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# Norms and normalisation: understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking

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## ABSTRACT

Young people who identify as lesbian, gay, bisexual, transgender and queer have elevated rates of suicidality. Despite the increased risk, there is a paucity of research on lesbian, gay, bisexual, transgender and queer help-seeking and suicidality. We report on a UK sequential exploratory, two-stage, mixed-method study. Stage 1 involved 29 online and face-to-face semi-structured interviews with lesbian, gay, bisexual, transgender and queer youth aged 16–25 years old. Stage 2 utilised an online youth questionnaire employing a community-based sampling strategy ( $n = 789$ ). Results indicated that participants only asked for help when they reached a crisis point because they were normalising their emotional distress. Those who self-harmed, had attempted or planned suicide or had experience of abuse related to their sexuality or gender were most likely to seek help. Results suggested that the reluctance to seek help was due to three interconnecting factors: negotiating sexuality, gender, mental health and age norms; being unable to talk about emotions; and coping and self-reliance. Policies aiming to prevent lesbian, gay, bisexual, transgender and queer youth suicide recognise that norms and normalising processes connected to sexual orientation and gender identity are additional difficulties that youth have accessing mental health support.

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Youth; sexuality; gender; suicide; help-seeking

## Introduction

Globally, suicide is the second leading cause of death among 15–29-year-olds (WHO 2014). Young people who identify as lesbian, gay, bisexual, transgender and queer have elevated rates of suicide attempts and self-harm. The risk of suicide is estimated to be between four and seven times that of their heterosexual peers (Haas et al. 2010) and appears to be higher in trans youth compared to young people who identify with their sex assigned at birth (male/female) (McDermott, Hughes, and Rawlings *forthcoming*). There has been less research in the UK but large scale population studies indicate that lesbian, gay, bisexual, transgender

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and queer youth are more likely to report suicidality and poor mental health compared to heterosexual young people (Chakraborty et al. 2011; Semlyen et al. 2016).

Many countries worldwide have introduced legislation that protects and promotes the rights of lesbian, gay, bisexual, transgender and queer people, but social hostility and stigma remain most strongly associated with the risk of suicide and self-harm in this group (King et al. 2008). Survey evidence from various countries (e.g. the USA, New Zealand, Canada, the UK, Belgium, Norway) has consistently highlighted that the key factors behind lesbian, gay, bisexual, transgender and queer youth suicide and self-harm are homophobic and transphobic abuse, social isolation, early identification of sexual or gender diversity, conflict with family or peers about sexual or gender identity, inability to disclose sexual or gender identity and common mental health problems (Haas et al. 2010).

Despite the well documented risks, there are only a small number of research studies specifically investigating the help-seeking behaviour of lesbian, gay, bisexual, transgender and queer youth with suicidal feelings and self-harm (McDermott and Roen 2016; McDermott 2015). The findings reported in this paper are part of a larger national study but we focus here on addressing the research question: 'In what circumstances do lesbian, gay, bisexual, transgender and queer young people seek help for suicidal feelings and self-harm?' We employed a sequential exploratory mixed-methodology (Creswell et al. 2008) and prioritised lesbian, gay, bisexual, transgender and queer youth perspectives and experiences. In the following section, we outline the background to the study, we then describe the study's methodology. The subsequent sections report firstly on the qualitative findings and then the questionnaire results. We finish with a summative analysis and discussion.

## Background

International research demonstrates that young people are reluctant to seek help for their mental health problems (Gulliver, Griffiths, and Christensen 2010; Michelmores and Hindley 2012; Rowe et al. 2014). Furthermore, young people with more acute mental health symptoms, such as self-harming and suicidal ideation, are less likely to seek help compared to those with mild to moderate symptoms of depression and anxiety (Evans, Hawton, and Rodham 2005; Labouliere, Kleinman, and Gould 2015; Michelmores and Hindley 2012). Research has tended to focus on barriers to help-seeking in young people with mental health problems, rather than examining the factors that facilitate help-seeking. In these studies the most prominent barriers to seeking help are: mental health stigma (Gulliver, Griffiths, and Christensen 2010; Rowe et al. 2014); the fear of negative consequences such as being seen at attention-seeking (Fortune, Sinclair, and Hawton 2008; Rowe et al. 2014); poor mental health literacy (Gulliver, Griffiths, and Christensen 2010); emotional competence, that is, difficulties expressing emotions and communicating (Fortune, Sinclair, and Hawton 2008); and self-reliance and viewing help-seeking as a sign of failure (Curtis 2010; Gulliver, Griffiths, and Christensen 2010; Michelmores and Hindley 2012; Rowe et al. 2014). In terms of demographic factors, those who are older are more likely to seek help (Michelmores and Hindley 2012) and young women are more likely to seek help than young men (Hawton, Rodham, and Evans 2006). Sexual orientation and gender diversity have been marginalised as a focus of enquiry within these mainstream help-seeking studies, despite the elevated rates of suicide and self-harm in lesbian, gay, bisexual, transgender and queer youth.

### ***Limits to the ‘barriers’ model of help-seeking***

Critics have argued that the dominant ‘barriers and facilitators’ model of help-seeking operationalised in research is static and have ‘limited explanatory potential as complex beliefs and actions become reduced to descriptive categories’ (Biddle et al. 2007, 985). These approaches do not acknowledge the importance of human agency, meaning making and interaction to understanding the reluctance of young people to ask for help. As a result, the ways that young people may understand and define mental health and the social meanings attached to help-seeking are usually absent within studies (Biddle et al. 2007; Fullagar 2005; McDermott and Roen 2016).

In our view, a further critique of the barriers/facilitators model that frames understandings of help-seeking in young people with mental distress is that the question of why these factors hinder or enable help-seeking is rarely addressed. We might ask why young people fear being seen as ‘attention-seeking’; why their mental health is stigmatised; why young people have difficulty articulating their emotions; or why they believe they must be self-reliant, cope alone and that it is weak to ask for help. By asking these deeper questions, we have a greater chance of generating evidence that can guide effective intervention and support. Our approach draws from Biddle et al.’s (2007) work that conceptualises help-seeking in relation to normalising and coping. Their ‘cycle of avoidance’ model ‘conceptualises help-seeking as a circular process and offers a model of “non-help-seeking” in which lay conceptions of mental distress, the social meanings attached to “help-seeking” and treatment, and the purposeful action of individuals, assume central importance’ (983). They suggest that young people normalise their emotional distress and cope as much as possible. The threshold to help-seeking is the point at which young people feel they can no longer help themselves. They indicate that it is not the inability to recognise mental distress that hinders help-seeking, but the deeper problem of ‘classifying’ the distress as abnormal and requiring help.

Some qualitative research indicates that lesbian, gay, bisexual, transgender and queer youth may process their suicidal distress and self-harming in a similar way. The evidence demonstrates that they may be reluctant to seek help due to shame and stigma, and instead attempt to deal with emotional distress through minimising its importance and trying to cope alone (McDermott 2015; McDermott and Roen 2016; McDermott, Roen, and Scourfield 2008). Our approach to exploring help-seeking among lesbian, gay, bisexual, transgender and queer youth puts the question of ‘What is normal?’ as central to understanding the ways in which young people who are already marginalised by their sexual and/or gender identity seek support for their self-harm and suicidal distress. Our research specifically pays attention to how heteronormativity and homophobia, biphobia and transphobia influence lesbian, gay, bisexual, transgender and queer youths’ help-seeking. Heteronormativity refers to the privileging and presumption that heterosexuality and the gender-binary (male/female) are the only natural and normal sexualities and genders (Clarke et al. 2010). Homophobia, biphobia and transphobia refer to the negative expression, verbal or physical, against those who are non-heterosexual and those who do not fit in the gender-binary of male/female (Agius and Tobler 2012). The theoretical perspective employed in this research proposes that lesbian, gay, bisexual, transgender and queer young people are negotiating norms and normalising processes in relation to age and development, sexuality, gender and their mental health, and these significantly influence the ways in which lesbian, gay, bisexual, transgender and queer youth who feel suicidal or self-harm ask for help (McDermott 2015; McDermott and Roen 2016).

## Methods

### *Research design*

This research drew on previous studies that had successfully used online methods to investigate lesbian, gay, bisexual, transgender and queer youth, self-harm and suicide (McDermott and Roen 2012; McDermott, Roen, and Piela 2013). The study was conducted between 2014 and 2016 and utilised a sequential exploratory mixed-methods research design (Alexander et al. 2008) with a qualitative first stage (online and face-to-face semi-structured interviews) and a second quantitative stage (online questionnaire). Mixed-methods studies allow for a more comprehensive investigation of a complex subject where there is limited existing research (Franz, Worrell, and Vögele 2013).

We employed a qualitatively-driven mixed methodology with a constructivist epistemology that emphasised the lived experiences of young people with the aim of uncovering subjugated knowledges (Hesse-Biber 2010; Mason 2006). In a sequential exploratory mixed-methods research design, an explicit theoretical perspective frames both stages of the study, and quantitative data and results are used to assist in the interpretation of the Stage one qualitative findings (Creswell et al. 2008). In this way, quantitative methods are used to enhance the generalisability of the qualitative component by way of 'analytical generalisation' where the researcher aims to generalise a specific set of results to wider theory (Yin 2009).

### *Sampling and recruitment strategy*

Studies indicate the most effective way of recruiting lesbian, gay, bisexual, transgender and queer population samples of a sufficient size is through nonprobability sampling strategies (Corliss, Cochran, and Mays 2009). The rationale for utilising online and community-based sampling strategies rather than an exclusive clinical sample in this study was because much self-harming and suicide ideation is hidden and does not result in clinical intervention in young people (Hawton, Rodham, and Evans 2006). In other words, clinical samples exclude a significant proportion of young people who self-harm and/or have suicidal feelings. Also, online sampling strategies have been successfully used to recruit lesbian, gay, bisexual, transgender and queer participants to studies examining suicide who may not otherwise participate in research (McDermott and Roen 2016).

Eligibility criteria for both stages of the research were that participants must live in England, identify as lesbian, gay, bisexual, transgender and queer, be aged 25 years and under and have experience of suicidal feelings and/or self-harm. For Stage 1 semi-structured interviews, we used a purposeful sampling strategy. We recruited participants using three approaches: (1) visits to lesbian, gay, bisexual, transgender and queer youth groups in the North East, South East and North West of England; (2) online and social media advertising; and (3) advertising through mental health services in two National Health Service (NHS) trusts. Online interview participants were exclusively recruited through the study website ([www.queerfutures.co.uk](http://www.queerfutures.co.uk)). Visitors to the website could access project information sheets, consent forms and support agency information. All potential interview participants voluntarily contacted the research team by email, telephone or face-to-face to discuss the study and complete the informed consent procedure. Stage 2 online questionnaire participants were recruited online via lesbian, gay, bisexual, transgender and queer organisations and

social media (e.g. twitter, Facebook, Tumblr). Questionnaire respondents were self-selected and were able to follow the web link to complete the questionnaire. The informed consent process was completed prior to entering the questionnaire.

The study was reviewed and authorised by the North-West NHS Research Ethics Committee. All participants had access to mental health and lesbian, gay, bisexual, transgender and queer-specific support. A procedure for reporting risk and adverse events was in place. The main researcher received training and a lead clinician (research team member) was on call for all scheduled interviews. No adverse incidents occurred during the research and many participants thanked the researchers for listening and taking an interest in their life difficulties. All data were anonymised (interview participants given pseudonyms) and stored electronically on a password protected secure drive on the Lancaster University server.

## **Data collection**

### ***Stage 1 semi-structured interviews***

The interviews were conducted by two members of the research team (EM, VR). Face-to-face interviews were held in private rooms on lesbian, gay, bisexual, transgender and queer youth group premises and online interviews were conducted via a university computer in a private office. The asynchronous online and face-to-face interviews used the same semi-structured interview schedule that was piloted online and face-to-face. The interview questions were open-ended to elicit the experiences of participants (Creswell 2009). The interview schedule contained seven sections: gender identity and sexual orientation; sources of emotional distress; self-harm and suicidal feelings; coping with emotional distress; help-seeking behaviour; experiences of mental health services; and demographic questions.

### ***Stage 2 questionnaire measurement***

The online questionnaire (using the Qualtrics platform) contained seven question sections: demography; gender identity and sexual orientation; self-harm and suicidal feelings; sources of emotional distress; disclosure of sexual orientation and gender identity; attitudes towards help-seeking; and help-seeking behaviour and experience of services. The questionnaire was designed to be completed within 15 minutes, contained 17 questions and was compatible with smart-phones and other hand-held devices. It was piloted with the project's lesbian, gay, bisexual, transgender and queer Youth Advisory Group using cognitive interviewing techniques (Addington-Hall 2007).

Measures of suicidality and self-harm used previously validated survey questions (Hawton, Rodham, and Evans 2006). Suicidality was measured using the Suicide Behaviors Questionnaire-Revised (Osman et al. 2001). Participants were asked 'Have you ever thought about or attempted to kill yourself?' and then provided with five options; 'No, never', 'Yes, it was a brief passing thought', 'I have wanted to stop existing, but did not want to kill myself', 'I have made a plan to kill myself at least once' and 'I have attempted to kill myself'. Self-harm was measured by asking participants whether they had ever tried to harm themselves in some way (yes/no). Self-harm was defined using the following phrase: 'This may include any behaviour that you purposely use to cause yourself physical or emotional discomfort, for example: using drugs, cutting, risky sexual practices, starving yourself or other behaviours'.

The UK Office for National Statistics (ONS) recommends asking a sexual identity question with five possible responses – ‘heterosexual or straight’, ‘gay or lesbian’, ‘bisexual’, ‘other’ and ‘prefer not to say’ (Haseldon and Joloza 2009). More recent literature recommends additional categories because the five-category measure does not adequately capture young people’s sexual identity diversity (McDermott 2010). An ONS sexual identity measure was adapted and included eight closed-option responses – ‘lesbian’, ‘gay’, ‘bisexual’, ‘heterosexual’, ‘queer’, ‘pansexual’, ‘questioning’, ‘unsure’ and one ‘other’ open ended response.

The measurement of gender identity is in its infancy and the UK Equality and Human Rights Commission recommend a question that measures sex at birth and/or a gender identity question (Equality and Human Rights Commission 2012). The combination of these two questions allows for transgender identity and history to be collected. However, research indicates that there is a proliferation of terms that young people use to describe their gender identity (McDermott 2010). Following pilot testing of the questionnaire, the questions were amended to ‘What is your gender identity?’ (options – Male, Female, Non-binary, Gender fluid, Other) and ‘Do you identify with the sex assigned to you at birth?’ (options – Yes, No, Unsure). Disability was measured using the UK Office for National Statistics question (White 2009).

Help-seeking was defined as any point of contact used for help because research indicates that suicidal youth have a tendency to seek assistance mainly from family and friends (Hawton, Rodham, and Evans 2006). Measures were drawn from previous validated survey questions on self-harming youth and help-seeking (Hawton, Rodham, and Evans 2006) and the qualitative findings. A distinction was made between informal (Internet, friends, parents, family, etc.) and formal (health, education, youth and welfare services including helplines) sources of help. Relevant questions were: ‘Thinking about times when you have self-harmed/had suicidal feelings (1) Why did you ask for help? (2) Why did you not ask for help from others?’

## **Data analysis**

### ***Stage 1 analysis of semi-structured interviews***

All interview data were inputted into the data analysis software Atlas.ti/6 for thematic analysis. Guided by the research questions, the data was coded descriptively and conceptually (Miles and Huberman 1994). Two research team members designed the coding frame and conducted the coding process to improve inter-code validity and inter-code reliability (Braun and Clarke 2006). The subsequent cross-sectional analysis involved clustering coded data relevant to the research question into potential themes through the constant comparison technique (Strauss and Corbin 1998). The data analysis generated two prominent themes in relation to the study research question ‘In what circumstances do lesbian, gay, bisexual, transgender and queer adolescents seek help for suicidal feelings and self-harm?’ These two themes were used to develop two new research questions to investigate in the quantitative phase: (1) Do lesbian, gay, bisexual, transgender and queer youth not seek help because of norms around their age, sexual orientation, gender identity and mental health status? (2) Do lesbian, gay, bisexual, transgender and queer youth tend to seek help when they can no longer cope? For these two research questions, four survey questions were designed for the



Stage 2 online questionnaire help-seeking component. These questions were drawn from already validated survey questions and the findings from the Stage 1 qualitative findings. The questions were: 'Thinking about times when you have self-harmed/ had suicidal feelings: (1) Why did you ask for help? (2) Why did you not ask for help from others? (3) Who did you tell about your sexual orientation/gender identity? (4) Why did you not tell some people about your sexual orientation/gender identity?'

### ***Stage 2 statistical analysis***

In the first instance the frequencies and responses for the four multi-response questions were examined. At this stage, some variables were re-categorised. The age variable was divided into three groups: '16 years and under', '17–19 years old' and '20–25 years old'. Categories were devised to reflect different life stages and development of participants. The suicidality variable was re-coded from five categories to two categories to measure the extent of suicidality experienced by participants. Responses were recoded into 'Has planned or attempted suicide' or 'No thoughts of suicide, or brief or abstract thoughts of suicide'. We also created a new two-category outcome variable with responses recoded to 'Asked for help' and 'Did not ask for help'.

Chi-squared tests were then conducted to determine associations between the new 'Asked for help' variable and demographic variables (sexual identity, gender identity, disability, ethnicity, age) and suicidality, self-harm and 'Experience of abuse related to sexuality or gender' variables. Probability criteria were set to  $p < 0.05$  and odds ratios (ORs) at 95% confidence intervals. We report here only the significant outcomes of these tests. Next logistic regression was performed to determine whether sexual identity, gender identity, disability, suicidality, self-harm and experience of abuse related to sexuality/gender predicted help seeking.

## **Results**

### ***Sample characteristics***

In all, 29 interviews (15 online, 14 face-to-face) were undertaken with lesbian, gay, bisexual, transgender and queer youth, and the questionnaire final sample size was 789 participants. Participants were aged from 13 to 25 years old, with a mean age of 18.59. Demographic details are shown in Table 1.

The largest proportion of participants in the study identified as White British (83.3%,  $n = 681$ ). The proportion of minority ethnic (including White other, Irish or Gypsy) participants (16.7%,  $n = 137$ ) and was higher than the UK 2011 Census (13%) (Office for National Statistics 2013). Participants who were trans or unsure were 2.23 times more likely to indicate that they had a disability/chronic illness/impairment compared to male/female participants ( $OR = 2.23$ , 95% CI: 1.61–3.09,  $p < 0.001$ ). Those who had a chronic illness, impairment or disability tended to be older (mean 20.07) compared to those who did not (mean 18.09) ( $X^2 = 57.688$ ,  $df = 2$ ,  $p < 0.001$ ). Males (10.1% with a disability) were the gender identity grouping least likely to report having a disability, impairment or chronic illness ( $X^2 = 40.736$ ,  $df = 4$ ,  $p < 0.001$ ).



**Table 1.** Sample characteristics of interviews and questionnaire.

	Interviews (n = 29)		Questionnaire (n = 789)	
	N	%	N	%
Age group (years)				
< 16	2	6.9	247	31.3
17–19	12	41.4	259	32.8
20–25	15	51.7	283	35.9
Sexual identity				
Lesbian	6	20.7	103	13.1
Gay	9	31	128	16.2
Bisexual	4	13.8	195	24.7
Pansexual and queer	6	20.7	213	27.0
Other	4	13.8	149	18.9
Gender identity				
Female	11	37.9	262	33.2
Male	6	20.7	167	21.2
Trans female	2	6.9	74	9.4
Trans male	5	17.2	104	13.2
Other	5	17.2	182	23.1
Ethnicity				
White British	26	89.7	655	83.0
Minority ethnic	3	10.3	71	9.0
White (other)	–	–	63	8.0
Disability				
Yes	6	20.7	199	25.2
No	23	79.3	590	74.8
Free school meals*				
Yes	–	–	188	23.8
No	–	–	556	70.5
Unsure	–	–	45	5.7
Parent/carer university* degree				
Yes	–	–	370	46.9
No	–	–	356	45.1
Unsure	–	–	63	8.0

\*Proxy measures for socioeconomic status.

## Stage 1 semi-structured interview findings

### Crisis points

In the interviews, participants spoke without exception about the difficulties they had asking for help. The interview analysis suggested that, like previous research (Biddle et al. 2007), young people looked for mental health support when they were at crisis point and/or they were no longer able to cope with their distress. Leigh described recognising that help was needed:

I suppose the turning point for me is the realisation that I would die if I didn't decide to get better. I decided I didn't want to feel like this for the rest of my life and wanted to achieve something in life. (Leigh, 17, trans man, pansexual, White British)

As this quotation indicates, young people tended to define that they were no longer coping when they were unable to have the type of life they wanted and/or they were anxious about their future. It was only then that they sought help. On further analysis, there were three strong themes that explained lesbian, gay, bisexual, transgender and queer youths' hesitancy to ask for help for their self-harm and suicidal feelings. These were: (1) negotiating

norms of age, mental health, sexuality and gender; (2) being unable to talk about emotions and feelings; and (3) coping and self-reliance. We elaborate on these below.

### ***Negotiating norms***

The interview analysis indicated that participants found it difficult to access support and assistance because they had (at a young age) to cope with the multiple stigmas of lesbian, gay, bisexual, transgender and queer identities and having a mental health problem. The complications of dealing with distressing emotions while they negotiated sexual orientation and gender norms that marginalised their own sexuality and gender identity often deterred young people from seeking help. In many cases, young people were fearful of, or had experience of, negative reactions, abuse and judgements regarding their sexuality and gender. This included hostile or dismissive reactions from adults when they had asked for help. Farouk, whose parents were deeply disapproving of homosexuality, kept his sexuality hidden from them. He explained in his interview that this made attending a mental health service challenging:

I was seeing the [gay friendly mental health service], that was just once a week I was seeing them but I really had to hide when I was seeing them. I always felt that like I'm going into the [gay friendly area of city] and imagine if someone sees me, imagine if I'm going to be outed to my parents, so I'd always hide away. But sometimes I just couldn't make the appointments, you know, to the [gay friendly area of city]. (Farouk, 24, gay, male, British Asian)

In addition to difficulties about their lesbian, gay, bisexual, transgender and queer identities, some participants were reluctant to access support because of the stigma of having a mental health problem. Anthony recounted his experience of non-help-seeking because of negative attitudes to mental health and talks about 'double stigma':

I don't think I've wanted to do a formal thing [seek mental health care] because I've never wanted to be labelled. Like because I had such a big thing about being labelled as gay, I didn't want to be labelled as the gay, depressed person. (Anthony, 16, gay, male, White British)

Furthermore, interviewees were hesitant to seek help because they believed that their emotions and distress would not be taken seriously by adults. Harry explained why he did not ask for help:

I think I kind of felt like they might think that my problems weren't like valid enough to get help. Sounds kind of ridiculous now but like I think that's how I felt at the time. (Harry, 17, trans man, pansexual, White British)

Many of the interviewees described feeling disinclined to seek help because they felt their troubles might be not taken seriously and they would be seen as attention-seeking rather than help-seeking. These fears led some to feel they were not worthy of assistance, and consequently they kept their problems a secret and remained silent. This may reflect the way that young people are precariously positioned within adolescent development discourses where their problems are temporised as a stage they will pass through. As a result, 'adults' have a tendency to view youth emotional distress as something they will 'outgrow' and not a matter of urgency (McDermott 2015; McDermott and Roen 2016).

### ***Being unable to talk about emotions***

A powerful theme in the analysis was the difficulty participants had verbalising their emotions and feelings in relation to their sexuality, gender, self-harm and suicidal feelings. Briana described her struggles in articulating her feelings:

I do find it difficult to talk openly and honestly with people about these things, especially face-to-face. I can talk in an online setting, but it is difficult to articulate and/or revisit certain things. With regards to sexuality, I never know how people are going to react, and the prospect of a negative reaction is certainly off-putting. (Briana, 19, female, pansexual, White British)

As this quotation indicates, being unable to talk is related to problems in expressing feelings or frightening emotions and the potential of a hostile reaction to being lesbian, gay, bisexual, transgender and queer. In some cases, young people felt it was too challenging to tell anyone about their predicaments, and they believed that talking would not help. Unsurprisingly they lacked confidence in speaking about difficult emotions and many spoke of the need for trust and confidentiality.

### ***Coping and self-reliance***

Self-reliance, autonomy and being in control were important reasons for not seeking help. Some young people felt asking for help was a sign of weakness, others stated they 'coped' through denying the problem or isolating themselves. Lex recounted her rationale for non-help seeking:

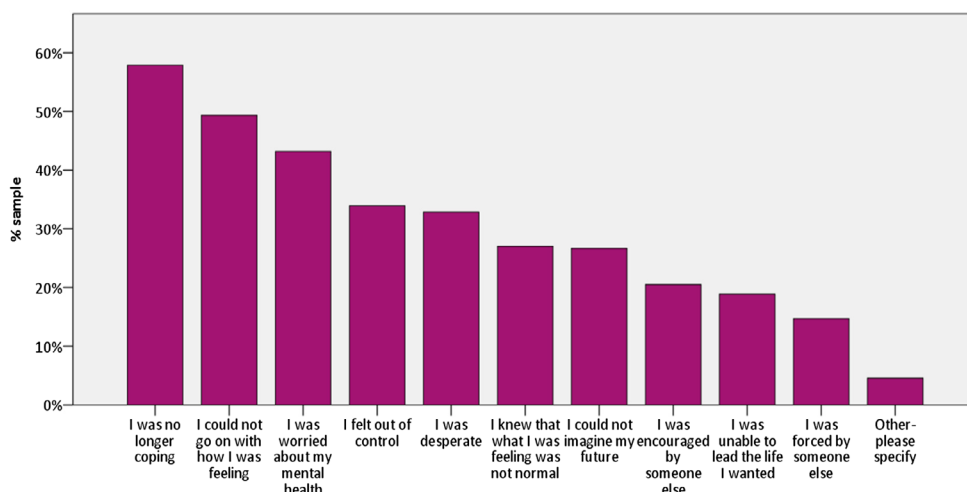
I knew of people thinking it was an attention seeking tool from listening to a late-night radio documentary on self-harm ... I didn't want anyone to think that of me or more importantly try to stop me. I was doing it as safely as possible to ensure minimal scarring and reduced chance of infection ... and it was acting as a successful coping strategy at a difficult time so I didn't want anyone to try to stop me from having access to it, therefore I needed to keep it hidden as best I could. (Lex, 25, genderqueer, gay, White British)

Our interpretation of this reluctance to seek help is explained by the ways that being responsible and coping are central to young people's understanding of what it means to be adult, mature and in control (Walkerdine, Lucey, and Melody 2001). For some of the interviewees, their self-harming was done safely, with minimum risk to their life and was perceived as a positive coping strategy. Some participants felt their low moods or suicidal feelings happened infrequently and they could cope alone. It was only if their feelings became unmanageable that they would seek help. These findings are the first in the England to indicate that lesbian, gay, bisexual, transgender and queer youth may not ask for help until they are at a crisis point, and the possible reasons why.

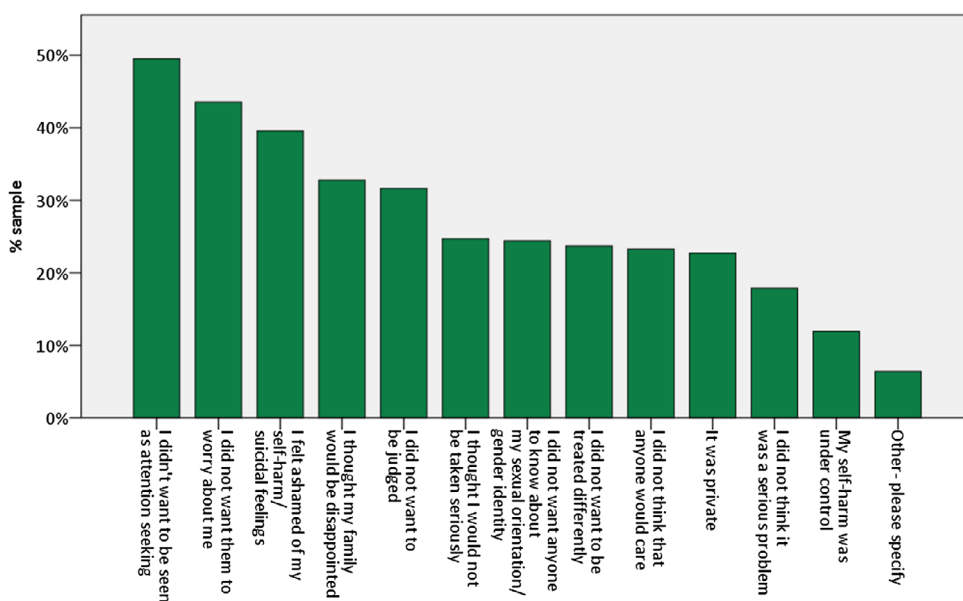
## **Stage 2 questionnaire results**

### ***Reasons for help-seeking***

Three quarters of questionnaire participants, 77.1% ( $n = 552$ ) had asked for help from at least one source and 22.9% had not asked for help ( $n = 164$ ). Participants were asked in a multiple response question (maximum of four) about why they asked for help when they were feeling suicidal or self-harming. Figure 1 illustrates that 'I was no longer coping' (57.9%,  $n = 319$ ) was selected by over 50% of the participants. This was followed by 'I could not go on with how I was feeling' (49.4%,  $n = 272$ ), and 'I was worried about my mental health' (43.2%,  $n = 238$ ). Feeling 'out of control' (33.9%,  $n = 187$ ) and 'desperate' (32.8%,  $n = 181$ ) were selected by over 30% of participants as reasons for seeking help. These results indicate that help-seeking was most frequently connected to no longer being able to cope or reaching a point of crisis.



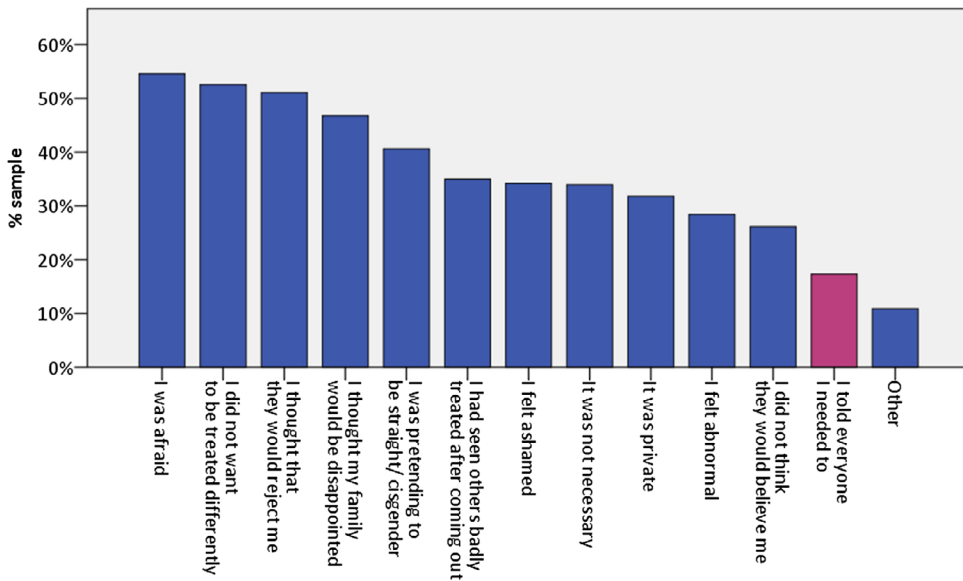
**Figure 1.** Reasons for help-seeking.



**Figure 2.** Reasons for not seeking help.

### ***Reasons for non-help-seeking***

Participants were asked in a multiple response question (maximum of four) about why they had not sought help. Figure 2 shows that the most frequently selected response, chosen by 49.5% ( $n = 349$ ) of respondents, was 'I didn't want to be seen as attention seeking', followed by 'I did not want them to worry about me' (43.5%,  $n = 307$ ). The next most common responses were 'I felt ashamed of my self-harm/suicidal feelings' (39.6%,  $n = 279$ ), 'I thought my family would be disappointed' (32.8%,  $n = 231$ ), 'I did not want to be judged' (31.6%,  $n = 223$ ). 'I did



**Figure 3.** Reasons for not telling some people about your sexual orientation/gender identity.

not want anyone to know about my sexual orientation/gender identity' was selected by 24.4% of participants ( $n = 172$ ). These results indicate that non-help seeking were related to fears that their problems would be belittled, concerns over their family, and stigma regarding mental health, sexuality and gender.

### ***Reasons for being unable to talk***

The questionnaire asked participants why they did not tell some people about their sexual orientation/gender identity when they were self-harming or feeling suicidal. Only 17.3% ( $n = 129$ ) of participants responded that they told everyone who they needed to about their sexuality and gender, suggesting that 82.3% ( $n = 617$ ) of participants had a reason to conceal their sexual orientation/gender identity at some point (Figure 3). The three most frequently chosen reasons for not disclosing their sexual orientation/gender identity were: (1) 'being afraid' (54.6%,  $n = 407$ ), (2) 'not wanting different treatment' (52.5%,  $n = 392$ ) and (3) 'expecting rejection' (51.1%,  $n = 381$ ). Importantly, 40.6% ( $n = 303$ ) of respondents reported that they were pretending to be heterosexual and/or non-transgender, which prevented them from telling some people about their sexual orientation/gender identity.

### ***Predicting help-seeking***

Further statistical analysis (Table 2) found that having a disability ( $OR = 1.83$ ), being transgender ( $OR = 1.54$ ), planned or attempted suicide ( $OR = 2.08$ ), engaging in self-harm ( $OR = 3.79$ ) and experience of abuse related to sexual orientation/gender identity ( $OR = 2.04$ ) were significantly associated with increased likelihood of help-seeking. Logistic regression incorporating these five variables is shown in Table 3. After controlling for age, significant  $OR$ s were seen for self-harm ( $OR = 2.82$ ), suicide plan or attempt ( $OR = 1.48$ ) and experience

**Table 2.** Associations and odds (95%CI) ratios between asking for help, disability, gender identity, sexual orientation, suicidality, self-harm and experience of abuse.

	Did not ask for help		Did ask for help		$\chi^2$	OR	95%CI	
	N	%	N	%			Lower	Upper
Disability, chronic illness or impairment					<b>7.13**</b>	1.83	1.17	2.86
No	136	19	401	56				
Yes	28	3.9	151	21.1				
Gender identity (2 categories)					<b>5.45*</b>	1.54	1.07	2.2
Cisgender <sup>1</sup>	106	14.8	300	41.9				
Transgender	58	8.1	252	35.2				
Sexual orientation					2.369	n/a		
Lesbian	23	3.2	66	9.2				
Gay	31	4.3	85	11.9				
Bisexual	43	6	142	19.9				
Queer or pansexual	39	5.5	151	21.1				
Other	28	3.9	107	15				
Suicidality					<b>16.84***</b>	2.08	1.46	2.96
Has not planned or attempted suicide	91	12.7	207	28.9				
Has planned or attempted suicide	73	10.2	345	48.2				
Self-harm					<b>32.96***</b>	3.79	2.35	6.11
Has not self-harmed	39	5.4	42	5.9				
Has self-harmed	125	17.5	510	71.2				
Experience of abuse					<b>14.85***</b>	2.04	1.41	2.95
Has not experienced abuse	67	9.4	141	19.8				
Has experienced abuse	95	13.4	408	57.4				

<sup>1</sup>Cisgender refers to those who identify with their sex at birth (i.e. male or female).

Bold values indicate statistical significance. \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ .

**Table 3.** Logistic regression: Help-seeking.

	P	OR	95%CI	
Gender identity	0.279	1.236	0.843	1.813
Disability	0.263	1.31	0.816	2.103
Self-harm	0.000	2.823	1.685	4.729
Suicide plan or attempt	0.047	1.482	1.005	2.186
Experience of abuse related to sexual orientation/ gender identity	0.002	1.804	1.232	2.643

of abuse related to sexual orientation/gender identity ( $OR = 1.80$ ). Participants that had self-harmed had almost three times the odds of asking for help ( $OR = 2.82$ ). Overall, the model only explained between 6.4% and 9.8% of the variance in help-seeking. However, for the Hosmer and Lemeshow 'goodness of fit' test, the value is 6.665 with a  $p$ -value of 0.465 indicating a good calibration of the model, and in the classification table, the rate of predicting help-seeking rises to 77%.

## Summative analysis and discussion

The aim of this paper was to examine the circumstances in which lesbian, gay, bisexual, transgender and queer young people seek help for suicidal feelings and self-harm. The

integrated analysis from both stages of the research suggest that lesbian, gay, bisexual, transgender and queer young people found it very difficult to ask for support, and when they did seek help they were usually at a crisis point. When asked why they asked for help, over half of the questionnaire participants selected 'I was no longer coping' followed by 'I could not go on with how I was feeling'. The results of the logistic regression supported this qualitative finding and found that planning or attempting suicide, self-harming and experience of abuse related to sexual orientation/gender identity were predictors of help-seeking in the model. This lends support to the idea that lesbian, gay, bisexual, transgender and queer participants who were most distressed were most likely to seek help. In a systematic review of young people's help-seeking for suicidal thoughts and self-harm, Michelmores and Hindley (2012) also found that those who were most vulnerable (increased frequency of self-harm and suicide ideation) had increased levels of professional help-seeking. Our results also suggest that lesbian, gay, bisexual, transgender and queer young people are normalising their emotional distress and only seeking help once they can no longer manage.

The stigma surrounding mental health is well documented in research as a barrier to young people seeking help and this was also evident in our study. Almost 40% of questionnaire respondents chose 'I felt ashamed of my self-harm/suicidal feelings' as a reason for non-help seeking. However, for lesbian, gay, bisexual, transgender and queer youth in our study, we found additional problems in asking for help that were connected to negotiating heteronormativity. Just under 25% of questionnaire participants selected 'I did not want anyone to know about my sexual orientation/gender identity' as a reason for non-help seeking. In the interviews, young people talked extensively about their fear of others' reactions to their gender and sexuality. Sometimes this was because they did not want to be judged, rejected or shamed themselves or they did not want others to feel disappointed. It was often also connected to previous negative and abusive experiences with adults, including those they had asked for help. As a result of anxieties about negotiating sexual and gender normative environments, the majority of participants partially concealed their sexuality or gender when they were feeling suicidal or self-harming, making it problematic to articulate their emotions, which added further difficulties to help-seeking.

In addition, the study highlights the importance of understanding the precarious position of young people in relation to adulthood. When asked why they did not ask for help, the response chosen by almost 50% of questionnaire respondents was 'I didn't want to be seen as attention seeking'. In the interviews, young people described feeling that their concerns and distress might not be taken seriously by adults in their lives. This may reflect the ways youth are viewed as 'not-quite' adults and their lack of autonomy and power. Within public discourses of 'growing up', adolescents' emotional problems tend to be temporised, 'blamed' on hormones and perceived as something that individuals will 'outgrow' and not a matter of urgency (McDermott 2015; McDermott and Roen 2016). The consequences of young people feeling their emotional distress would not be taken seriously are that, in this sample, many therefore did not seek help.

The summative analysis suggests that lesbian, gay, bisexual, transgender and queer young people were reluctant to seek help for their self-harm and suicidal distress because they were afraid of being judged, rejected and humiliated in relation to normative expectations of adolescent development, heteronormativity and mental health. Their own fears and the desire to not disappoint others demonstrate the importance of understanding young



people's help-seeking behaviours as an affective process (Fullagar 2005; McDermott and Roen 2016). Seeking help for suicidal feelings and self-harm is profoundly influenced by multiple normative pressures that silence and isolate young people, they then normalise their emotional distress and do not ask for help until they can no longer cope. By this point they are extremely vulnerable and more at risk of attempting suicide.

Our study is limited by the non-representative sample of self-selected participants and therefore the findings may not necessarily be generalised to the wider population. However, the sample obtained was diverse in terms of age, disability, sexual orientation, gender identity and socioeconomic background. There was an over-representation of White British and educated participants in the sample, which is often associated with the use of online methods, and this is a limitation of the study.

## Conclusion

Lesbian, gay, bisexual, transgender and queer youth have elevated rates of suicidality and self-harm, but these youth have been marginalised in mainstream studies investigating help-seeking in young people who self-harm or feel suicidal. Our study is a significant contribution to the understanding of lesbian, gay, bisexual, transgender and queer youths' help-seeking. Our results are compatible with previous research on young people's help-seeking for mental health distress. We found that the most significant barriers to lesbian, gay, bisexual, transgender and queer youths' help-seeking were related to the stigma of a mental health label, fear of being perceived as attention-seeking, difficulties verbalising emotions and communicating, and self-reliance. However, crucially, our study also indicates that lesbian, gay, bisexual, transgender and queer youth have additional problems in help-seeking.

Lesbian, gay, bisexual, transgender and queer youth participants found it problematic to access support because they had to manage normative environments where they wanted to avoid the multiple stigma of having both a lesbian, gay, bisexual, transgender and queer identity and a mental health problem, and they were anxious that their emotional distress would not be taken seriously by adults. In our view, mental health policies designed to prevent suicide and self-harm in young people must develop elements that address both the higher risk of suicide and self-harm in lesbian, gay, bisexual, transgender and queer youth and the specific problems this population group have in asking for help. We advocate a more imaginative approach to providing support and help, such as providing lesbian, gay, bisexual, transgender and queer specific mental health staff and services. Situating services in non-clinical setting such as online or in lesbian, gay, bisexual, transgender and queer youth groups may encourage young people to feel safer to disclose their sexuality and/or gender and articulate painful emotions. The dearth of research on the topic means there is a great deal more to be learnt about the ways in which lesbian, gay, bisexual, transgender and queer youth seek help for their self-harm and suicidal feelings, particularly what type of help and support would encourage them to request help.

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