guy who runs the counselling end of it and he said to me, 'But you can talk to me'. I said, 'I don't fucking want to talk to you, I want to talk to someone that's professional'. And he said, 'Well we don't have anybody, we can't get anybody to help you, you're working so you're not available during the day'. So I just left that night and he knew I was angry because I was angry. It's the first time I ever actually spoke to anybody like that in my life. Here I was, I really needed help and they fucked the whole thing up and I was annoyed. I never went back. I never want anything off them again (Gay, Male, 46).

Lack of confidentiality, and the fear of being labelled, also emerged as significant barriers to service access for all LGBT people and young people, in particular.

> *There is counselling but I don't feel there are people I would go to. I don't feel there is anyone I can trust in terms of the counselling (Gay, Male, 33).*

> *I think LGBT people are just forgotten. Even the way people see people initially, I think they assume that you're straight. They shouldn't assume anything really. I think society is just geared towards heterosexual people. Unless you kind of let them know there's gay people out there I don't think the really do anything about it like (Gay, Male, 20).*

Participants' accounts, from both the online survey and in-depth interviews, reveal marked variation in experiences of service provision, a finding which is consistent with those documented in a recent North West study of the recognition of LGBT identities within Irish health services (Gibbons et al., 2007). Typical accounts indicate that economic factors and poor accessibility are significant barriers to health service access for LGBT people. Furthermore, on approaching such services many reported that their needs and concerns were not adequately addressed, an experience which appears to be strongly related to an implicit assumption of heterosexuality by health care providers. Others reported insensitive or biased treatment once LGBT orientation was disclosed.

CONCLUSION

The international literature has consistently identified health care as a particularly problematic arena for LGBT people. Research suggests that there are significant disparities in access to and receipt of health care for men and women based on their sexual orientation or transgender identity (Diamant et al., 2000; Heck et al., 2006). Findings also show that LGBT patients frequently withhold information about their sexual orientation or gender identity, possibly in an effort to avoid health provider bias (Clover, 2006; Meckler et al., 2006; Stein & Bonuck, 2001). It also appears that health care providers may be uncomfortable, reluctant, and inadequately trained to take the sexual histories of LGBT persons or to discuss minority sexuality issues more generally (Jillson, 2002). Lesbians, gay men and transgender people report low satisfaction with health services because of negative provider attitudes and lack of cultural understanding of the context in which their health is shaped (Clover 2006; Dean et al., 2000; Solarz, 1999).

The marked variation in LGBT people's experiences of service provision, uncovered by survey and in-depth interview in this analysis, is largely consistent with other Irish studies (Gibbons et al., 2007; Dillon & Collins, 2004). There were many dimensions to the experiences and contexts that created barriers to service access and engagement. Structural barriers – including distance, the absence of services, and financial considerations – featured strongly in some accounts. Alongside these structural barriers, it is important to recognise the level of alienation and possible discrimination that LGBT people may face when they attempt to access services that might otherwise impact positively on their physical and/or mental health. The negative effects of hostility towards LGBT people and lack of understanding of minority sexual identity are particularly noteworthy, as are people's fears about confidentiality, non-acceptance and rejection. The findings, therefore, reveal particularly problematic experiences as LGBT people attempt to seek support and advice in relation to physical or mental health concerns. This may not be so surprising since health and well-being are discussed predominantly 'within a heterosexual frame of reference' (Neville & Henrickson, 2006: 409) and with limited mention of the specific needs of the LGBT population (Heapy et al., 1994). The

development of 'cultural competence' in LGBT health issues includes understanding the reasons behind LGBT people's reluctance to seek health care, the impact of homophobia on physical and mental health, and an awareness of the range of specific health risks and problems experienced by LGBT individuals (McNair, 2003; Solarz, 1999).

CHAPTER 7 RESILIENCE

RESILIENCE

The findings presented in earlier chapters strongly suggest that LGBT people's lives are negotiated under varying degrees of adversity. Many in this study feared and experienced profound rejection from family, friends and loved ones following the disclosure of their sexual orientation or transgender identity. A large number reported discrimination, harassment and homophobic bullying, and many others experienced problems at school or the workplace that were damaging to their self-esteem, well-being and mental health. The negative ramifications of these experiences are amply documented in Chapter 5. Nonetheless, it would be mistaken to interpret these adversities as the only, or indeed the defining, characteristics of the lives of *all* LGBT people. Such a picture of universal exclusion or marginalisation may, in fact, serve to perpetuate a misrepresentation and misunderstanding of LGBT people's lives. The accounts of the study's participants are far more nuanced, pointing to ways in which people overcome adversity and also to positive aspects of sexual minority identities and experience.

Quantitative findings from the online survey based on measures of subjective well-being suggest that LGBT people in Ireland today are, on the whole, more happy than they are unhappy with their lives. When asked how happy they considered themselves to be, the average score was 7 out of 10 (mean = 6.87, s.d. = 2.20, n = 1097), where 0 was 'extremely unhappy' and 10 was 'extremely happy'. Satisfaction with life as a whole was also generally high amongst the survey sample. Again, the average score was 7 out of 10 (mean = 6.96, s.d. = 2.29, n = 1092).[1] While many of the findings presented thus far have highlighted negative experiences impacting on the lives of LGBT people living in Ireland, these findings suggest that, despite the often difficult circumstances within which LGBT people live their lives, most LGBT people are "OK" (Murdock & Bolch, 2005) and have developed the ability to be resilient to these adverse experiences and contexts.

This chapter places particular emphasis on LGBT people's *narratives of resilience*. While aspects of resilience have been referred to throughout this report, resilience is specifically explored here in relation to self and others, and also in relation to the social environments or contexts where LGBT people interact. We lean heavily throughout the chapter on the study's qualitative data. Qualitative/interpretative methods are especially useful for the study of resilience because of their ability to capture complex processes and the construction of meaning (McCubbin et al., 1999). 'Stories' or narratives are therefore particularly suited to unravelling contexts and processes that guide individuals and help them to cope with adversity. They can also help to illuminate aspects of sexual minority identity that contribute to psychosocial health and well-being. Where appropriate, we also provide statistics from the online survey that help to illuminate some of the narrative accounts.

SOCIAL SOURCES OF RESILIENCE

Strong social networks are recognised as improving people's general well-being, as well as promoting self-confidence and a sense of connectedness. The concept of social support is valuable since it suggests that it is possible to identify specific relational sources of resilience. It also implies that resilience can be cultivated and sustained, through both external and internal processes, in individuals who experience adversity. The online survey assessed social support using the Multidimensional Scale of Perceived Social Support (MSPSS), a validated self-report questionnaire measuring the perception of the adequacy of support from family, friends, and significant others (Zimet, Dahlem, Zimet, & Farley, 1988). It consists of 12 items, each scored on a 7-point scale (1 = very strongly disagree -7 = very strongly agree), yielding three subscale scores called family support, friends support, and significant others support. Subscale scores are added to give a total social support score in a range from 7 to 84, with higher scores indicating greater perceived support. Table 7.1 below presents mean scores for each item and sub-scale in the MSPSS. Support from friends was the strongest form of social support amongst the survey sample (mean = 21.81, s.d. = 6.20), followed closely by support from significant others (mean = 21.27, s.d. = 5.46). Consistent

1 For each of the questions respondents were asked to place themselves on an 11-point scale running from 0 to 10, were 0 was 'extremely dissatisfied/unhappy' and 10 was 'extremely satisfied/happy'. This standard survey scale has been widely used in research into subjective well-being and based on questions used in the European Social Survey (ESS).

with this finding, two thirds of survey respondents reported that talking with friends was the thing they were most likely to do when feeling 'down' in order to help them to feel better or to forget about their problems. This underscores the crucially important role that friendship plays in people's lives (See Table 7.2 further in this chapter for a complete breakdown of activities and coping strategies employed by survey respondents to help them feel better when feeling down). Respondents on average tended to hold more neutral views regarding the perceived social support they received from their families, based on the MSPSS.

Analysis of qualitative data uncovered four key sources of sources of social support in the lives of LGBT people: friends, family, the LGBT community, and specific social environments including school and the workplace. We explore each in full in the following sections.

Table 7. 1: Mean scores on the Multidimensional Scale of Perceived Social Support (MSPSS): survey sample

MSPSS Sub-scales		mean	s.d.	α
Friends' Support		21.81	6.20	0.95
6	My friends really try to help me.	5.41	1.52	
7	I can count on my friends when things go wrong.	5.44	1.59	
9	I have friends with whom I can share my joys and sorrows.	5.53	1.55	
12	I can talk about my problems with my friends	5.43	1.60	
Significant Other		21.27	5.46	0.96
1	There is a special person who is around when I am in need.	5.37	1.79	
2	There is a special person with whom I can share my joys and sorrows.	5.32	1.82	
5	I have a special person who is a real source of comfort to me.	5.27	1.83	
10	There is a special person in my life who cares about my feelings.	5.31	1.84	
Family Support		17.55	7.18	0.94
3	My family really tries to help me.	4.74	1.73	
4	I get the emotional help and support I need from my family.	4.28	1.81	
8	I can talk about my problems with my family.	4.11	1.86	
11	My family is willing to help me make decisions.	4.42	1.78	
Total		60.63	18.84	0.95

Friendships as a source of resilience

Consistent with the findings of the online survey, the support of friends was the most frequently cited source of positive well-being amongst interview respondents. Loyal and reliable friends were important particularly during stressful times, but also in terms of day-to-day companionship. A number were keen to emphasise the positive support provided by their long-term friends.

> *... we go way back, way, way back and I'm very, very fond of him. He's straight. He's never judged me and he's always been very loyal and there's very few people in the world you can say that about in your life (Gay, Male, 40).*

The man quoted above went on to talk about intimacy and honesty as important components of reliable friendships.

> *I think there is an intimacy between us and honesty about each other that we can bare ourselves emotionally to each other and if anything goes wrong in our lives there's somebody we can go to who will help out and listen and give advice. And I've done that for them and they've done that for me. And that kind of relationship is a very precious one. There's not many people in your life who you can do that*

with. If I hadn't I might be in a very bad way. I really mean that (Gay, Male, 40).
Supportive friendships afforded LGBT people opportunities to articulate shared experience, particularly in the context of perceiving themselves to be isolated, as indicated in the account below.

[After meeting a lesbian woman in College] ... The more we got talking, the more it just made me feel good. It was just so much better to speak and interact with somebody who basically had the exact same experience as me. I mean they came out, they felt really bad, then they met lots of open gay people and they were, 'You know something, it's not so bad'. It doesn't have to be dreadful; it can be a perfectly happy, rewarding life. And it was through, you know, speaking to her and other people in the GLB [society] it just made me happier about myself like, it was nice to have similar-minded friends ... (Lesbian, Female, 25).

Close friends were also people in whom respondents confided when they felt they needed advice or support.

I've always had my support and people I can actually talk to that can help me sort out my problems ... (Gay, Male, 21).

I have a friend, he's a boy I tell him everything (Gay, Male, 16).

Others stated that they depended on close friends at times when they felt 'down' or depressed.

When I get depressed I ring one of my friends and they come over and we sit down with a cup of coffee with everything on the table and it's fine, you know ... I don't go out and get drunk ... I just don't think it's the way to deal with things like that ... So my friends are great. I've two really brilliant friends and I just ring them, they come over, bring the biscuits, I make the coffee and we all sit and talk about it, so it's great (Lesbian, Female, 31).

I definitely felt down, but not, I wouldn't have felt down to the point where I felt down but I never had any, we'll say suicidal tendencies or notions or anything like that. I just knew I felt down and I needed to talk to somebody and that's when I would have talked to friends (Lesbian, Female, 32).

Friends also emerged as key figures in the lives of LGBT people during times of transition and change. This was particularly apparent when respondents talked about the 'coming out' process. The degree to which LGBT people are visible within peer or family networks, or in settings such as school or the workplace, will vary over time. Hence, the management of disclosure is best understood as a process rather than a one-off event (Barrett and Pollack, 2005; Abes & Jones, 2004; Floyd and Stein, 2002; Whitman et al, 2000). As indicated in Chapter 4, this process differed for each individual and was influenced by a range of complex factors. However, irrespective of this variation respondents almost always mentioned friends who supported them. A gay man, aged 20, explained how acceptance from his school friends fostered self-acceptance as he tried to come to terms with his sexual identity.

INTERVIEWER: So gradually you were telling more and more people ...
RESPONDENT: Yeah I was just looking for their acceptance. I was kind of depending more on everyone else rather then having my own self-esteem and my own inner strength. It was like, if they like me then maybe I mustn't be that bad (Gay, Male, 20).

Managing disclosure is a boundary that can promote resilience by bringing people that are gay-affirmative together while creating distance from those who are more hostile (Oswald, 2000). Given the stigmatisation of same-sex relationships and transgender identity in society it is perhaps unsurprising that so many in the study relied on people who they perceived as trustworthy, non-judgemental and accepting during the 'coming out' process. These supportive friendships reduced the sense of fear and isolation experienced by LGBT youth in particular, as they considered the 'safe' individuals and contexts for disclosure. In common with Riggle et al's (2008) analysis of positive aspects of being gay or lesbian, several accounts also indicate that 'coming out' enhanced the well-being of many participants through the creation of social support systems and support for other life activities. Indeed, a considerable number indicated that friends sometimes played a role as a kind of 'surrogate' family, particularly during the

process of coming out. Some felt for example that, even in situations where they had supportive family members, they could communicate more easily with their 'community' of friends, particularly in relation to issues that may have caused anxiety or stress.

Reciprocation appeared to be a key feature of these relationships and friendships and it is perhaps important to note the majority talked about giving support as intrinsically rewarding. This two-way process was perceived to be an important element of dynamic, supportive friendships. Furthermore, giving support was framed by a number as an important source of personal affirmation, as demonstrated in the following narratives.

> *I think things are, people are mutually supportive, maybe they're not always 50-50 or whatever it is like, but that's what a good friendship is, so I don't really see it as 'leaning on'... I probably give my friends more help and advice and support and stuff a lot of the time than I would get from them (Gay, Male, 40).*

> *I tell her everything about me because the fact that we are so close that she understands you know – she knows that she can tell me anything you know and that I would understand her too (Bisexual, Female, 20).*

The issue of friends' sexuality was referenced in several accounts. As indicated, long-term or close friends who provided acceptance and support may have been heterosexual, and it seems that the formation of strong friendships was based on many different experiential factors. Obviously, as a minority, LGBT people are likely to traverse 'straight and gay society' in terms of venues, work and so on, and much of our data indicate that support was available to LGBT people from individuals across the social spectrum regardless of sexual/gender identity.

> *I have two separate groups of friends, I'd have like a straight one and a gay one... you can talk to them about different issues and things like that. And even if it's just for a chat, like knowing that someone is wondering like you does sort of make you feel a bit better (Gay, Male, 18).*

> *Like you wouldn't exactly care about people's sexuality exactly, it doesn't make a difference to who I'm going to talk to about my problems (Gay, Male, 21).*

> *My really good friends overlap so I've got really good gay friends that are part of the straight sort of thing as well...but there's very clearly gay nights out and straight nights out at the same time (Lesbian, Female, 20).*

Nonetheless, to suggest that the sexual orientation of LGBT people's friends lacks relevance would be to discount the influence of everyday experiences of heterosexism and/or homophobia. In a general sense, lesbian, gay, bisexual or transgender people were perceived to be more empathetic, particularly in relation to LGBT-specific issues. A number of narratives also suggest that supportive LGBT networks were crucial in terms of having access to individuals who shared similar experiences. One transgender person explained.

> *I don't think I can talk about these issues, unless they themselves have been like you know, very close in touch with these issues or else have experienced them themselves. I'm very grateful because I do have a number of friends like that [transgendered] who have gone through it, so I can always turn to them and talk about things and I've got other friends who I can talk to about other things, I've got support from both sides (Male-to-Female Trans, Heterosexual, 27).*

Another respondent highlighted the significance of her contact with another lesbian woman during her teenage years.

> *One of my best friends that I went to school with, her sister is gay and was in a permanent relationship at that stage, so I knew them, and I still do. And I would have met a lot of gay friends through them over the years. So like it wasn't like I was completely on my own, I would have got help from them like earlier on, discussed it, all that sort of thing. Yeah, I didn't feel totally isolated, I had people that I could talk to (Lesbian, Female, 32).*

Secure and supportive personal relationships help to bolster positive concepts and self-worth (Rutter, 1987), a claim which the data presented here appear to support. Friendships emerged as key sources of resilience and helped respondents to negotiate contexts and environments they perceived to be hostile. Friends also enabled many to cope with experiences that evoked sadness, fear or distress.

Family as a supportive environment

Earlier sections of this report have uncovered the numerous challenges and difficulties faced by LGBT people due to lack of family support. However, over two thirds (n = 748) of online participants had at least one person in their immediate families who they could talk openly to about their sexual orientation or transgender identity. In addition, several interview respondents reported positive family relationships and highlighted the importance of a supportive family environment. Others noted that, over time, family members had become more understanding and accepting of their LGBT identity. The following are examples of respondents who specifically noted the importance of their parents' acceptance, particularly at the point of 'coming out'.

> *My Dad goes, 'Oh he's my son'. And at that point I realised that Dad did not have a problem like, he could say it to other people that he had no problem with that aspect of it. It meant quite a lot to me like, that he didn't care. He said it straight away, he didn't have to think about it or anything (Gay, Male, 17).*

> *So I told them both [parents] that I was gay and my father straight away stood up and went over to me, pulled me off my seat, gave me a hug and said, 'Do you know what, that doesn't matter a bit'. He was great and my mother was like, em, they still love me, d'you know, it doesn't matter. But they were both brilliant and they continue to be very supportive (Gay, Male, 21).*

> *I just think that I am lucky that I had the balls to be able to come out when I came back here [to rural locality]. It was a conscious decision and I had the support of my family and I'm lucky. I know a lot of people don't have the support of their family and its really important (Lesbian, Female, 50).*

A number of others clearly valued relationships that permitted them to talk openly with a parent or sibling.

> *Like my Mam, like she is very, she's very good to talk to. She's very supportive and she's very open-minded (Gay, Male, 26).*

> *I'm fairly close with my brother especially. We're very close, we tell each other loads of things. He has no problem talking to me about anything and the same with me talking to him (Gay, Male, 21).*

A point of crucial significance is that those who felt supported by family members benefited in ways that appeared to impact positively on their sense of security and well-being. For example, there was evidence to suggest that family relationships characterised by acceptance fostered self-confidence and the ability to manage negative emotions and environments. These accounts also indicate that when people experienced personal challenges family support acted as an important buffer. One transgender respondent portrayed family support as vital in the context of her gender transition. Elsewhere, this woman noted that her peers, who lacked these supports, faced very challenging journeys.

> *At the moment life is very good, you know I have no problem, I am unusual in that I have the support at home, and do you know, I haven't had problems with family members or people disowning me or anything like that. I've always had the support at home to be me; it's never been a problem (Male-to-Female Trans, Heterosexual, 37).*While many in this study experienced difficulties when they initially 'came out' to family members, some indicated that these relationships were re-negotiated over time in a process that led to resolution and acceptance.

> *At the time [of coming out] my parents just went, 'Okay we're grand with it but just leave it and let it sink in'. But for months I was just going in my own head, 'They're not accepting it'. But last week my*

> *mother told me that she'd told the sister. I think that was a big a relief as actually telling them. The fact that she'd actually told somebody, she's actually accepting it and getting used to the idea (Gay, Male, 21).*

For a number, the acceptance of their partner into a family network was an important marker of positive change.

> *I mean (my country of origin) is basically is very sort of backward when it comes to any sort of, anything that does not conform to the norm and I knew it was going to be a bit of an upwards struggle with my mother. The rest of the family was actually ok and over the years they've not only welcomed me, they've welcomed my partner as well into the family. My father's been fantastic. But it took a little work, so I'd say it took about two, three years where relationships were extremely strained ... (Lesbian, Female, 34).*

Because of the complex interconnections of lives in the family, critical events create 'countertransitions' (Boxer et al., 1991: 64). Put differently, events that occur in the life of one family member affect others in the family also. So, for example, certain changes in a parent's life have meaning and implications for a child. Thus, 'the coming out process in a child may potentially initiate a parallel process for the parent' (Boxer et al., 1991: 64). Studies exploring how families negotiate a member's LGBT identity have noted that acceptance of that member's chosen partner and/or friends is key to supportive family relationships (Herdt & Koff, 2000; Oswald, 2002). Respondents in this study who felt supported within an affirmative family environment appeared to benefit greatly from this experience. Family support certainly enhanced self-confidence and self-esteem and also appeared to facilitate respondents' ability to negotiate challenges with greater confidence and ease.

LGBT community as a source of resilience

> **INTERVIEWER:** *What's your idea of what an LGBT community is?*
> **RESPONDENT:** *Just kind of like a group of gay and lesbian people that support each other (Gay, Male, 21).*

Several studies have highlighted ways in which LGBT people benefit from integration into the LGBT community. This community has been found to be a source of support (Russell & Richards, 2003), to provide a safe space for LGBT youth (Scourfield et al., 2008), and to promote self-understanding and self-acceptance (Anderson, 1998). These features are claimed to foster resilience in LGBT people of all ages.

Over three quarters of the overall survey sample (n = 846) felt that there was, in fact, such a thing as an LGBT community in Ireland, two thirds of whom (n = 560) felt that they were a part of, or in some way connected to, this community. In-depth interview participants' ideas about 'LGBT community' provoked a variety of responses and people clearly differed in terms of the time they invested in attending and integrating into LGBT groups. Furthermore, some expressed disappointment about what they found when they made connections with LGBT venues and 'scenes'. Despite this diversity of perspective, there was strong evidence to suggest that the LGBT community provided support to people in their everyday lives, and also at specific junctures and during particular times of need. Here we focus on LGBT community venues not directly connected with social 'scenes' such as pubs and clubs. The themes of *connectedness*, *safety* and *solidarity* featured centrally in respondents' accounts of the benefits of participation in LGBT communities.

Participants appeared to draw to a greater or lesser extent on the LGBT community at different times in their lives. Age was a factor here, as was the degree to which people were 'out'. LGBT community participation was also influenced by geographical area of residence with fewer opportunities for participation being reported by many rural respondents. Community participation also varied by the extent to which people felt the need for support and participation at different junctures. These factors aside, for the majority who engaged with the LGBT community, participation was overwhelmingly perceived to be positive, particularly in terms of making contact with others who shared similar experiences. Several, for example, talked about how youth groups/gay men's groups outside of pub and

club were important in terms of meeting others and of feeling valued and 'connected'.

> *I like it there [LGBT community centre] because there's no loud music, there's no booze, there's no obnoxious people and it's nice, intelligent conversation with some very nice decent people. You feel you're valued by people as yourself, you know. You can't underestimate how important that feels to me right now (Gay, Male, 40).*

> **INTERVIEWER:** *What was it about [men's group] that connects with you in particular?*
> **RESPONDENT:** *The fact that I could then have very deep genuine relationships with other gay people that were in*
> *the group.*
> **INTERVIEWER:** *Before that were you having difficulty with people or...?*
> **RESPONDENT**: *I suppose in general I was having difficulty with gay people as a group, yes (Gay, Male, 50).*

Young people particularly emphasised the confidence and sense of 'belonging' they experienced through participation in LGBT youth groups. Indeed, several characterised their initial visit to these settings as a positive 'turning point' experience.

> *It did give me a circle of close knit gay friends... we were such good friends from the group and we're really close. Then I made more friends. It sort of gave me the confidence to just be myself in any setting, not just in here [gay youth centre] (Gay, Male, 21).*

> **INTERVIEWER**: *What makes you feel part of it [gay community]?*
> **RESPONDENT**: *Just going to [youth project], every Sunday, doing things like that, meeting different people. Meeting people from all walks of life, getting different numbers of friends (Gay, Male, 17).*

It is perhaps noteworthy that social involvement in LGBT-specific settings allowed some young people to see themselves as positive role models and to aspire to engaging in positive action that might help others.

> *I'd love to help people. Going there [LGBT youth project] was such a good place for me. Like I know other people in different circumstances might not have the same support that I have. I'd love to be a youth worker of some description and help people who wouldn't have the same family and opportunities that I have (Gay, Male, 17).*

Contact with an LGBT support group enabled others to share specific and sometimes challenging life experiences. For one woman, contact with a lesbian women's group in a nearby town allowed her to meet others with similar experiences for the first time.

> *I went to [LGBT support group] and I did actually meet a couple of women who were married. One woman that is married, still married and identifies as gay and another woman had left her husband and she was gay. So they were in similar situations. So I figured, 'Thank God I'm not the only one' (Lesbian, Female, 51).*

Apart from fostering a sense of connectedness, participation in the LGBT community provided a 'safe space' for people to meet and interact. The issue of safety is one of particular importance in light of the number homophobic and transphobic experiences reported by the study's participants (see Chapters 4, 5 and 6).

> *There are people who believe in the community model and they create a community that provides a very safe place for somebody like myself to operate in (Gay, Male, 62).*

> *When I got there [football] it was this really cool group of girls, very friendly, d'you know, none of them trying to hit on me, very nice. They have like a social element where they would go drinking on a Friday night together... and I think it's really important because it's nice to have this safe place to come, and especially girls from the countryside (Lesbian, Female, 31).*

The safety of LGBT youth groups provided environments that enabled young people to positively negotiate formative life stages such as 'coming out'.

> *I had low self esteem and confidence before I came here, but from talking to other gay people you get to know their life, and how they live through it, and it just kind of boosted my confidence (Gay, Male, 16).*

This perceived safety also afforded opportunities to individuals to look more acutely at themselves and how their lives may have been affected by homophobia, discrimination, or rejection. In confronting such negative experiences, LGBT respondents used these situations as occasions for understanding how they had affected their lives.

> *It was just the way they [staff and volunteers] were explaining their everyday life, and like it was a normal person's life. I was just thinking that my life is never going to be like an ordinary person's life. But when I got to know them, they were all leading perfectly normal lives, and everything was grand with them there, so I just felt more confident (Gay, Male, 16).*

Thus, in keeping with the findings of Russell & Richards (2003: 324), there was evidence that through participation LGBT people could directly confront and address aspects of negative experience and transform it 'into grounds for enhanced self-understanding and the courage to be more out'. In this regard, a number specifically mentioned their participation in Gay Pride. [2]

> *We made a banner here [in a youth group] and went out on the street with it ... I was actually kind of afraid but at the same time there's a thrill in it, I enjoyed it. The atmosphere around you and everyone having the craic and jumping around the place (Gay, Male, 21).*

Solidarity was the final theme to emerge from the accounts of respondents who were members of LGBT groups. This solidarity was most strongly expressed in reference to positive LGBT identity (sometimes expressed as 'pride'), which acted as a counterbalance to homophobia and transphobia.

> *I feel a certain affinity with other LGBT people ... I'd never miss Pride, which I think is the key community event of the year. It's just a certain, a certain identity, just a certain level of solidarity there. I mean, if you're in the street and someone's getting homophobic abuse or something like that, you'd be immediately inclined to step in support them (Gay, Male, 28).*

To summarise, contact with the LGBT community provided an important source of information about LGBT people's lives, information that is not easily accessible through other means. The community further represented a personal source of support and an environment in which LGBT people could feel respected, confident and capable. In keeping with the findings of international studies (Russell & Richards, 2003; Scourfield et al., 2008), contact with other LGBT people in a safe and relatively structured environment appeared to foster a sense of belonging. It also exposed participants to positive messages and a created a means for them to question, contest or deconstruct negative stereotypes.

School and the workplace as supportive environments

As highlighted earlier in this report, school was an environment where many LGBT people experienced particular stress. There were also numerous reports from participants of feeling uncomfortable or isolated in the workplace because of their LGBT identity. Nonetheless, positive school and work experiences were reported by a number and these accounts suggest that positive affirmation in these environments was valued as a source of social support.

A small number of young people mentioned an individual teacher who was particularly empathetic and who supported them in the school environment. These accounts point to the positive influence of this support and also to the sense of well being that young people enjoyed as a result. They also demonstrate

2 Almost sixty percent of online survey participants (n = 644) had attended, or taken part in Pride event(s) in Ireland; almost a third had participated in Pride outside of Ireland.

ways in which schools can impact positively, rather than negatively, on the lives of LGBT youth.

> *The female teacher was very supportive and got me through that time and helped me to get into outside curriculum, you know, a drama group and different things. And I could talk to her about anything (Lesbian, Female, 29).*

> *He [male teacher] would have been a role model. He was extremely out, like everyone knew he was gay and no one ever had a problem with it because he wouldn't let anyone have a problem with it. If there was anything homophobic that happened he'd be on top of it straight away ... you know, if anyone was using the word gay or faggot, he'd be on top of it. People would respect him for that like (Gay, Male, 21).*

The workplace was portrayed far more frequently as an environment where LGBT people experienced acceptance.

> *Actually at work, as soon as I came out I actually got a lot closer with all my work mates and everything. I didn't really talk to them as much until one day one of them asked me was I gay and I just went, 'Yeah'. Since that she's become one of my best friends (Gay, Male, 21).*

> *They [work colleagues] became my surrogate family. It was a very small company, it had only just started when I joined, so it was the three directors and myself and then over the seven years the company grew and the family of four became a family of twelve. And it was brilliant, you know (Lesbian, Female, 34).*

> *We just bonded and everybody was really cool and it was just nice to walk into somewhere and come out and not have to come out any more; your coming out was done for this particular aspect of your career (Lesbian, Female, 25).*

Positive work environments were places LGBT people felt valued for their skills and talents and where their contributions were readily acknowledged. They were also places where people did not experience stress related to their LGBT identity.

> **INTERVIEWER**: *What does your work mean to you, just the stuff that you do?*
> **RESPONDENT**: *It's meaningful work, its hard work. But I don't get any pain there (Gay, Male, 50).*

> *I'd say to date it's [current work place] probably the two years of my life where I feel that I've been most challenged and most, you know, alert. So like, if there's one decision that I've made in my life, going for that was definitely one of the good ones. Things would have gone right from it, you know (Gay, Male, 28).*

Clearly, for some in this study, work was a place where LGBT identity was affirmed and supported. In these cases, respondents tended to specifically mention positive responses to 'coming out' as well as the absence of sources of anxiety and stress which, for others, were related to discrimination and/or homophobia in the workplace.

'BECOMING' RESILIENT

> *I am happy to conclude by saying that I am now a very content, confident, well-adjusted gay man, fully out and very happy to be gay. I have grown and thrived with the love and support of my friends and two of my sisters ... being gay was never my problem but how people reacted to me being gay was certainly part of what made life very hard in the past. (Gay, Male, 35, Survey Participant).*

Resilience, or 'protecting against stressors and rebounding from adversity, is an important relational process' (Connolly, 2005: 267). For example, self-esteem and self-efficacy can increase throughout the lifespan, mediated by positive life experiences or 'turning points'. Thus, resilience is ongoing and emerging rather than simply a trait possessed by some individuals and not by others. This section

examines accounts where reports of positive change were evident and examines the extent to which these developments may signify a process of resilience. Whilst such reports of positive change did not feature in *all* narratives, and many in this study continued to experience stress related to homophobia, transphobia, discrimination or harassment, it is nonetheless important to understand experiences, both internal and external to individuals, which may bolster resilience. This section is particularly concerned with unravelling some of the most salient dimensions of LGBT people's narratives of resilience, paying particular attention to both behavioural strategies and the ongoing construction of meaning.

Reframing the 'self'

Respondents sometimes referenced changes in their lives over time, in the process reflecting on how their own perspectives had altered, often in the context of considerable adversity and distress. Accounts such as these indicate resilience across several areas of life, but most notably in the manner in which life events and perspectives can be *re-framed* over time. An individual's capacity to 'reframe' events is referred to variously in the literature on resilience. In the specific context of LGB people, Oswald (2002: 375) uses the term 'redefinition' to refer to 'the ongoing development of a belief system that affirms gay and lesbian people'. Redefinition or reframing is a process – often associated with the cultivation of new meanings and interpretations – that leads LGBT people towards a more positive understanding of themselves and of aspects of social experience that may otherwise be constructed negatively. Here we examine this feature of some respondents' narratives in more detail.

Possibly one of the greatest challenges facing LGBT people is their early and ongoing exposure to negative attitudes towards their sexual orientation or transgender identity. As demonstrated in the previous chapter, this negativity impacted in profound ways on the psychological well-being of a very considerable number. Feelings of inadequacy, isolation and depression were just some of the consequences. However, LGBT identity also provided some with an insight and awareness that enabled them to make sense of their lives and circumstances over time. In the excerpt below, a lesbian woman of fifty reflected on her struggle to feel 'comfortable' with her sexuality in the context of a society and culture where she previously perceived that being gay was not 'normal'.

> *I had all those wishes to be just normal, not knowing at the time that most people feel the same way in some way or another ... It has been a hard auld' struggle, it hasn't been easy but many years later, 25 years later. I am comfortable now (Lesbian, Female, 50).*

The following account is also suggestive of a reframing of experiences over time and signals ways in which this process was supported by positive relationships.

> *It was really a stage of my life in my early twenties and I came through the other side. I am so glad I didn't do anything foolish. It was totally 100% to do with me not accepting my sexuality and thinking I was some sort of freak. I think meeting other LGB people my age really helped me and I think for that to happen people need to be able to be open about themselves. I think a lot has changed even since I started college and it is increasingly better for young LGB people to come out earlier and start to develop relationships, sexual and otherwise (Gay, Male, 28, Survey Participant).*

Others clearly viewed being gay or lesbian as a source of strength and had re-framed their sexual orientation in a positive way. A number, for example, indicated that the process of self-acceptance had greatly enhanced their well-being. These accounts strongly suggest that, over time, several enjoyed deepened personal insight and a stronger sense of self and identity.

> *I think I've become more comfortable with my sexuality as I've got older, and my mental health is definitely a lot better around it too (Lesbian, Female, 38, Survey Participant).*

> *Since I accepted my sexuality quite a few years after 'coming out', I don't feel it has affected any aspect of life in either a positive or negative way (Gay, Male, 23, Survey Participant).*

A further point to note in the context of unravelling sources of resilience is the manner in which

respondents articulated a sense of ownership and control over their lives. Accounts often portrayed a personal or internal locus of control and a sense of 'authorship' of one's life (Abes & Jones, 2004). This 'authorship', as indicated in the accounts below, is also noteworthy as a counterpoint to the limited social scripts available to LGBT people.

> *So I have my ups and downs like everybody. I've never had any serious psychiatric illness or anything. I've been a fighter, a survivor is how I would see myself, so I've always managed somehow or another to get by, even at times of great stress. So, as I said, I've got my downs as well as ups. There were days I would have felt like not getting out of the bed. I managed to keep going one way or another (Lesbian, Female, 54).*

> *I can describe my life in two halves, my experience of struggle and depression before I came out and my life since coming out. Having only come out at the age of 42, the past 4 years have been incredibly liberating for me as a person. The turmoil of spending all my life believing I was evil took a very heavy toll on me psychologically. When I came out I lost a large number of friends which was very painful but, on the other side, it is the first time in my life I believe I can be really honest and the years of inner darkness appear to have gone (Gay, Male, 46, Survey Participant).*

LGBT people taking strength from resisting prejudice or discrimination was another important dimension of re-framing. The following narratives are examples of gay and lesbian people seeing their sexual orientation as a source of strength and asserting their sexual orientation in positive ways.

> *I was sick of being bullied. I decided, 'I don't care, people can think what they want'. When I seemed to be going that way I made more friends and became more social. From that point everything was good like (Gay, Male, 21).*

> *I was just anti-gay myself and, even coming out, I found a struggle. But again it was just over time you let go of that. You get to a stage in your life and you say, 'So what, you're the person who has the problem with it. This is my life and I'm living my life for me'. If people have a problem with it, that's fine but, you know (Lesbian, Female, 47).*

It is important to note that references to 'redefinition' or 'reframing' (Oswald, 2002) should not be interpreted as making LGBT people carry the burden of responsibility to counter homophobia, transphobia or heterosexist experiences. The intention is not, in other words, to endorse a naïve view that individuals can simply or necessarily transform such experiences. A number of respondents in fact expressed this dynamic succinctly.

> *I am proud to be a lesbian but it took me a long time to accept my sexuality and it would have been easier to accept if society was a little more understanding (Lesbian, Female, 26, Survey Participant).*

> *Society definitely seems to be becoming more tolerant of 'alternative' relationships but there's still some way to go (Bisexual, Male, 21, Survey Participant).*

Self-efficacy and self-esteem

Self-esteem amongst online survey participants was assessed using Rosenberg's Self Esteem Scale (RSES), a ten item, four point global measure of esteem with total scores ranging from 0-30, where higher scores are indicative of higher self-esteem.[3] The overall mean self-esteem score for survey participants was 20.24 (s.d. = 6.06), suggesting that self-esteem amongst the sample as a whole was relatively high. As noted in Chapter 5, there was also a statistically significant relationship between self-esteem and suicidality, such that higher levels of self-esteem were associated with fewer thoughts about ending one's life within the past year ($r = -.53$, $p < .01$).

The development of self-esteem and self-efficacy despite adversity featured strongly in many of the narrative accounts of resilience. For example, although recounting earlier negative experiences, a number of respondents drew specific attention to their personal growth and to ways in which they had positively managed stress. In some cases this was a facilitated process (e.g. through a specific support group) whilst, in others, it was a resource that people appeared to have cultivated over time. A gay man, aged 21, related his experience of gaining confidence within the context of a 'safe' environment, a 'frame of mind' which also extended to places and contexts beyond the LGBT youth group he attended.

> *It [LGBT youth group] sort of gave me the confidence to just be myself in any setting, not just in the group, because sometimes when you are out you don't feel comfortable enough to be yourself everywhere like, I seemed to gain confidence to not change who I am in whatever setting, like working, college, out, like in any club. It put me in a good frame of mind (Gay, Male, 21).*

Another respondent explained how she had learned to cope with depression and emotional distress over time.

> *I mean now that I deal with my mental health problem, I very rarely get depressed now, not in the same way that I did before. So now I suppose I don't really have many emotional issues. I like to try and keep things as simplified as possible, so when I do have relationship problems with my girlfriend, like they just have to be dealt with immediately. I hate to let things fester, things have to be dealt with and then, I mean, if it's a good outcome it's good, if it's bad it's bad ... So that I suppose is my key to mental success or mental health is to just know that if something is bad so I won't be always be bad, and if something is good it won't always be good either but you know (Lesbian, Female, 25).*

These accounts are examples of ways in which LGBT people develop competencies that assist them in managing their identity and/or in dealing with specific issues such as low self-esteem, depression or other distressing emotional states. It is significant that these accounts also reference the development of self-understanding and the construction of interpretations and meanings that support, rather than threaten, well-being.

3 Items on the RSES were measured on a four-point scale (strongly agree = 3 to strongly disagree = 0). The scale ranges from 0-30, with 30 indicating the highest possible score. Five items are reversed in valence.

Turning points

Significant amid accounts of prior experience of distress were the references made by some respondents to 'turning point' experiences that led to positive change in their lives. A notable characteristic of these narratives was that individuals asserted their agency, often in the context of considerable stress, in seeking to affect change in their lives. In the following excerpt a lesbian woman described her decision to address a pattern of problematic drinking.

> *I was never a heavy whiskey drinker or anything like that but I would have used alcohol to take the edge off for at least fifteen years ... ... And then you wake up one morning and you think, 'No, you've got to stop all of this and cop on, you're going to kill yourself'. And there's a lot of living to do (Lesbian, Female, 47).*

The account of this male-to-female transgender person also identifies turning point experiences and draws attention to ways in which LGBT people mobilise considerable personal resources in an effort to affect change in their lives.

> *I think I was 28 and I said, 'I better do something before I get too old because your life is just flying by and, you know, you have to do something about it'. At that stage, you have two choices, you do something about it, or you commit suicide, it gets to that stage, so I went off to the UK and I got some sort of help (Male-to-Female Trans, Heterosexual, 37).*

While a large number of this study's respondents reported psychological distress, several also related experiences and events that appeared to strengthen them at specific, and sometimes crucial, junctures. Peer and parental acceptance, as demonstrated earlier, was framed as a positive turning point experiences for a considerable number. In addition to highlighting ways in which particular events may affect positive development and change, these narratives demonstrate the capacity of LGBT people to address negative feelings and their ability to seek out and use social support.

Coping strategies

Further to the process of 'reframing' and the positive impact of specific turning points, many spoke about the strategies they used to alleviate stress. These accounts highlight a range of positive coping strategies which are noteworthy in the context of understanding resilience.

> *Nature and quietness. I find it very healing (Gay, Male, 50).*

> *Sometimes I paint. Like I've been painting a while, painting when ever I feel like, I suppose they are the ways that I kind of release stress (Bisexual, Female, 20).*

> *If I'm really annoyed I love going to the gym and just spending hours in the gym on treadmills ... and then go swimming, just go swimming for hours (Lesbian, Female, 27).*

Table 7.2 presents the range of coping strategies that survey participants engaged in when feeling down, in order to help them to feel better or to forget about their problems. As described above, significant others and friends, in particular, were important sources of support in people's lives.

Table 7.2: Activities engaged in to feel better/forget about one's problems: survey sample

Activity	n	%
Talk to friends	692	62.3
Listen to music	527	47.5
Talk to partner	411	37.0
Exercise	394	35.5
Drink alcohol to get drunk	313	28.2
Go clubbing/dancing	303	27.3
Drink alcohol (not to get drunk)	283	25.5
Smoke cigarettes	272	24.5
Talk to a therapist/councillor or other mental health professional	260	23.4
Talk to family (other than partner)	258	23.2
Go to the cinema	244	22.0
Meditate/pray	215	19.4
Take medication that is prescribed for you by a doctor/psychiatrist (e.g., anti-depressants)	192	17.3
Yoga (or similar relaxation technique)	162	14.6
Alternative/complementary medicine (e.g. acupuncture)	160	14.4
Attend GP/family doctor	143	12.9
Attend LGBT support group	139	12.5
Take prescription drugs (without a doctor or medical worker telling you to do so)	136	12.3
Attend other support group	132	11.9
Take illegal drugs	111	10.0
Other (please tell us)	179	16.1

In-depth interview participants sometimes described both constructive and negative coping strategies in response to stress. For example, some who reported self-harm or other self-destructive behaviour also referenced more positive coping strategies, as well as offering insights into feelings and behaviour that might be viewed as important sources of resilience.

> *I started drawing so that's how I got my stress out. When I got angry I'd just draw and draw and draw and then I go for walks. But that's only the healthy side of things. It was worse with the cutting and I'd hit myself and punch myself and punch walls and very self- destructive kind of things. Some days recently enough I've really wanted to cut but that was only recently where I kind of got that really strong urge again like. But generally I draw or I ring my friends (Gay, Male, 20).*

Accounts such as the one above, which simultaneously reference aspects of resilience and risk, are instructive in that they direct attention to the multiplicity and complexity of experience. People may engage in behaviour that is 'risky' but they may be also aware and seek to address this behaviour. These accounts highlight the incremental or developmental nature of resilience, thus challenging the reductionist perspective which views resilience as an inherent trait. Indeed, much of the data strongly suggest that people do not develop resilience individualistically or in isolation but rather in interaction with supportive others.

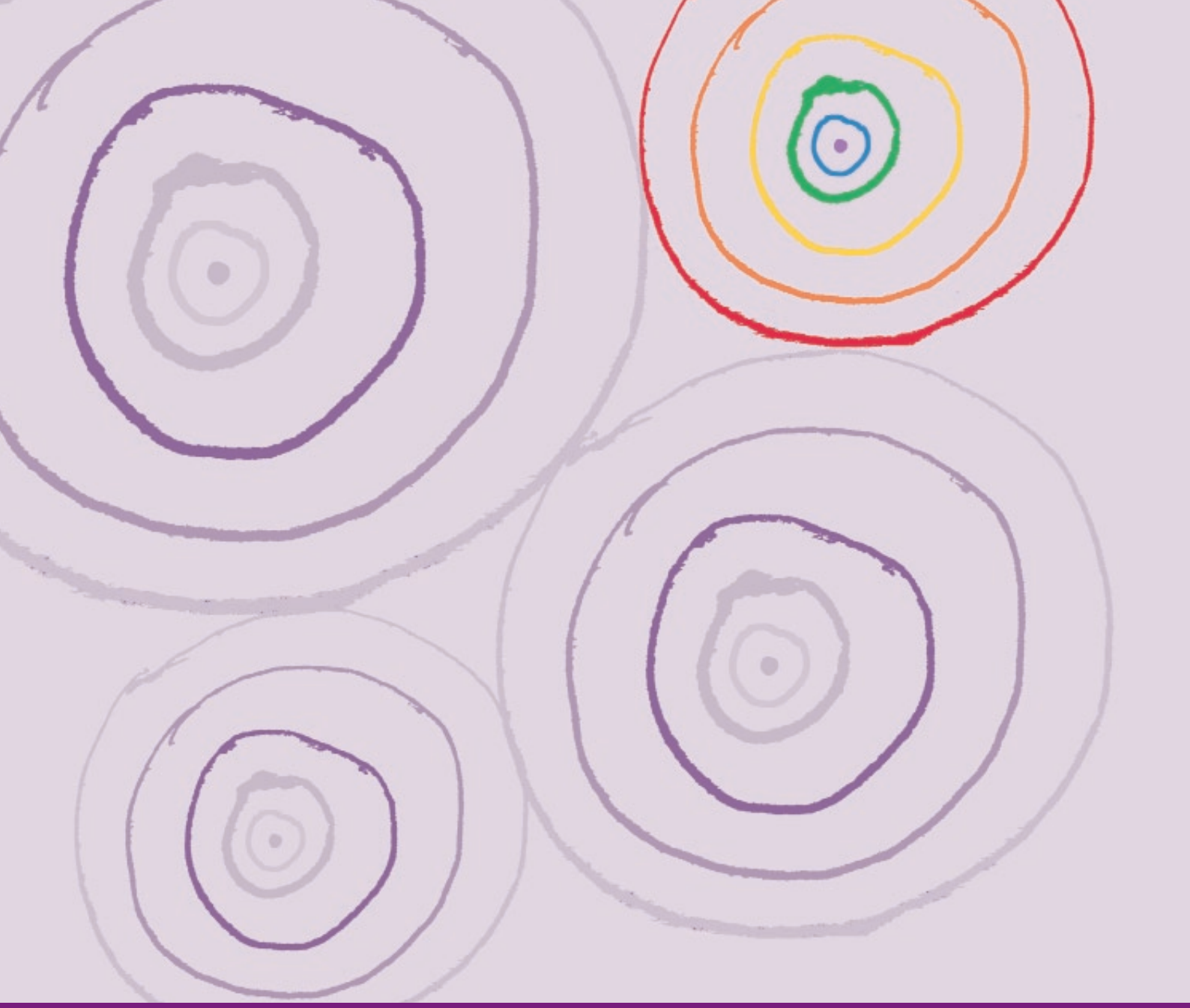
> *I'm lucky at the moment that I suppose my outlook and everything like that is a lot more positive than it was in the past. And I think the more positive you can try to be, the more positive you kind of get back in the way people deal with you or the stuff that happens to you, or the way you perceive the things that happen to you (Lesbian, Female, 25).*

CONCLUSION

This chapter has attempted to unravel key sources of resilience in the lives of LGBT people, providing an important counterbalance to earlier chapters which focused on life events and experiences that have negative consequences for lesbian, gay, bisexual and transgender people living in Ireland. The discussion concentrated on sources of social support, highlighting a range of individuals and contexts that foster resilience and enable LGBT people to cope positively with minority stress. Friends emerged as the most commonly cited source of support, friendships playing a critical role in terms of everyday companionship and during difficult or challenging periods. Trusted friends were particularly important during the 'coming out' process, with typical accounts illuminating ways in which friends bolstered positive concepts and self-worth, thereby mitigating the perpetuation of negativity and risk.

When people come out as LGBT they contradict commonplace expectations of heterosexuality and many are not accepted by family members. However, as demonstrated, some families are positive and supportive of their LGBT children or siblings, even if full endorsement or acceptance is not apparent at the time of disclosure. It is in fact argued that many families of LGBT people gradually adapt and that supportive family relationships resume over time (Savin-Williams, 1998). Certainly, for LGBT people who received support and affirmation from family members, the consequences were extremely positive. Apart from friends and family, study respondents related the positive aspects of belonging to, or having strong connections with, others who are gay, lesbian, bisexual or transgendered. The LGBT community fostered a sense of connectedness, provided a 'safe' space for people to interact, and helped to cultivate solidarity. Exposure to positive role models in these contexts also appeared to enhance people's self-perceptions. Finally, supportive school and/or work environments provided affirmation and enabled LGBT people to engage and develop without the fear of disapproval or censure.

As the accumulating evidence on resilience tells us (Rutter, 1987), people's capacity to overcome challenges should not be underestimated nor should it be assumed that resilience is a trait possessed by some individuals and not by others. The findings presented suggest that complex developments and meanings surround the process of becoming resilient. For example, some participants reported ways in which they gained deepened insight into their lives and situations over time and how this, in turn, enabled them to positively re-frame their sense of self and their identity. Others described turning points which fostered positive growth and heightened confidence. It must also be remembered that LGBT people have positive everyday experiences (Riggle et al., 2008). Indeed, a majority of this study's survey participants indicated that they were, on the whole, happier than they were unhappy with their lives. Life may have been difficult for many in the past and, for a considerable number, challenges clearly remain. Nonetheless, a large number talked about the 'ordinariness' (Savin-Williams, 2001a) of everyday life and the pleasure they gained from their lives and relationships



CHAPTER 8 SUMMARY AND CONCLUSION

SUMMARY AND CONCLUSION

This chapter will summarise the study's key findings and comment briefly on how they compare with the international literature. First, however, it is important to briefly return to the study's methodology and, in particular, to some of the limitations that must be borne in mind when drawing conclusions about the mental health of lesbian, gay, bisexual and transgender people in Ireland.

THE STUDY

This study set out to examine mental health and well-being, including an investigation of suicide vulnerability (risk) and resilience, among LGBT people in Ireland. An exploratory multi-modal approach, using a combination of quantitative and qualitative research techniques, was used to study the mental health and well-being of LGBT adults and young people. This involved the administration of a quantitative on-line survey, the conduct of a Community Assessment Process' and the conduct of in-depth individual interviews with individuals who identify as lesbian, gay, bisexual or transgender (see Chapter 2 for a detailed account of the research methodology). A total of 14 key informants were interviewed during the community assessment phase, 1,100 responded to the online survey and 40 individual in-depth interviews were conducted.

Several factors should be considered in evaluating the results of this study. First, the quantitative sample was self-selected, non-random, and limited to those with internet access, thereby possibly limiting representativeness of the general population of LGBT people in Ireland. Furthermore, the recruitment of prospective participants through targeted LGBT venues, web-sites and groups, combined with a focus on those who self-identify as LGBT, means that the experiences of those who may have same sex, or bi-attraction, but who do not identify with such labels, are not captured here. In particular young people with same sex attraction may not yet have labelled their identity (Diamond, 2003). A further sampling-related constraint is that the limited number of school-goers in the online sample means that much of our understanding of school-based experiences in particular is garnered from retrospective data and accounts.

Another critical area where limitations need to be borne in mind, given the focus and aims of the study, relates to the methodological challenges associated with researching suicidality. As previously highlighted, the measurement or assessment of suicide risk is notoriously fraught and is the subject of intense debate where both LGBT and non-LGBT people are concerned (e.g., McDaniel, Purcell & D'Augelli, 2001; Savin-Williams & Ream, 2003).

As pointed out in Chapter 5, the lack of a comparison or control group is another methodological constraint limiting a fuller understanding of the issues under investigation. This means that we are unable to draw conclusions about the probability of LGBT people (especially LGBT youth) attempting suicide, in comparison with the probability of non-LGBT people doing so (e.g. Russell & Joyner, 2001).

One of the limitations of the in-depth interview dimension of the research pertains to the absence of young people from the qualitative sample who were not out to their parents. This situation arose as a consequence of restrictions imposed by the ethical review board at the academic institution where one of the researchers was based. Many LGBT people, and youth in particular could be 'at risk' if they disclosed their sexual orientation or gender identity to their families (Murdock & Bolch, 2005), yet institutional ethical approval to conduct interviews with minors necessitated parental consent. This impacted on the recruitment of young people to the study, as it meant that the only under-18s who could participate in the interview dimension of the research were those who were already out—or who were willing to come out—to their parents, in order to take part.

Despite the limitations noted above, this is the first published study of its kind to be conducted in the Irish context. It offers insights into the unique aspects of the context of being LGBT in Ireland. While highlighting the marginalisation, discrimination and inequality experienced by LGBT people precisely because of their minority status, it also sheds light on the positive dimensions of people's lives. Findings

from the study as a whole are quite consistent with the results of prior research on sources of stress/distress and resilience among LGBT people in other jurisdictions. The application of the theoretical concept of minority stress, which has been used as a lens through which to better understand LGBT people's social and psychological experiences in other geographical contexts, further enhances the present study's theoretical generalisability. The study's findings tell us a great deal about the relationship between minority sexuality status and key indicators of mental health, including depression, self-harm and suicidiality. Importantly, the study provides insight into LGBT social experiences and the impact of heterosexism, homophobia and prejudice on people's lives and mental health. It also highlights the strengths and competencies of LGBT individuals and draws attention to the personal and social resources which they mobilise in negotiating social arenas and institutions that pose a potential risk to their well being.

Methodologically, the mixed-methods approach enabled us to develop stronger insights than that afforded by an exclusively qualitative or quantitative approach. Furthermore, the fact that so many of the online participants also provided narrative accounts meant that we were able to supplement and substantiate the qualitative data garnered from the in-depth interviews, thereby informing and further strengthening our understanding of key issues and themes that emerged.

MENTAL HEALTH RISKS

Chapter 5 focused on negative experiences in the lives of LGBT people that are directly or indirectly related to their sexual or transgender identity, examining indicators of mental health and well-being among LGBT people in Ireland. Collectively, the findings on mental health indicators suggest that the stigma and discrimination surrounding minority sexuality and/or transgender identity can result in an extremely negative sense of self, causing many to experience depression, and a significant minority to engage in self-injurious behaviour and to have, and in some cases act upon, suicidal thoughts.

Findings from the in-depth interviews suggest that a majority who had experienced depression related this psychological distress directly to their sexual orientation and/or transgender identity. Similarly, many of those who had contemplated, planned, and/or attempted suicide related their suicidality directly (although not exclusively) to their LGBT identification, and a range of experiences or feelings associated with this identity. In the case of the online survey, close to half of all suicide attempters viewed their first attempt as 'very related' (n = 24) or 'very much related' (n = 68) to their LGBT status.

Narratives of self-harm, depression and suicidality were often tinged with feelings of disconnectedness from family and peers, social isolation, loneliness or aloneness. These were compounded by feelings of lack of self-worth and self-loathing, which often linked to the internalisation of discrimination, victimisation, and/or heteronormative expectations about what constitutes a 'normal' life. Those who experienced homophobic bullying and/or lack of acceptance by significant others in their lives as a consequence of their LGBT identification were particularly susceptible to depression, self-harm and or suicidality.

RESILIENCE IN LGBT PEOPLE

As stated in Chapter 1, much less time has been devoted to researching strengths and competencies than to vulnerabilities and risks in LGBT populations. While attention to the difficulties LGBT people face is central to any attempt to better their lives, this focus is claimed to have resulted in 'considerable misinformation and a distorted picture of sexual minorities lives' (Savin-Williams, 2001a: 5). While this study's findings certainly point to numerous features of LGBT experience that can potentially pose a risk to mental health and well-being they also demonstrate that the vast majority of participants never self-harmed or attempted suicide and that a large number reported positive everyday experiences. It is important to reiterate in this context that a preoccupation with risks – frequently (mis)interpreted as individual deficits – belies the reality of LGBT lives and potentially contributes to a construction of LGBT people as deficient and dysfunctional.

Apart from challenging many common assumptions and misrepresentations of LGBT people's lives, the study's exploration of resilience provides important insight into experiences, people, places and

relationships that act as enablers, thereby protecting LGBT people against stressors. Four key sources of social support – friends, family, the LGBT community, and specific environments such as school and the workplace – were found to foster resilience and enable LGBT people to cope positively with stress. The identification of these sources of support has important implications for practice since they highlight potential for positive action in strengthening resilience in LGBT people. For example, if parents of LGBT youth have access to information, education, support, and advice, they will be better positioned to support their children.

There was also strong evidence that strengths can be fostered or developed over time, taking us beyond the common view of resilience as static. Respondents described a process of *becoming* resilient, a path that can be broadly characterised as an emerging capacity to move on in a positive way from negative, traumatic or stressful experiences. Indeed for some, negative experiences appeared to act as a catalyst for change, propelling people to resist and transform negative perceptions of self. Taking strength from resisting prejudice or discrimination was therefore an important dimension of the process of 're-framing', i.e., the development of a belief system that affirms gay and lesbian people (Oswald, 2002). In this sense, there was evidence that LGBT people actively participate in the development and strengthening of their own resilience to reduce their vulnerability to adversity and stress. For example, several respondents reported ways in which they gained deepened insight into their lives over time. They conveyed how this enabled them to positively appraise their situations and experiences, making them more comprehensible, manageable and meaningful. These findings largely confirm that resilience is 'a dynamic process encompassing positive adaptation within the context of considerable adversity' (Coleman & Ganong, 2002:1). They are also broadly consistent with an emerging international literature which has begun to examine ways in which LGBT people rebound from adversity (Connolly, 2005), develop strengths and competencies (Anderson, 1998; Riggle et al., 2008), and source support and resilience during times of particular stress (Russell & Richards, 2003).

LGBT SERVICE ACCESS AND UTILISATION

In keeping with the international literature, the findings of the study demonstrate diverse experiences as well as specific barriers to healthcare access, including presumed heterosexuality, homophobia and lack of cultural competence on the part of healthcare providers (Clover, 2006; Diamant et al., 2000; Jillson, 2002). The study also reveals marked variation in people's ability to access services which is consistent with previous research in the Irish context (Gibbons et al., 2007; Dillon & Collins, 2004). Lack of appropriate services is a particular issue for LGBT people living in rural areas. Structural barriers to service access included distance, financial considerations and the absence of services. Alongside these structural barriers, the findings highlight the alienation and discrimination that LGBT people may face when they attempt to access services that might otherwise impact positively on their physical and/or mental health. In addition to difficulties in accessing health care, lesbian, gay, bisexual, and transgender individuals faced significant obstacles in communication with healthcare providers. First, and most challenging, were the negative attitudes towards LGBT people held by many providers, with a quarter of online participants admitting to hiding the fact that they were LGBT because of how the service provider might respond. While two thirds of respondents with prior experience of healthcare professionals felt that the health advice they received was generally useful, over three quarters were of the opinion that healthcare providers needed to have more knowledge of, and sensitivity to, LGBT issues. Furthermore, the interview data demonstrate that many healthcare providers – from GPs to psychiatrists to counsellors – were perceived not to have adequate understanding of LGBT sexuality and several respondents commented on their lack of awareness of the healthcare needs of LGBT people. People's fears about confidentiality, non-acceptance and rejection also emerged strongly in these narratives. Young LGBT people were particularly reluctant to contact a health care professional and to disclose their sexual orientation when they attended a GP or other healthcare provider. However, the reports of those who attended LGBT-specific youth services were more positive and demonstrate the importance of 'safe' spaces and environments for LGBT people. These services clearly play an important role in counteracting experiences of homophobia and promoting positive mental health.

The prejudicial attitudes and practices that many LGBT people encountered within healthcare settings strongly suggests a lack of understanding of the context in which LGBT health is shaped. Health

professionals need to develop relevant cultural competence, highlighting the need to train providers and agencies in this area.

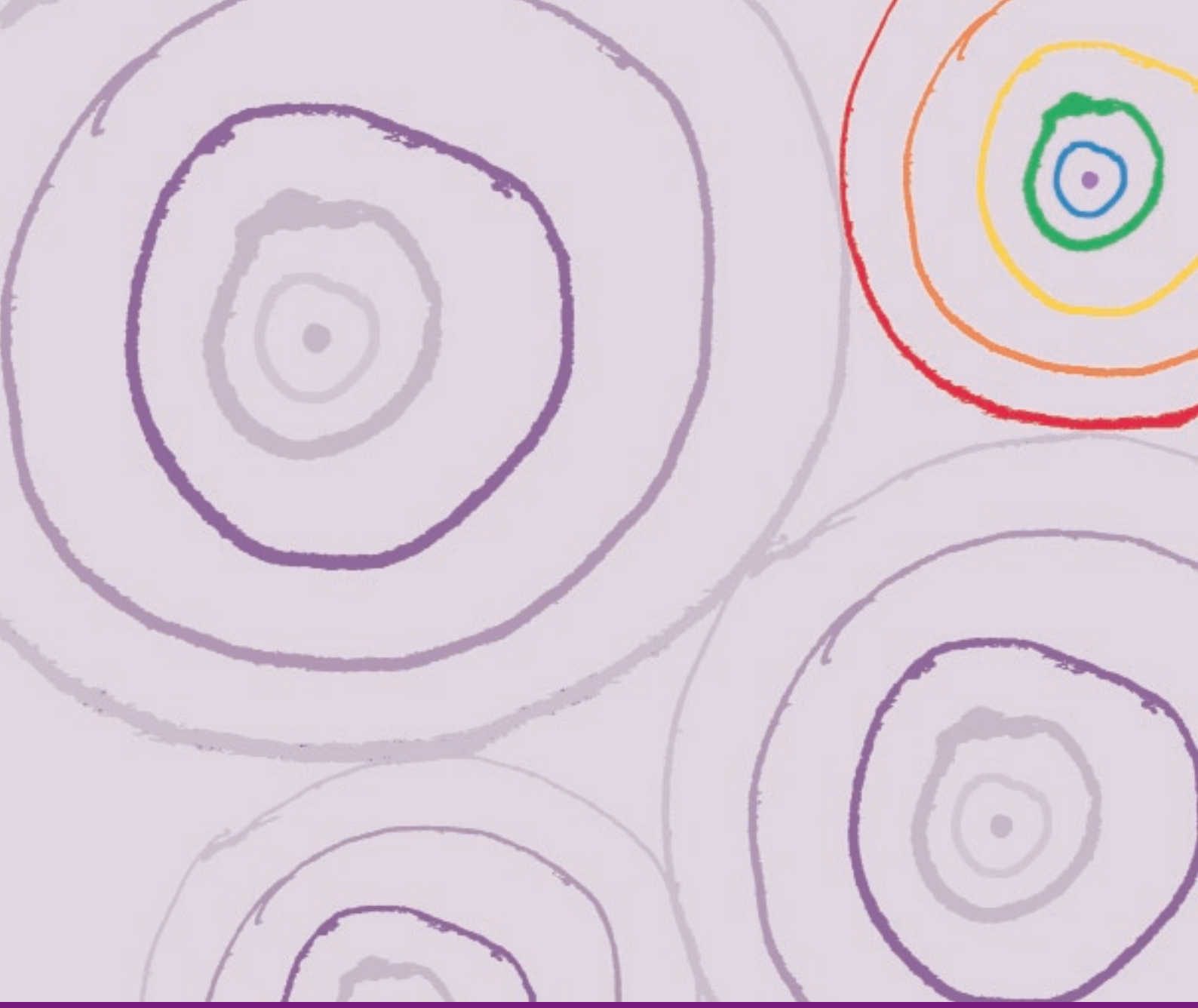
MINORITY STRESS

The minority stress model, which is a conceptual framework for understanding the negative impact on health and well-being caused by a stigmatising social context (Brooks, 1981; Meyer, 1995, 2003), has provided a useful lens through which to better understand LGBT people's lives. The findings indicate that the stress experienced by LGBT people was strongly associated with external stressors such as presumed heterosexuality, homophobia, prejudice and victimisation. Internal stressors related to self-disclosure, the anxiety of 'coming out' and negative 'coming out' reactions from others also featured strongly in the narratives, as did internalised homophobia and the stress of self-concealment in a range of contexts and settings. Some of the common manifestations of minority stress included anxiety, sadness, depression and distress. For a smaller but nonetheless significant number, these emotional states found expression in self-harm and/or suicidal thoughts or behaviour. Many who had contemplated, planned, and/or attempted suicide related their suicidality directly (although typically not exclusively) to their LGBT identification.

LGBT youth were particularly vulnerable to distressing experiences and emotions, with stress particularly evident in their narratives of 'coming out'. Most feared rejection by family and friends and many also feared for their safety in a range of contexts. They had few individuals in whom to confide and limited opportunities to discuss their feelings with people who had similar experiences. While heterosexual teenagers have opportunities to explore their romantic attractions in the process of becoming social and sexual beings, lesbian, gay, bisexual and transgender youth learn to hide (Savin-Williams, 1995). Self-acceptance is difficult for young people whose sexual orientation or gender identity is stigmatised. It is therefore imperative that communities address their needs, as well as the causes and consequences of their continued stigmatisation. These needs are particularly apparent to service providers who see today's LGBT youth coming out earlier than in previous generations.

The findings related to the school-based experiences of LGBT people closely parallel assertions made elsewhere that school life is often marred by routine harassment and victimisation for some LGBT youth. In addition to more overt manifestations and expressions of LGBT-related harassment, such as homophobic bullying and taunting, we also presented evidence of more subtle aspects of victimisation, discrimination, and social exclusion on the part of schools themselves, such as exclusion from participating in the mainstream of school life ('Debs' dance, school events), as well as a failure to address LGBT issues in the curriculum. Collectively, the findings underscore the need for school personnel to advocate on behalf of LGBT youth in contexts characterised by homophobic bullying and taunting by peers, and in school climates which otherwise invalidate or seek to render LGBT lives invisible.

This study's findings largely confirm that LGBT people face unique challenges and stressors that are in large part derived from being a member of a minority group that is stigmatised and marginalised (Brooks, 1981). According to Meyer (2003: 692), 'policy makers should use the stress model to attend to the full spectrum of interventions it suggests'. The following and final chapter outlines the recommendations arising from the study findings.



CHAPTER 9 RECOMMENDATIONS

RECOMMENDATIONS

This chapter offers a series of recommendations about how to respond to some of the key issues raised in the research as they relate to the social and mental health experiences of LGBT people in an Irish context. Clearly, challenging homophobia and transphobia are complex and multi-dimensional processes requiring us to think differently about gender and sexual orientation and how social institutions are structured. There are few, if any, quick-fix solutions that can address the marginalisation and homophobia facing many LGBT people in Irish society today (Macintosh, 2007). As acknowledged in *Reach Out, National Strategy for Action on Suicide Prevention, 2005-2014*, 'there is no single intervention or approach that will, in itself, adequately challenge the problem of suicide in Ireland' (Health Service Executive, 2005: 4). In keeping with this strategic stance, we believe that there is no one approach that can comprehensively address the problem of suicide, or other mental health risks, among the LGBT population. Ensuring the mental health and well-being of LGBT people must be a collective and cross-sectoral effort, with shared responsibilities across relevant government departments and policy sectors.

The findings of this research highlight the significant role played by social and structural factors in determining the mental health of LGBT people. The recommendations are therefore directed primarily at achieving social and institutional change as a means of tackling LGBT minority stress. They are targeted, in some cases, at particular government departments, while others relate to the provision or development of LGBT services and are directed at the Health Service Executive (HSE), National Office of Suicide Prevention (NOSP), community and voluntary organisations, or health professionals. A number of the listed recommendations are relevant to more than one stakeholder. While recognising the need for transformation of those political, economic, and cultural structures and ideologies that underlie LGBT minority stress, we also identify a number of areas or spaces that offer scope for positive intervention or change, at the personal and interpersonal levels. Some of the recommendations, therefore, are developed in recognition of the role that individuals, as well as institutions, can take in affirming minority sexual orientation and gender identities and in promoting more positive mental health outcomes for LGBT people.

LGBT HEALTH AND MENTAL HEALTH

The study's findings have drawn attention to the heteronormative assumptions that can underpin health service provision. They also demonstrate ways in which social policy in general, and health policy in particular, can act to support the marginalisation of LGBT people and/or reinforce their feelings of isolation and powerlessness. This may have deleterious consequences for those who need health-related help or advice and may also discourage LGBT people from seeking the help and support they need at different junctures.

HEALTH/MENTAL HEALTH POLICY

- LGBT mental health related policies and programmes should avoid representing LGBT people, as a whole, as being at risk for poor mental health or suicidality. At the same time, they should recognise that a significant proportion of the LGBT population, particularly young LGBT people, are vulnerable to psychological distress, suicidal behaviour and self-harm related to their experience of minority stress.

- The Department of Health and Children should ensure that the needs of LGBT people are integrated into all health policies, particularly those pertaining to:

  - Mental health
  - Men's health
  - Women's health
  - Older people's health
  - Suicide and self-harm
  - Alcohol and drug (mis)use

- Health promotion
- Sexual health

- The HSE should ensure that health and mental health services are provided in a way that is accessible and appropriate to LGBT people.

- Agencies and Departments with responsibility for suicide prevention and mental health promotion should identify and recommend good practice in caring for members of the LGBT population who might be at risk of suicidal behaviour. In particular, the National Office for Suicide Prevention (NOSP) should ensure that its mental health and Suicide Prevention Strategies are inclusive of—and where appropriate, specific to—LGBT people at risk for suicidality and self-harm.

- The Mental Health Commission should ensure that mental health service standards include care policies for LGBT people.

- The voluntary mental health sector, in collaboration with LGBT organisations, should ensure that its service provision is inclusive of LGBT people.

- Specific attention should be paid to the needs of transgender people within health policy. The Department of Health and Children should develop a national policy on access to healthcare and standards of care for transgender people. The mental health and emotional needs of transgender people should be recognised within health and mental health policy.

Health Professionals

- The HSE should specifically target health professionals (e.g. GPs, A&E doctors and nurses, and hospital liaison psychiatrists) to increase their understanding of LGBT identity as a potential risk factor for self-harm, suicidal behaviour and depression.

- Cultural competency training specific to LGBT populations should be a standard component of all health professional training curricula and be made available to the healthcare workforce through continuing education institutes/initiatives or other appropriate mechanisms. This training should pay particular attention to:

  - The specific health needs of LGBT people.
  - The assumption that all clients are heterosexual (heteronormativity).
  - Responding to individuals who disclose LGBT identity.
  - The 'coming out' process and its potential impact on health and well-being.
  - The impact of stigma and discrimination on the lives and mental health and well-being of LGBT people.
  - Concerns that LGBT people may have in relation to confidentiality.
  - Guidelines for LGBT-inclusive practice.

- Professional bodies and training institutions should provide appropriate training on the standards of care required, and on issues concerning access to health services for transgender people.

Programme/Service development and delivery

- Relevant partners, including the HSE and NOSP, should further resource LGBT-specific groups and organisations nationally to engage in mental health promotion and suicide prevention work.

- The HSE should support front-line responses, in particular the voluntary LGBT helplines throughout the country, to be fully resourced to carry out mental health promotion and suicide prevention work.

- LGBT-specific services, particularly those targeting young LGBT people need to be resourced to provide programmes aimed at transforming internalised homophobia and building individual strengths.

- The HSE should resource LGBT-specific services to develop programmes that are appropriate to the needs of older LGBT people.

- The HSE should resource LGBT-specific services to develop programmes that are appropriate to the needs of LGBT people living in rural areas.

LGBT YOUNG PEOPLE

LGBT young people and education

Schools are one of the key arenas within which heterosexual identities are constructed as 'normal', while LGBT identities are constructed as 'outside acceptability' (Youdell, 2005: 251). Heteronormative and transphobic school cultures can adversely affect school attendance and achievement outcomes, as well as the construction of self and identity, self-expression, self-worth and self-esteem, and one's sense of belonging. Schools and teacher education programmes are therefore crucial sites where LGBT issues and concerns need to be addressed. Yet, with the great majority of Irish schools under the direction or control of religious institutions which do not accept homosexuality, countering heterosexism, homophobia and transphobia are all the more challenging. Moreover, existing research on the teaching of RSE suggests that the current curriculum affords limited scope to engage with issues of homophobia and heteronormativity.

Recent scholarship cautions against many popular educational interventions aimed at LGBT youth and issues, including 'add-and-stir' curricular interventions which offer limited scope to engage with issues of homophobia and heteronormativity on the grounds that they constitute a 'band-aid' approach to the issue of LGBT marginalisation (Macintosh, 2007). Other concerns relate to the adoption of anti-homophobic models which seek to enhance the visibility and inclusion of LGBT people in schools and anti-bullying policies which do not, in and of themselves, address the embeddedness of heteronormativity within schools or provide a framework for structural change (ibid).

- Teacher education programmes should offer courses that will assist both early and in-career educators in taking action to challenge heterosexism, homophobia and transphobia in their schools and classrooms. Such interventions should not comprise 'one-off' anti-homophobia lectures and workshops addressing LGBT issues, which are likely to further marginalise LGBT youth, but rather should be infused throughout teacher education programmes (Macintosh, 2007).

- While educators need to be aware of the stressors that affect LGBT young peoples' day-to-day lives, educational interventions should not be premised on the idea that all LGBT young people are victims or that they are inevitably 'at risk' of developing mental health difficulties. Rather, educators must attend carefully to the diverse experiences and concerns of LGBT young people, particularly as they relate to areas that may affect their schooling and well-being both inside and outside the classroom.

- The formal school curriculum, and Social Personal and Health Education (SPHE) and Relationships and Sexuality Education (RSE) in particular, should provide far greater scope for the exploration of minority sexuality and gender identity. LGBT identities should be equally validated through the informal curriculum such as school social events.

- Training packs should be made available to schools by the Department of Education and Science (DES), complete with topics and issues relevant or specific to the experiences and concerns of LGBT students. These packs should include resources to help early and in-career teachers to recognise the presence of heteronormativity in their curricula and classrooms.

- The Department of Education and Science and individual schools should take action on their obligation to ensure the safety of school environments for all students by ensuring that school bullying policies incorporate directives and guidelines that specifically recognise and address the problem of homophobic bullying in schools.
- The DES should provide a dedicated support service to schools and the education partners (e.g. Institute of Guidance Counsellors) on issues related to sexual orientation and gender identity.

- There should be increased recognition within policies and programmes designed to tackle early school leaving that a significant minority of LGBT youth are at risk of dropping out of school early.

LGBT young people in the community

- The youth sector needs to devise clear mechanisms to promote greater awareness of the needs and rights of LGBT young people. This may include developing an LGBT Strategy for the sector, developing comprehensive training packages, holding a national conference on LGBT young people, and ensuring that all policy developed in the sector is inclusive of the needs of LGBT young people.

- The Quality Standards Framework currently being developed for the youth sector should be fully inclusive of LGBT young people.

- The National Youth Work Development Plan should give full recognition to, and be fully inclusive of, LGBT young people.

- All youth work training should offer comprehensive courses that raise awareness of the needs of LGBT youth and also help them to appropriately address and challenge heterosexism, homophobia and transphobia in the context of their work with young people.

- LGBT-specific youth services require further development nationally. Such designated spaces play an important role in helping LGBT young people to access knowledge and social support, make connections and develop confidence and self-esteem. They also provide an appropriate setting in which to address mental health issues with young people.

Parents of LGBT young people

- LGBT youth organisations should be resourced to work with the parents of LGBT young people to provide guidance to them on how best to support their children.

- The Department of Health and Children should develop a booklet and resource pack and make it accessible to the parents of LGBT teenagers.

- The Department of Health and Children and the Health Service Executive should develop a resource and information pack for transgender people and their families.

LGBT PEOPLE IN THE WORKPLACE

Indirect discrimination and heteronormativity, which are commonplace in the workplace, limit the ability of LGBT people to discuss or construct their own identities at work. Despite recent advances in equality legislation protecting against discrimination on nine grounds, including sexual orientation and gender, Section 37 of the Employment Equality Act, which permits certain medical, educational and religious organisations to discriminate in order to protect their religious ethos, can have a range of effects for LGBT people. At best, Section 37 renders LGBT people invisible in certain workplace settings or at least makes it difficult for them to be open about their sexuality (Walsh, Conlon, Fitzpatrick & Hansson, 2007).

The Department of Enterprise, Trade and Employment should develop initiatives to support employers in making workplaces, and workplace cultures, more supportive and inclusive of LGBT people. Such initiatives should include the development and/or effective implementation of relevant policies that extend relevant employee benefits and entitlements to same-sex couples and which counteract homophobia and transphopbia in the workplace.

- Existing employment equality legislation exemptions permitting certain religious, educational and medical institutions to take action deemed reasonably necessary to prevent an employee, or a prospective employee, from undermining the religious ethos of the institution should be eradicated. This has particular relevance to LGBT personnel working in, or seeking employment in, schools as it means that many who might otherwise serve as role models for LGBT youth may feel obliged to hide their sexual orientation or gender identity in these settings.

FUTURE RESEARCH

This study has gone some way towards exploring the experiences and issues that impact on the mental health and well-being of LGBT people of all ages in an Irish context. Nonetheless, the study has limitations (see Chapters 5 and 8) and, in any case, cannot hope to address the range of complex dimensions of LGBT lives in Ireland. Serious gaps in knowledge remain and further research is clearly required if we are to fully appreciate and understand the lives and experiences of LGBT people.

A notable feature of Irish social research is its lack of recognition of LGBT people, as evidenced in the absence of questions pertaining to sexual orientation and/or gender identity within most quantitative and qualitative research studies. According to Reynolds (2001), this 'silence on sexuality allows a perpetuation of the idea that sexual diversity, and prejudice and discrimination on the basis of sexuality, is a private trouble with no public issues or consequences'.

- All national administrative databases in Ireland should include items which capture sexual orientation, gender identity and same-sex partnership/cohabitation.
- General population surveys should include questions on sexual orientation, gender identity and same-sex co-habitation.
- Longitudinal and other large-scale survey research on children, young people and families should include questions on sexual orientation, gender identity and same-sex cohabitation.

Particular LGBT-specific topics where research (including qualitative, quantitative and mixed-methods research) is urgently required include:

- LGBT youth development and identity, with particular attention to the 'coming out' process.
- LGBT youth and schooling.
- Transgender people.
- Older LGBT people.
- LGBT families, partnerships and parenting.

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APPENDICES

APPENDIX 1

GLOSSARY OF TERMS

Bisexual: term used to describe anyone sexually and romantically attracted to both males and females.

Female-to-Male Transgender: transgender persons who were assigned female at birth but consider themselves to be male (see definition of Transgender below).

Gay: a man whose primary sexual and romantic attraction is to other men. The term is more commonly applied to men who self-identify as same sex attracted, rather than men who have sex with men but do not self-identify as gay. While many women identify as gay, the term lesbian is commonly used to describe same-sex attracted women.

Gender identity: a person's internal sense of whether one is male or female.

Gender Identity Disorder: the formal diagnosis used by psychiatrists and physicians to describe persons who experience discontent with the biological sex they were born with. It is a diagnostic classification in the *Diagnostic and Statistical Manual of Mental Disorders (4th Ed.) (DSM-IV)* (American Psychiatric Association, 1994).

Heteronormativity: the assumption that heterosexuality and heterosexual norms are universal, or at least the only acceptable, conditions. Closely related to heterosexism (see below), heteronormativity negatively affects LGBT people in a variety of ways, from actively oppressing those who do not fulfil heterosexual expectations to rendering them invisible.

Heterosexism: is the presumption that heterosexuality is the norm or standard, or is considered the 'natural' or superior sexual preference.

Heterosexual: a person whose primary sexual and romantic attraction is to people of the opposite sex.

Homonegativity: a term used to describe a negative attitude towards LGBT identification or LGBT people.

Homophobia: describes a fear, dislike or hatred of same-sex relationships, of gays and lesbians, and/or of one's own feelings for individuals of the same gender.

Internalised Homophobia: For many people, regardless of sexual orientation, homophobia can be internal and not always recognised by the individual. However, internalised homophobia can and does cause many negative effects for lesbian, gay and bisexual people. It can affect the way people see themselves and the way others (heterosexual society) treat them. Internalised homophobia often leads to denial of one's true sexuality in situations that are threatening or require the individual to "come out".

Lesbian: a woman whose primary sexual and romantic attraction is to other women. This term often refers to women who are same sex attracted rather than women who have sex with other women but do not self-identify as lesbian.

LGB: acronym for lesbian, gay and bisexual. Sometimes written as GLB

LGBT: acronym for lesbian, gay, bisexual and transgender.

LGBT-sensitive: is used to describe programmes, services, and individuals that have made a commitment to serving the needs of LGBT people and communities. That commitment is rooted in knowledge and awareness of the needs of this population.

LGBT-specific is used to describe supports, programmes or activities geared primarily or exclusively to LGBT people.

Male-to-Female Transgender: transgender persons who were assigned male at birth but consider themselves female.

Minority Stress: Minority stress can be understood as a psychosocial stress derived from minority status. When applied to lesbians, gay men, bisexual and transgender people, a minority stress model proposes that prejudice based on sexual orientation is stressful and may lead to adverse mental health outcomes.

'Out', 'Coming out' is the more or less public act of declaring oneself lesbian, gay, bisexual or transgender. It is important to remember that a person may be out in selected circumstances, such as to friends, but not to family, co-workers or neighbours. In this report 'coming out' is also used to describe the process through which transgender people come to recognise and publicly acknowledge their gender identity. As the coming out process is never over for LGBT people, this is an ongoing, sometimes daily, decision and can cause the person significant stress.

Self-Harm: deliberate injury inflicted by a person on his/her own body without suicidal intent. The term includes a wide range of behaviours ranging from highly lethal to less lethal to superficial self-injury.

Sexual Identity: A person's sense of identity defined in relation to the categories of sexual orientation (see below), usually only using the four main terms, lesbian, gay bisexual and heterosexual. Someone's sexual identity may not necessarily match their sexual behaviour.

Sexual Minority: a group whose sexual identity, orientation or practices differ from a majority in society. The term is used throughout this report to refer to lesbian, gay, bisexual and transgender people.

Sexual Orientation: an umbrella term which describes the whole spectrum of sexual and emotional attraction, including the four most commonly used terms, lesbian, gay, bisexual and heterosexual.

Suicidality: the term covers a wide spectrum of behaviours, including completed suicide, suicide attempts, and suicidal ideation. Completed suicide refers to death from injury, poisoning or suffocation where there is evidence to suggest the injury was self-inflicted and that the deceased person intended to kill him/herself. A suicide attempt is a potentially self-injurious behaviour with a non-fatal outcome for which there is some evidence that the person intended to kill him/herself. Suicidal ideation refers to thinking about suicide, which can be of varying degrees of intensity and severity.

Transgender: an umbrella term to refer to people whose gender identity and/or gender expression differ(s) from the sex assigned to them at birth.

Transphobia: a fear, dislike or hatred of people who are transgender, transsexual or challenge conventional gender categories of male/female.