



Understanding Suicide and Promoting Survival in LGBT communities

Katherine Johnson
Paul Faulkner
Helen Jones
Emma Welsh



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young people's trust



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Understanding Suicidal Distress and Promoting Survival in Lesbian, Gay, Bisexual and Transgender (LGBT) Communities.

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January 2007

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About the authors

Katherine Johnson is a Senior Lecturer in Psychology, School of Applied Social Science, University of Brighton and a member of the Health & Social Policy Research Centre (HSPRC). Her research interests focus on LGBT mental health, community and critical psychology, and she is currently writing a book *On Sexualities* (Polity Press).

She can be contacted via email K.E.Johnson@brighton.ac.uk

Paul Faulkner worked as a Research Assistant on this project whilst based in the Health & Social Policy Research Centre at the University of Brighton. The HSPRC aims to:

- Foster and sustain quality research in health and social policy
- Contribute to knowledge, theoretical development and debate
- Inform policy making and practice

For more information about HSPRC email Sallie White (s.s.white@brighton.ac.uk) or telephone (01273) 643480

Helen Jones is the Service Manager for MindOut. **MindOUT** is a LGBT Mental Health Project that provides support, advice, information, advocacy and group work for LGBT people who have mental health issues. We work to promote mental health and reduce stigma within the LGBT community, to raise awareness about LGBT mental health about the effects of homophobia and transphobia. In addition, we have been running an LGBT Suicide Prevention Development Project which has allowed us to pilot suicide prevention initiatives aimed at individuals and the LGBT community.

You can contact us on (01273) 739847 or by email info@lgbtmind.com, or visit our website www.lgbtmind.com for more information on the services we provide.

Emma Welsh represents Allsorts Youth Project. **Allsorts Youth Project** is for young people under 26 who identify as lesbian, gay, bisexual, transgender or unsure of their sexuality and/or gender orientation. We aim to engage vulnerable, alienated or marginalized LGBTU young people, and provide them with a variety of support services designed to promote and protect their well being as they emerge into an LGBT adult identity. Currently we have around 70 young people who use our services, with on average 25 young people accessing our weekly drop-in. This provides a safe and supported space for young people to meet and engage in fun and educational activities, including a youth forum. We also offer one to one support for young people, including face-to-face, phone and email support. We do outreach work in the wider community by providing workshops for young people in schools and colleges, to promote awareness about LGBT issues and the impact of discrimination. We also offer training for people working with young people in the statutory services and voluntary agencies, to raise awareness, promote good practice

and facilitate the creation of safer and more supportive environments for LGBT young people in the wider community.

You can contact us by email on info@allsortsyouth.org.uk, or phone us on (01273)721211 or visit our website at www.allsortsyouth.org.uk

Acknowledgements

We would like to thank the following people for the important contributions they have made to this study:

MindOut and Allsorts service users who participated in the development and design of the research and as participants.

BSCKE for funding the research project.

The Children and Young People Trust for funding the transcription of our research data.

The Steering Group members: Eli Brownlee (MindOut), Dana Cohen (BSCKE), Jason Saw (MindOut), Jess Woods (Allsorts) and Elaine McDonald (BSCKE)

Arthur Law (Spectrum), Natalie Woods (Brighton Lesbian and Gay Switchboard), Rose Hall (MindOut), Jim Apted (Allsorts), Sallie White and Pippa Lewis (Health & Social Policy Research Centre, University of Brighton)

The LGBT suicide prevention working party and Chris Morgan CSIP SEDC Suicide Prevention Lead.

National Mind for their interest in our work.

1 Executive Summary

1.1. Overview of the study

Given the growing consensus that LGBT people experience elevated rates of suicidal thoughts, intentions and behaviours (King et al 2003) and that this is linked to discrimination (Warner et al, 2004), this study focused on generating a qualitative understanding of the way in which suicidal distress is experienced by members of the LGBT community in Brighton & Hove. The second aim was to document strategies and resources LGBT people found useful in minimising their suicidal distress in order to inform local and national suicide prevention strategies. The project was funded by Brighton & Sussex Community Knowledge Exchange Programme (BSCKE) in order to foster better links between universities and community partners and to exchange knowledge that is beneficial for both the university and the local community. The research is a collaborative endeavour and co-owned by MindOut, Allsorts and the University of Brighton.

1.2 How the study was conducted

Participatory-action research was conducted with two local LGBT groups whose members are considered to be at risk of suicide related behaviours: MindOut (a support group for LGBT mental health service users) and Allsorts (a youth group for lesbian, gay, bisexual, transgendered and unsure people aged 14- 26). Participants from both groups took part in a focus group to discuss why LGBT people might become suicidal. These group discussions were used to formulate questions for one-to-one interviews. In total 12 people (5 from Allsorts and 7 from MindOut) spoke in detail about their own suicidal thoughts, feelings and actions as well as experiences surrounding their sexual and gender identifications, including 'coming out' and the impact this had on relationships with family, friends and peers. Drawing participants from two specific groups allowed us to compare and contrast themes relating to the experience of suicide related behaviour between the groups and to provide accounts from a range of people, including those who are already accessing mental health services (MindOut), and young LGBTU people, (Allsorts) who have less experience of mental health services or community support for mental health issues. It also ensured we could provide appropriate follow-up support for participants as all participants had an ongoing relationship with community support staff.

1.3 Key Findings

1.3(i) The experience of suicidal distress

Suicidal distress was experienced in terms of feelings of worthlessness, hopelessness and acute isolation. We found similarities in the qualitative experiences associated with suicidal distress but differences in the type of suicide related behaviours and length of experience between participants from different groups. At Allsorts 2 of the 5 participants had been hospitalised after

a suicide attempt while the others spoke of a range of self-harming behaviours they associated with suicidal distress. In contrast, all the participants at MindOut had been hospitalised on at least one occasion. A second difference was that Allsorts members tended to speak of suicidal distress as something in the past and were more optimistic about their futures than participants from MindOut. This is not to suggest that suicidal feelings will not re-emerge later in life. The MindOut narratives showed us that suicidal distress can disappear and then reappear at various junctures in response to particular stressful events, as well as being an ongoing everyday concern. It is argued that access to youth support services might help mediate later occurrences of suicidal distress and mental health issues for LGBT people by offering ongoing support in the aftermath of a suicide event during teenage and early adult years.

1.3(ii) The experience of LGBT identity formation

This theme outlined the social context in which LGBT people formed their identity and the psychosocial pressures they have to negotiate in order to develop a healthy sense of self. None of the participants at Allsorts described 'coming out' as a positive experience and their accounts made references to feelings of shame, confusion and fear of rejection. These were linked to the recent popularity of using the term 'gay' to refer to something 'lame' and 'rubbish', or as a form of insult, and the impact this had on their feelings of self-worth. The same sentiments were also found at MindOut, however these participants had taken much longer to 'come out' and find more positive representations of LGBT lives. A second difference was in relation to child sexual abuse. Abuse was spoken of within the MindOut narratives and participants expressed how experiences of child sexual abuse intensify confusions around sexual orientation. Particular concerns were raised about how a lesbian identity had been explained by mental health professionals as a response to sexual abuse. This shows how heterosexism still underpins some mental health practice and how LGBT identities are seen as abnormal developmental responses. Negative constructions of LGBT lives impact on people's ability to form a positive self-identity within a heterosexist, homophobic and transphobic climate. This can lead LGBT people to internalise feelings of low self-worth and shame, alongside fear of abuse and rejection, and these feelings are exacerbated by institutionalised forms of discrimination.

1.3(iii) Relationship between LGBT discrimination and suicidal distress

This theme exposes the direct and indirect impact of institutionalised and everyday practices of discrimination on LGBT mental health, in particular suicidal distress. There were accounts in both groups of explicit events that pre-empted suicide attempts, often from a young age. These included homophobic bullying in school and transphobic physical abuse in temporary housing. However, for most of the participants suicidal thoughts and feelings were bound up in a range of experiences of the negative construction of

LGBT lives, rather than linked to isolated events. These included homophobic abuse from parents, failure to recognise the significance of same-sex relationships by friends and family (particularly after a relationship breakdown), perceived parental disappointment at LGBT identification, and rejection from religious friends. A central concern for participants at MindOut was the 'double stigma' they experienced in terms of being alienated from the LGBT community because of mental health issues and isolated, and sometimes pathologised, within mental health services because of their LGBT identification. Thus, it is argued that suicidal distress is not simply the result of individualised problems but the response by some LGBT people to institutionalised discriminatory practices perpetuated through education, health, religion, media and the family.

1.3(iv) Strategies for survival and suicide prevention

A range of strategies and resources to promote survival were described by the participants, including self-attributes, interpersonal connections and service provision. Many of the participants acknowledged that finding a part of themselves that wanted to live was important for surviving suicidal thoughts and intentions. However, there are dangers in over-relying on personal strengths as evidenced by an Allsorts participant who misjudged his ability to cope with the homophobic bullying he was experiencing at school, and eventually attempted suicide to escape it. While individual processes such as establishing a routine are useful strategies for participants the dominant theme within this section was reducing isolation and alienation through the formation of interpersonal connections. Within this participants outlined the role of services in facilitating these connections and pinpointed the importance of LGBT services for establishing relationships with other LGBT people (e.g. Allsorts & MindOut) and the importance of LGBT sensitive services within mainstream provision for particular needs (e.g. education, health, housing). Finally participants outlined some of the limitations of a range of services for supporting LGBT individuals who are experiencing suicidal distress. Problems included homophobic, transphobic or heterosexist discrimination within educational and health services; lack of a prompt referral system for expressions of suicidal distress; inconsistent and fragmented system of care for suicidal individuals; a focus on diagnosis of mental health issues rather than treatment; lack of mentoring or foster care for young homeless LGBT people; limited access to crisis support when existing services are unavailable.

1.4 Recommendations

A number of recommendations are made in order to act on the key findings of the report. These include presenting good practice guidelines for interventions with LGBT people who are experiencing suicidal distress, proposals for interventions that will improve the context of identity formation for LGBT people and encourage better mental health, and recommendations for future

research questions in order to broaden further our understanding of suicidal distress and survival in LGBT communities.

- There is a need for prompt responses to expressions of suicidal distress from primary health services including GPs.
- There is a need for statutory services to develop support services that focus on care, rather than diagnosis and referral, for individuals who experience suicidal distress and other mental health issues.
- There is a need for continuity in service provision and care for suicidal individuals in recognition of the crucial role of interpersonal connections for reducing suicidal distress.
- There is a need for training of front line health professionals to have a greater understanding of the complex links between childhood experiences of sexual abuse and mental health.
- There is a need for training of front line health professionals in order to challenge discriminatory practices that pathologise LGBT people.
- There is a need for training provision of service providers in all sectors in order to challenge institutionalised discriminatory practices and better recognise how these practices impact on LGBT mental health.
- There is a need for a flexible referral system for LGBT people who are experiencing suicidal distress that offers the use of a range of LGBT specific and LGBT sensitive support services. It is important to make LGBT community connections (for some) to reduce isolation and it is important to provide positive representations of LGBT lives within mainstream services to support those that may be unsure of their identity status.
- There is a need for the development of mentoring systems for young LGBT people and LGBT people with mental health issues through peer support and/or community and voluntary sector organisations to reduce isolation and facilitate interpersonal connections within wider LGBT community support structures.
- There is a need for mentoring systems, including Fostering, to support young LGBT people with housing needs as housing concerns are one of the primary themes in young LGBT narratives of suicidal distress.
- There is a need for greater recognition of the impact of transgender violence on mental health and the need for safety initiatives in terms of community safety and safety evaluation of housing services.

- There is a need for an in-depth review of the 'crisis support' currently offered to LGBT individuals experiencing suicidal distress. This includes establishing a greater knowledge base by:
 - Monitoring the number of LGBT people who are referred from GP practices for suicide related behaviours
 - Monitoring the number of LGBT people who access A&E services after suicide related behaviours
 - Clarifying the types of interventions that existing services offer LGBT people who are in suicidal distress

- There is a need to improve 'crisis support' for LGBT individuals by:
 - Establishing clear guidelines on referral practice for LGBT individuals
 - Providing out-of-hours support to cover weekends and evenings incorporating peer support and the development of on-line communities
 - Establishing and developing existing links between LGBT sensitive services and LGBT specific services that support suicidal individuals.
 - Providing clear guidelines for LGBT individuals on the type of support that existing services offer and widely publicising and maintaining up-to-date contact information on how they might access support for suicide and other mental health issues

- There is a need to provide early prevention measures through educational policy, training of education professionals, and development of practices to tackle homophobia in schools. This might include:
 - Development of policies that challenge use of language and terms of insult such as 'gay'
 - Development of policies that tackle homophobic bullying to encourage disclosure of bullying on the basis of sexuality.
 - Training for educational professionals and support staff, including counselling services, to increase awareness of the impact of homophobia and heterosexism on young people's mental health.
 - Provision of pastoral support for pupils that is sensitive to the needs of young people who might be unsure about their gender or sexuality identity.
 - Greater recognition in the school curriculum of diversity in people's sexuality and gender identities and the relationships they form through citizenship training and sex education.

- There is a need to challenge societal stigma about LGBT lives by developing and promoting positive images of LGBT lives in order to reduce discriminatory practices and promote better mental health for LGBT people.

- There is a need to challenge stigma about mental health problems through a wider understanding of mental health issues and generation of positive images of people who have experienced them. The de-stigmatisation of mental illness is required in both the LGBT community and wider society.

2. Introduction

This study arose from the Brighton and Sussex Community-University Knowledge Exchange Programme (BSCKE) initiative in 2005-6. The broad aim of the programme was to fund a series of projects that would lead to an 'exchange of knowledge' through collaborative work between the university and community groups, with a specific focus on the impact of marginalisation and issues of social exclusion. Our successful submission outlined a key concern involving the seeming elevated rate for suicide distress amongst lesbian, gay, bisexual, and transgendered individuals. A series of studies have shown high rates of suicidal thoughts and suicide attempts amongst some LGBT groups, such as LGB youth (e.g. Herschberger & D'Augelli, 1995) and transgender youth and adults (e.g. Israel & Tarver, 1997) and higher rates of self-harm and suicide amongst lesbians than heterosexual women (e.g. McNair et al, 2005). In light of this knowledge, and the high density of LGBT individuals living in the local area, *MindOut* received funding from the South East Development Centre of *the National Institute for Mental Health England* (NIMHE) to conduct a pilot project on suicide prevention in the local LGBT community. Our project set out to support this development work by conducting in-depth qualitative research into the *experiences* of suicidal distress and survival by those who identify as lesbian, gay, bisexual or transgendered.

3. Background to the study and literature review

3.1 Studying LGBT mental health

Studying the mental health of LGBT people is not a straightforward issue. In recent years there has been a growing acknowledgement that some LGBT people suffer from high levels of mental distress, including anxiety disorders, mood disorders, suicide and self-harming behaviour, as well as substance misuse problems, and that this is related to elevated levels of discriminatory practices including physical and verbal abuse (King et al, 2003; Warner et al, 2004). Yet, because of the socio-medical origins of 'homosexuality' that led to the pathologising of same-sex activities and the classification of homosexuality as a mental illness there is a well-placed resistance within LGBT communities to associate with psychological and psychiatric practices. The legacy of pathology is difficult to shake off and studies have pointed to the homophobia and heterosexism that still exists within the mental health services (e.g. Pace, 1998). A qualitative account of the experiences of LGB people who had accessed mental health services noted problematic encounters that ranged from "instances of overt homophobia and discrimination, to a perceived lack of empathy around sexuality issues by the clinician" (King et al, 2003b: 3). Transgendered people have their own ongoing battles as 'gender identity disorders' are still classified within DSM IV, thus their identity status is considered one of mental illness, and despite political lobbying psychiatrists still regulate gender reassignment processes (Johnson, 2007).

This poses two problems for those who wish to understand how LGBT people experience mental health issues and provide appropriate services to meet their needs without reconstructing a pathologising narrative for all. Firstly, to speak of elevated rates of psychological distress or suicide related behaviour in the LGBT population runs the risk of reinforcing a relationship between sexuality/trans status and mental health issues that might imply that mental health problems are the result of being LGBT. This is not the case. Recent research in the area suggests that mental health problems are related to levels of anxiety created by discriminatory practices and minority stress (Warner et al, 2004). Whether these experiences cause mental health problems is less clear but they would inevitably exacerbate any coexisting mental health issues. The second problem for researchers is to gain access to a research sample willing to take part in psychological research. This is because of the level of suspicion already surrounding the psychological professions coupled with the problem of accessing hard-to-reach and/or hidden minorities. In order to overcome this we worked within a 'community psychology' and participatory-action research model that sought to involve participants within the research process and create a sense of belief in and ownership of the research objectives and outcomes.

3.2 Suicide research and related terminology

The vast majority of research on suicide seeks to distinguish between people's suicidal thoughts, suicidal behaviour and non-fatal, self-harm related

practices. To investigate, a range of questions are incorporated into a questionnaire in order to measure the prevalence and classify the experience of suicide and self-harm as 'suicidal ideation', 'suicidal intention' or 'self-harming related behaviour' (e.g. Meltzer, 2002; King et al, 2003). Example questions include: Have you ever thought that life was not worth living? (suicide ideation); Have you ever thought of taking your own life even though you would not actually do it? (suicide ideation); Have you ever made an attempt to take your own life by taking an overdose of tablets or in some other way? (suicide intention); Have you deliberately harmed yourself in anyway but not with the intention of killing yourself? (deliberate self-harm without suicide intention). For our research we wanted to include a broad definition of 'suicide' as we were aware from the community groups that people experienced distress in a variety of ways. Thus, for the purpose of this research we utilised the term 'suicidal distress' in order to recruit a range of participants and allowed the nuances between ideation, intention and self-harm to emerge in the interview process.

3.3 Suicide Rates: National and Local

Reducing the number of deaths from suicide has been a key focus of the *Department of Health* since the publication of *Our Healthier Nation Strategy* (1999) as reducing the annual number of suicides provides one means of measuring improved mental health amongst the general population. A recent press release from the *Office of National Statistics* claims that suicide rates have seen a reduction in overall rates of completed suicide since 1998 following the rising rates that took place through the 1970s and 1980s. However within this trend there are marked differences for men and women. In 2003 men accounted for three-quarters of all suicides contrasting with 56 per cent in 1971. Suicide rates for women fell gradually during the 1980s and early 1990s, but have decreased only slightly since the mid 1990s (ONS, 2005). While suicide rates are lower for women it should be noted that females are much more likely to engage in deliberate self-harm practices such as cutting than males, and recent research has suggested that worries about sexual orientation is a key factor in elevated levels of self-harm amongst teenage girls and boys (Hawton, Rodham & Evans, 2006).

There are also marked differences in rates of suicide across geographical regions. For instance, in the period 2000-2003, the South East had one of the lowest regional rates for adults with 10.8 suicides recorded per 100,000 compared to the national rate 11.4 per 100,000. Yet, in the local area Brighton & Hove returned the 4th highest regional rate with 19.8 per 100,000. Similarly, amongst men, the South East region has a lower rate of 16.4 per 100,000 compared with the national average 17.6 per 100,000. But, again, Brighton & Hove has the 7th highest regional rate for suicides amongst men recording 19.6 per 100,000 (ONS, 2005). No precise figures are available for this period that monitor sexual orientation or transgender status, however this data suggests that reducing suicide rates through appropriate suicide prevention strategies is a pressing issue for the local area.

3.4 Vulnerability factors for suicide and suicide related behaviours

Durkheim's (1897) classic sociological study of suicide concluded that suicide is the result of societal factors rather than individual personality traits. Of particular relevance to our research is his argument that suicide occurs in those who feel socially excluded, with little social support and lack societal integration. This leads to isolation and a sense of personal failure. This thematic account usefully highlights the way societal pressures impact on individual action but it is limited in providing sufficient information about who will be 'at risk' because of their sense of failure, or the impact of isolation. In contrast, large-scale population based surveys are helpful tools for ascertaining the prevalence of suicidal related behaviours and for drawing associations between a range of socio-demographic and personal factors. This type of information can be used to predict which groups might be particularly vulnerable or 'at risk' in order to target suicide prevention strategies, and they can also draw associations between factors to offer explanations for why certain groups are more susceptible to suicide related behaviour.

Various studies of this type have highlighted that while men account for the majority of completed suicides socio-demographic data pinpoints a range of characteristics that are more likely to lead to the classification 'at risk' in terms of suicidal thoughts and suicide attempts. In a general population study conducted in the UK in 2000 (Meltzer et al, 2002: 28) concluded that of those who had attempted suicide at least once, compared to those that had never, respondents were more likely to be "women; younger; single or divorced; living in a one-person family unit; economically inactive; in lower socio-economic classes; and renting accommodation from the Local Authority or a Housing Association". One of the limitations of this account for our research is that it does not account for respondents' sexual orientation or transgender status. This is a common issue as LGBT identity is rarely recorded on general population data, including the Census, and therefore it is often difficult to predict the size of this group or their health and welfare needs.

However, a recent UK based large-scale study that compared the mental health of heterosexual men and women with lesbians, gay men and bisexual men and women found that LGB people under the age of 40 were 3 times more likely to have considered taking their life than a heterosexual comparison group (Warner et al 2004). This finding is consistent with a range of research studies from other western cultures that stress concern with levels of suicidal distress, particularly amongst LGBT youth (e.g Ramafedi, 1987; Bagley & D'Augelli, 2000; Jorm et al, 2002; McNamee 2006). In a survey of 1100 LGBT respondents from Brighton and Hove conducted by *Count Me In* (2001) 40% of respondents were found to have had serious thoughts of suicide and 20% had attempted suicide. From this information we can draw two conclusions. Firstly, that as a group there is a higher prevalence of suicidal distress amongst LGBT people than heterosexual people, particularly the young, but secondly, only some LGBT people have suicidal thoughts and even fewer go on to attempt suicide. This is one of the shortfalls with studies

that highly the relationship between suicide and socio-demographic factors. While factors such as age, gender, ethnicity and sexual orientation aid policymakers to focus services towards sections of the population that may be more susceptible, they tell us little of the personality and situation factors that inevitably determine which individuals are more at risk.

In contrast, psychological studies have sought to establish how other variables such as psychological disorder-related factors, personality-related factors, family history and cognitive style impact on risk and vulnerability. Depression and other psychological disorders dramatically increase the likelihood of suicidal behaviour. Meltzer et al (2002) found in their sample that 40% of people with phobic symptoms, depressive ideas, obsessions and compulsions had lifetime suicidal thoughts, and 20% had attempted suicide at least once. Situation factors such as stressful life events also had a major impact on the rates of suicidal thoughts and behaviour. These events include legal and financial problems, family difficulties, relationship breakdown, illness, bereavement, and physical and sexual abuse. Meltzer et al (2002: 5) found that as the number of stressful events increased so did the number reporting suicidal thoughts. In particular, “higher rates of lifetime suicidal thoughts were found among groups who reported ever having been homeless (48%), running away from home (45%), experiencing violence in the home (44%) and being expelled from school” and of these approximately 25% had attempted suicide. While some stressful events such as separation and divorce, serious illness, injury or assault and a serious problem with a close friend or relative increase risk of an isolated suicide attempt, other factors associated with adolescence increase the risk of suicidal ideation throughout the lifespan. This raises an important but unsubstantiated proposition for research into LGBT suicidal distress. Research with LGBT youth has shown that they are particularly vulnerable to these situational factors (see Section 3.6 for detailed discussion) yet there is little research on the long-term impact on mental health as they mature. The relationship between problems in the family home and lifetime suicidal ideation may be one explanation for why some LGBT people develop long-term mental health problems.

It has also been argued that other personal factors that impact on the way people make sense of themselves and the world around them may be associated with suicidal behaviours. For example, O'Connor and Sheeny (2001) suggest that perfectionism and impulsivity are implicated as they can lead to reduced levels of self-esteem and social hopelessness. However, it is the component 'hopelessness' that is most associated with suicidal ideation, intention and completion. Hopelessness is conceptualised as the result of a cognitive style of thinking that promotes profound pessimism about the future. While it is often associated with depression it is seen to be an acute form of psychological distress, sometime referred to as 'psychache' (Schneidman, 1995). This ability to generate positive future thinking is seen to be a factor that can differentiate between suicidal and non-suicidal individuals independently of depression (O'Connor & Sheeny, 2001). The notion of imagining the future has also been highlighted as a key factor by Chandler et al (2003) who point to the importance of being able to locate a future self in a cultural narrative. They pointed to the elevated rates of suicide for Native

American adolescents and suggested that the erasure of their indigenous culture impacted on their ability to construct future versions of self. This notion of 'future self' is of interest in relation to LGBT suicide as positive models of the life-trajectories of lesbians, gay men, bisexuals and transpeople are difficult to find, particularly for young people who are likely to grow-up in a heterosexual environment.

3.5 Mental Health Research and the LGBT population

It should be noted that the vast majority of research into LGBT mental health and suicide emanates from the US, with far less published material available about similar groups in the UK or other western cultures. Another point of caution is that most of these studies do not include transgendered people within their samples and focus on generic summaries of LGB issues. Within this, bisexual men and women are also frequently collapsed into the 'gay men' or 'lesbian' category, which does not allow for comparison across these distinct sexual orientations. While such issues raise validity concerns in terms of grounding our research within an existing body of literature there are some factors that diminish these limitations. The few studies that have taken place in the UK and Australia have corroborated US based findings (e.g. King et al, 2003; McNair et al, 2005). This implies it is safe to generalise other research findings without thinking they are particular to LGB people in the US.

Furthermore, almost all research that indicates poor levels of mental health and elevated risk of suicide explains these findings in relation to victimisation, alienation and discrimination. These forms of practices are the same, if not worse, for transgendered people who also report high levels of verbal and physical abuse as well as discrimination in schools and the workplace. Studies that focus specifically on transgendered people also find elevated rates of suicide and suicide related behaviour both with adolescents and adults (e.g. Israel & Tarver, 1997). Thus, we think it is possible to apply the sentiments from studies of LGB mental health/suicidality to trans people, while acknowledging that there may be other factors that become psychosocial stressors.

Finally, only a few studies have compared the mental health of bisexual men and women with gay men/lesbians and heterosexual men/women. These have found that bisexuals have higher levels of psychological distress, suicidal thoughts and attempts than both comparison groups (Jorm et al, 2002; King et al, 2003). Hence, it should be noted that bisexual men and women share certain characteristics and risk factors with lesbians, gay men and transgendered people but it is likely that they also have other psychosocial stressors that impact on their everyday interactions and subsequent mental health. The reason that distinctions are not clearly stated between 'lesbian', 'gay', 'bisexual men', 'bisexual women' and 'transmen' and 'transwomen' in many studies is a result of the methodological approach. In order to draw these types of distinctions a sufficient sample size is required for each category, and if the number of people identifying as transgendered or

bisexual is small significant conclusions cannot be asserted about these groups. In our research we are using the term LGBT as a collective term because we propose to include people who identify as LGB and/or T and belong to local community groups that provide support for LGBT people. However, because we are using a qualitative approach and a small research sample we will not be implying our respondents speak for all lesbian, gay, bisexual or transpeople who have felt suicidal and we will not be able to generalise particularities of experience within the LGBT community. Rather, we will be providing descriptive detail about the stressors some LGBT people may face.

3.6 Suicide and Adolescent Sexual Orientation

In an attempt to explain rising suicide levels for adolescent populations, studies have consistently pointed to the potentially high rates of suicide attempts amongst LGB youth who may be struggling with their identity formation in a hostile environment. These estimates range from 2-3 times more likely than other young people to attempt suicide to more conservative estimates that suggest LGB suicide only accounts for 2.5% of completed suicides (Ramafedi et al, 1998). These prevalence rates have been explained by a range of factors that underpin forms of victimisation and discrimination and are presumed to impact on development (Rivers, 2002). In a US based study with 194 participants Hershberger & D'Augelli (1995) found that 42% of LGB youth had attempted suicide on at least one occasion as result of victimisation and/or alienation. They theorised that a combination of familial and societal homophobia contributed to their participants' pre-disposition toward self-destructive behaviours. For example, studies highlight that the home and family can be particularly risky for adolescent LGBT people. From a sample of 500 Hunter (1990) found 46% had experienced a violent assault because of their sexual orientation and 61% of these assaults had occurred in the home. In another study involving 194 participants Pilkington & D'Augelli (1995) found 36% had been assaulted or degraded by a family member. In this study mothers were found to be more likely to be abusive than fathers, brothers or sisters. Research indicates this may be because mothers fear social condemnation if others perceive their child's sexuality as 'their fault', as they have been responsible for their up-bringing (Rivers, 2002). Elsewhere, D'Augelli (1991) found that after 'coming-out' to parents 26% of mothers and 57% of fathers were seen as intolerant or rejecting. In another US study Goldfried (2001) found 33% of LGB adolescents had been verbally abused and 10% physically abused by a member of their family. Worse still is the fear of rejection amongst young people who have yet to 'come-out' to their family and the level of distress disclosing sexual orientation to parents causes (D'Augelli & Hershberger, 1993). As D'Augelli et al (1998) found, only 10-14% of those not 'out' predicted an accepting response from their parents. All these themes point to an underlying sense of shame within the family and some young people either decide to or are forced to leave home, often ending up in large cities, homeless and at risk of sexual exploitation (Nelson, 1997; Rivers, 2002, Cochran et al, 2002). In a study of lesbian and gay street youth in California in the early 1990s Kruks (1991) found young people caught in a

cycle of sexual exploitation and rejection that had resulted in 53% of the sample attempting suicide on at least one occasion and 47% more than once. Similar concerns have been found in a recent study of LGBT homelessness in Brighton & Hove where 66% of the young people reported a previous suicide attempt (Cull et al, 2006).

Other forms of victimisation take place outside of the home and are related to bullying and forms of physical and verbal abuse. For young LGBT people the school environment can be a source of great distress (Rivers, 1995) where heterosexism and homophobia abound (Epstein & Johnson, 1994) and they are afforded little protection or support from teachers (Douglas et al, 1997). Meyer (2003: 674) explains how stigma, prejudice and discrimination create such a hostile environment that it leads to mental health problems that are the result of 'minority stress'. The key aspects of minority stress are the "experience of prejudice events, hiding and concealing, internalized homophobia, and ameliorative coping processes". While other groups such as ethnic minorities may also experience minority stress, LGB young people frequently do not have a supportive home or school environment to mediate the prejudice they are experiencing. Furthermore, living in heterosexist and homophobic culture can seriously impact on a young person's ability to construct a positive self-identity, particular at an early stage of identity development, resulting in expectations of rejection, low self-esteem, internalized homophobia, depression, inner conflict, feelings of isolation and alienation and anxiety about 'coming out' (Flowers & Buston, 2001). The experience of 'coming out' is thus a crucial point in the development of both sexuality/gender identity and self-acceptance.

3.7 Suicide amongst LGBT adults

Less is known about suicide behaviour among LGBT adults as it has not received the same degree of attention as LGBT youth. However a range of studies have reported that the impact of minority stress is not limited to the adolescent period. Victimisation can continue into adulthood and is associated with poor self-esteem and depression (e.g. Otis & Skinner, 1996). While bullying, physical and verbal abuse is common for young LGBT people other research has suggested that this continues into adult life. King et al (2003) found that lesbians were significantly more likely than heterosexual women to be the victims of violence and bullying in adult life. In a subsequent paper from the same study Warner et al (2004) illustrated a link between elevated rates of contemplated suicide and self-harm with higher levels of reported physical and verbal attacks. Given few participants were younger than 18 years it would appear that abuse continues to impact on LGB people as they age. D'Augelli & Grossman (2001) conducted research with 416 LGB older adults (60 years plus) and found that almost 75% of participants had experienced some form of victimization. Supporting the relationship between victimization and poor mental health they found those that had been physically attacked also reported lower self-esteem, more loneliness and more suicide attempts.

Others highlight the long-term impact of teenage experience on adult mental health. In a study of 119 LGB men & women who had been bullied at school, Rivers (1999 cited in Rivers, 2002) found those exposed to indirect methods of victimization such as rumour-mongering or social isolation had higher scores on a measurement scale of Post Traumatic Stress Disorder (PTSD) than those who were exposed to direct aggression. Rivers interpreted these findings as suggestive that direct aggression was easier to handle than indirect, as there was no means for retaliation against forms of bullying that focused on ostracizing the LGB individual from social networks. In a later study he argued that PTSD might be a feature through adult life for those who experienced prolonged bullying at school because of their actual or perceived sexual orientation (Rivers, 2004). Similarly Rosario et al (2005) suggest that LGB youths who attempted suicide continue to experience elevated rates of psychological distress long after the attempt and Graaf et al (2006) argue that there is little difference in risk for suicidality between young and older lesbian and gay men. Here, they suggest that even in Holland - a supposedly tolerant climate for same-sex relationships - gay men are at much higher risk for all measures of suicidality than heterosexual men, while lesbians have a higher level of suicidal ideation than heterosexual women.

While many of the studies do not mention transgendered people, as stated earlier, it is likely that the impact of victimization, family problems, bullying, verbal and physical abuse have the same effects on transgendered adolescence and adults as they do on LGB people. However, 'coming out' can raise a different set of concerns. It is necessary in the first instance for both teenagers and adults to be 'out' about their gender non-conformity if they wish to transition but, because of current medical practice, this instantly leads the young trans person into a process of psychiatric assessment for their identity 'disorder'. This 'pathology' reference can be detrimental for issues of self-esteem and self-acceptance precisely at the point at which a trans individual begins to assemble their 'new' gender identity, and telling family members frequently results in relationship tensions and breakdown as well as profound fears of rejection (Johnson, 2007, 2007b). Furthermore, after transitioning, being 'out' may not be the desired state of being for trans people. While some argue it is important for trans-people to claim their identity as 'transsexual' or 'transgendered' (e.g. Stryker, 1998) others argue this undoes the realness of the new gender category and leaves the trans person with no comfortable sense of gender identity, or 'place to call home', that all non-transgendered people take for granted (Prosser, 1998). Furthermore, being 'out' carries greater risk of violence for both LGB and trans people, but it should be noted that many trans-people have difficulty 'passing' as simply 'male' or 'female' and experience regular and extreme levels of physical and verbal abuse because of this.

Despite research showing a link between suicidality and sexuality/transgender identity, it has not been determined that suicide attempts can be directly attributed to sexual orientation itself. Rather, suicide attempts amongst LGBT people are associated with a range of psychosocial stresses including gender nonconformity, early awareness of being gay, victimisation, lack of support, family problems, knowing someone who has made suicide attempts,

homelessness, substance misuse and other psychiatric problems (Ramefedi, 1999). Yet, not all LGBT people experience suicidal distress. It is therefore likely that the relationship between sexuality/gender identity and suicidality is mediated by other factors such as 'family connectedness' and school/work safety, which may act as protective factors (Eisenberg & Resnick, 2006) and promote resilience (Fenaughty & Harré, 2003). A greater understanding of what is happening or not happening in an individual's life prior to a suicide attempt should enable us to theorise the situational factors that participants report as underpinning their suicidal distress. Similarly an in-depth discussion of the strategies LGBT people have developed to promote their own survival should enable us to add to the emerging literature that seeks to understand and foster resilience amongst a vulnerable population. In order to do this we worked with two groups of LGBT people who are considered to be particularly 'vulnerable' to suicide: young people and those who identify as having mental health problems.

4. Research Aims

- To understand the way in which young LGBT people and LGBT mental health service users have experienced suicidal distress.
- To understand how, if at all, their experience of sexuality and/or gender identity development is linked to their suicidal distress.
- To collate accounts of survival techniques to better inform LGBT suicide prevention strategies.

5. Methodology

With a relationship between sexuality/transgender identity and suicide already established the method focused on creating more detailed understanding of the specificities of suicidal distress in LGBT participants' lives. Only a few studies have conducted qualitative interviews with people who have suicidal thoughts or have made suicide attempts (e.g. Asberg et al, 2003; Greenland et al, 2004; Kidd & Krul, 2002) with fewer still focusing on LGBT issues (e.g. Fenaughty & Harré, 2003) and none that we are aware of include young LGBT people and LGBT mental health service users. Working in this relatively recent area within the context of the BSCKE programme directed the methodology and raised a number of ethical questions.

5.1 Participatory-Action Research

In line with the principles of community psychology (e.g. Nelson & Prilleltensky, 2005) and the goals of the BSCKE program this project worked within a collaborative framework throughout. The research aims and objectives were constructed via a process of negotiation between the principal author and the community supervisor from MindOut. Shortly afterwards the research team was joined by a research assistant and a community representative from Allsorts and further development took place. The research is co-owned by University of Brighton, MindOut and Allsorts and the research steering group included the BSCKE program co-ordinator and a service-user representative from MindOut. All members of the research team identify as members of the local LGBT community.

Participatory-action research is an approach to research that challenges the power balance of tradition research methods. Rather than a researcher entering the field to observe and interview 'subjects' and leave with a set of recommendations, the aim is to involve participants throughout the research process in order to facilitate social action and change at community level. While there are certain points at which research expertise has to be negotiated with a team of researchers this project endeavoured to promote participation and ownership of the research amongst our research respondents and community group representatives. For example, a service-user from MindOut was on the interview panel for the employment of the research assistant, participants took part in the designing of the interview schedule and a young person from Allsorts took part in a conference, alongside community group supervisors and researchers, where we discussed our experience of the research process.

5.2 Ethical Considerations

A number of ethical issues were raised by this study because of the nature of the topic area and the methodological approach employed. The topic 'suicide' is considered a very sensitive research area particularly when discussing personal narratives with two groups of people who are considered to be 'at risk' or 'vulnerable'. In response to this due care was taken to layer in levels of support for our participants so that they had the opportunity to discuss their

participation both before and after the interview. All participants were provided with a list of local and national services and help-lines, but the community groups played a crucial role in ensuring participants had sufficient support for their emotional needs and were available to provide follow up sessions in the weeks following the interviews, if it was required. A second issue relating to confidentiality also arose because of the topic area. Participants were informed that their accounts would be treated as confidential unless they mentioned any current plans to take their life. It was agreed with participants before the interviews that this type of information would be discussed with their community group worker so that appropriate interventions could be provided. Finally, a third consideration became apparent because the research was co-owned by the university and named community groups and this factor jeopardised the standard aim of protecting the anonymity of the participants. All participants were informed that it would not be possible to guarantee their anonymity as the names MindOut and Allsorts would appear on the report and interview extracts would be used to illustrate the findings. Thus, there was an increased chance of participants being recognised. All respondents were aware of this and given the opportunity to withdraw from the research.

5.3 Research Design

The research involved several stages in order to ensure a collaborative design and maximise user involvement in the process. The first stage entailed focus group discussions with participants to generate the interview themes. The second stage involved the clarification of the interview schedule and a series of face-to-face interviews. These stages are discussed in turn.

5.4 Focus Groups

The research associate attended a drop-in session at both community groups where he was able to speak to all service-users and introduce the research by speaking freely with them about the aims, the comprehensive layers of support, and emphasise the importance and significance of their participation. Two focus groups were carried out, one at each community group in order for participants to generate themes to be included in an interview schedule for the forthcoming in-depth interviews.

5.4(i) Participants & Procedure

5 people took part in the focus group at MindOut [1 male, 3 female and 1 person identifying as a transgendered woman]. 4 participants took part in the Allsorts focus group [3 male and 1 female]. Participants were asked to provide examples of questions that they thought should be included in an interview with someone who had been suicidal. The focus was on collecting themes and questions that the group thought were important in order to access the needs and experiences of LGBT people at times of crisis, while allowing them to articulate this without having to refer to their own personalised experiences. Focus group discussions were facilitated by the research assistant and a

community group support worker in order to maintain the flow of discussion, and they were tape recorded. The tapes were transcribed and individually summarised into key themes for each group. A generic interview schedule was then constructed with the intention of utilising the same questions in in-depth interviews with members from each group. Thus, the research team drafted six open-ended questions for the interviews that were considered broad enough to capture the range of experiences and events discussed in both focus groups. A questionnaire was then sent to each participant who had taken part in the focus groups, as a member-checking exercise, with the proposed interview schedule included. This afforded participants the opportunity to judge the appropriateness of the questions for addressing issues discussed in the focus groups and feedback to the research team on their experience of taking part in this stage of the research. No requests for alterations to the interview schedule were made.

5.5 Interviews

5.5 (i) Interview-Schedule

The formal interview schedule was then agreed through lengthy negotiation with both community groups. The schedule consisted of two sections; the first asked about how participants understood and identified with their sexual orientation/transgender. The second section consisted of questions surrounding suicidal distress and survival strategies. Although the order of questions could be asked according to the narrative and pace of the interviewee, the intention was to delineate two separate sections in a conscious attempt not to imply a relationship between the participants' sexual orientation or transgender status and their suicidal experiences. The interview schedule comprised of open-ended questions constructed in reference to the literature and focus group discussions. These questions were posed to elicit information around the themes of sexuality/gender identification, 'coming out', changes in self, experience of suicide, strategies for survival, and perceptions of the future.

5.5 (ii) Participants & Procedure

In total 12 in-depth semi-structured interviews took place. 7 participants from MindOut [3 males, 2 females, 1 transgendered women] and 5 from Allsorts [3 males, 2 females]. The average age of the participants from MindOut was 38 years (range 27-53) and Allsorts 18 years (range 17-20). It should be noted that no participant identified as 'bisexual' and the transgendered woman did not provide a sexual orientation identity, but rather spoke in terms of transsexual and transgender issues.

Two interviews were conducted by the first author as two participants specifically requested speaking to a female researcher. The remaining interviews were conducted by the second author. Interviews were carried out at MindOut, Allsorts or at Brighton Lesbian & Gay Switchboard Counselling rooms. All locations provided a safe and secure environment and were agreed

with the participants before the interviews. At the end of the interview each participant was provided with a stamped addressed envelope, a questionnaire, an information sheet detailing local and national support organisations and £10 to cover costs incurred by attending the interview. The questionnaire comprised of three questions specifically asking for their comments on the research process and whether they felt they had been suitably supported. The questionnaire also allowed the interviewee to reflect on the discussion and offer new insights into their interview experience, participation with the research, or add to their narrative if they had anything further to contribute. Each participant also had a debriefing meeting with a community support worker to discuss any outstanding concerns they might have after a discussion of their suicidal experiences and feelings. With the prior agreement of the participants, all interviews were recorded using a Dictaphone, and all tapes were transcribed by an outside agency.

5.6 Analysis

Each transcript was analysed in turn by noting key concepts and themes relating to our overall interest in experiences of sexuality and/or transgenderism, suicide and survival. A summary for each transcript was written, highlighting themes, categories and contradictions. In order to code the data the summaries were collated to give a comprehensive overview of themes emerging from each community group. The themes were then compared to highlight similarities and differences across the groups, as well as divergent experiences within the groups. An independent coding exercise was also conducted by the second author which showed a high level of compatibility with the key themes extracted and presented here. Thus, the following analysis presents a narrative picture of the experience of suicidal distress amongst members of two different LGBT community groups. Findings highlight the way in which this group of LGBT people have experienced their sexuality and transgender identity formation and their own suicidal distress. While similarities exist between some group members, the small sample size dictates that these findings on their own cannot and should not be generalised to all LGBT people. Thus, while every attempt is made to compare and contrast themes across groups, attention is also paid to the difference within them.

6. Findings and Discussion

The findings are presented in relation to four grand themes: the experience of suicidal distress; the experience of LGBT identity formation; the relationship between discrimination and LGBT suicidal distress; strategies for survival and suicide prevention. Each theme is presented in turn and similarities and differences within themes are highlighted.

6.1 The experience of suicidal distress

In line with psychological studies of predictors of suicidal thoughts and intentions all our participants explained their suicidal episodes in terms of feeling 'worthless', 'hopeless', 'depressed' and/or 'isolated'. For example, a participant from MindOut described a range of negative emotional affects that emerged when she was housed in temporary accommodation and the impact these had on her mental health and suicidal distress.

I: How do you mean your mental health declined?

P: Um, well, insomnia, anxiety, depression, feelings of (no) self worth and self esteem. Um, hah, yes, I mean I was lucky to have survived that year (MindOut, transwoman, Int. 6: 559-566).

Similarly, a female participant from Allsorts described her suicidal feelings in terms of an overwhelming sense of 'worthlessness', highlighting in particular exam pressures and alienation from friends and family:

...it was so bad at that time that there was no point in living any more. Like everything just felt so bad, that, that it was never going to get any better, it was only going to get worse, so it would be easier to just be dead. That's how I felt anyway... I was living with my parents then and I just felt like I was completely worthless and that I wasn't going to succeed. I had exams coming up and I thought I was going to fail all of them and it was going to be really bad and nobody liked me anyway, so why did it really matter. Um, and then it was difficult because people did like me and they were like, and they had to sort of step in and say no wait, wait and I was going no you all hate me (Allsorts, female, Int. 11: 205-209, 214-218).

Despite her feelings of worthlessness at the time, retrospectively this participant is able to see that people around her did not dislike her and attempted to protect her from her suicidal intentions. In contrast, a participant from MindOut described how his feelings of isolation and withdrawal prior to 'coming out' were exacerbated by the rejection of his friends who were unable to cope with his mood swings and suicidal distress:

It was a feeling of isolation, totally withdrawn, aah, this was just before I came out, aah totally withdrawn couldn't go out. Aaah, I wasn't worth living - nobody cared about me, no friends. At that time the two friends I

did have more or less said to me we can't handle you anymore and they walked away.

I: In what way could they not handle you?

P: My mood swings – my mood swings. There was one day I was great – on cloud nine – next day I was really suicidal, really down like a big weight over your head, couldn't lift it, you know. And they said we can't handle your mood swings – we've our lives to lead, cheerio, bye, bye (MindOut, male, Int. 4: 446-457).

The withdrawal of his friends' emotional support resulted in another suicide attempt for this participant. However, even with friends, peers and/or family available to provide support it may not be within the capacity of the suicidal person to make this emotional connection. For example, a participant from Allsort summarises his debilitating experience of suicidal distress in terms of acute isolation and an inability to reach out, connect and/or talk to people around him about the extent of his psychological distress:

...you've got to a point where everything feels so crap that you feel like talking to people isn't going to help - that what is there that they can actually do. You've got, you feel like you've got to this point now where there is no going back – it is too late to talk to people (Allsorts, male, Int.12: 532-535).

While there were many similarities between the two groups with regards to the emotional affect of suicidal distress differences occurred between the groups in terms of the type and length of the distress experienced. For example, members from both groups described a range of suicidal thoughts and behaviours such as cutting and overdoses, but for three Allsort participants suicidal distress was more likely to be related to suicidal thoughts played out through a range of self-harming behaviours rather than suicide intentions that led to hospitalisation. Another trend within this group was that, even for the two male participants from Allsorts who had been hospitalised after a suicide attempt, suicide distress was primarily discussed as an experience in the past, rather than as an ongoing concern. For example, one participant described her suicidal thoughts and behaviours relating to a time when she was younger and unhappy, but as a time that has passed by:

I was about 14, 15 and um I just generally hated life... but looking back on it, I mean, I still have scars on my arm and it says 'why' and it means why am I not dead, why have I kept myself alive... I am glad I have that on my arm because I can look at it now and think I don't need to do that anymore. And that was over two years ago and it is still there but I am happy to have that, you know, most people are like 'why do you have scars on yourself' but it reminds me of my past and that I am not there now and I am happy now (Allsorts, female, Int.3: 328-329, 338-340, 342-346).

In contrast, most MindOut members described a profound and ongoing sense of worthlessness and despair. For example, one participant outlined her

sense of hopelessness and fantasy about dying as something that existed independently of her experience of suicidal intention:

I: What's the relationship between the two (being down and wanting to kill yourself?)

P: Um, for a start I think wanting to kill myself, I've only felt like that once really so I kind of see the fantasising as very, very separate from being suicidal. So what kind of brings me to the fantasising about being dead first. I think despair, despair and hopelessness. Um (...) and pain, just fucking pain, horrible pain. But again the older I get the more I am able to stick with my pain...and even though I do believe that essentially I am alone and everything is worthless, as I say, I do fill my time with worthwhile things. But in the absence of worthwhile things um, it can just shock me a bit (MindOut, female, Int. 5:713-723, 726-729).

For others, however, it was the very state of feeling suicidal that was either ongoing or recurred through out the lifespan:

I: Can you tell me about your suicidal thoughts and feelings?

P: Um, (...), um, I have been thinking about it for years really (MindOut, female, Int. 9: 465-467).

The times I have felt suicidal are just that time in 1984 and the make or break time after my very close female friend did commit suicide...And about just under a year ago I felt suicidal (MindOut, male, Int. 2: 495-498).

These two extracts highlight a difference between MindOut members who appear to become suicidal as a result of stressful life events and those who find it difficult to step outside of long-term suicidal ideation. If, as in the second response, suicidal feelings and intentions return at isolated incidents it should not be presumed that people who appear beyond a stage of suicidal risk are completely resilient to the return of such intentions. This is particularly the case for those who have made previous suicide attempts: as the literature tells us one of the most consistent associations with completed suicide is a previous suicide attempt. Rosario et al (2005) suggest that young LGBT people need to be supported beyond the suicide event, as psychological distress can continue into adult life. This should be heeded in the light of the suicidal experiences of participants from MindOut and Allsorts.

Within the MindOut group there were also differences in the consequences of suicidal distress for some group members. For some, as shown above in interview 2, their experience of suicidal distress was underpinned by problems that become more or less acute at different junctures. For other members of the MindOut group the outcome of their psychological distress was clear in their expectation that they would eventually take their own life:

I ended up in hospital and people tried to say to me, you haven't tried the crisis team and you haven't tried the hospital and you know, there

are other things you can do and um (...), but even now I still think it is my only option – I know it is my only option ... I went to a session in a closed group and somebody was feeling really, really down and she was saying how (...) difficult things had been for the last thirty years and um, and I'm thinking, yes I've been like that for at least ten years – I'm not going to spend another twenty years feeling like that (MindOut female, Int. 9: 636-639, 660-663).

The following quote drives home a sense of sheer hopelessness about the future and a desire for death, but no access to the means for a swift and painless ending:

I'm not optimistic about things anymore. I've found that a pessimistic view, or what other people call pessimistic is more often truly a predictor of the outcome... You know one day I will be dead and the world shall go on, as though I had never existed. So, perhaps, I don't know, perhaps my ideas have become more realistic in time, in that I can see my own insignificance in the world and (.....) I've pretty much come to the, the idea that there isn't actually any point in my own existence ... I've only got a sort of primitive instinct to survive that keeps me going really – nothing else. And certainly the only reason that I am here speaking to you now is because I don't have any sure and certain method of killing myself, um, because I'm not afraid of dying, or rather let's say I'm not afraid of being dead at all. In fact, I would like to be if you mean by that the termination of all thought processes and all awareness but I don't want to do something which will result in my being caught in some sort of agonising pain, so, if I had a hand gun, for instance, I would immediately pick it up and shoot myself with it because, you know, I would feel confident in that immediately stopping vital signs and consciousness whereas there is no other means I am aware of will do that (MindOut, transwoman, Int. 6:310-312, 323-327, 344-352).

It is perhaps not surprising to find a greater level of bleak despair in the accounts of current mental health service users compared with a non-clinical sample of LGBT youth who have found a support system through Allsorts Youth Project. It is possible that access to a service such as Allsorts will mediate the re-occurrence of future suicidal episodes for this group of young people, as the value of such projects is apparent in supporting marginalised young people (see Kirby & Pettitt, 2002), and all the Allsorts participants spoke of their suicidal distress in the time prior to attending Allsorts. It is also notable that only one MindOut participant spoke of accessing a youth group, and he was the youngest participant who had grown-up in the local area and had also attended Allsorts during his early 20s. Yet, while the expressed severity of suicidal distress and expectations for the future differed between the groups there were similarities across the two groups in participants' accounts of LGBT identity construction, and in the precursors to suicidal distress through the relationship between discrimination and suicidality.

6.2 The experience of LGBT identity formation

In this section we outline the social context in which these LGBT people formed their identity and the psychosocial pressures they negotiated in order to develop a healthy sense of self. Much can be ascertained about the social-cultural attitude towards LGBT lives from a close examination of participants' accounts of how they came to define themselves as lesbian, gay, bisexual or transgendered, and the perceived responses of their friends and families. Most of the Allsorts participants talked about feelings towards members of the same sex that felt comfortable and positive for them prior to realising that those feelings positioned them as 'gay':

I: Can you tell me about the time when you first thought you might be gay or lesbian or transgendered, or whatever (term) you like to use to define yourself.

P: I was 10 (..) and I fancied my teacher

I: ok

P: And I don't know, I didn't freak out at that point. I didn't realise it was called gay. I thought it was normal to fancy you know the person themselves not, you know, the anatomy but who they are, and it was when I was about 12 really when it really hit me and I freaked out and thought oh crap I am not normal, I didn't like it. My mum tried getting me counselling to say I am not gay... (Allsorts, female, Int. 3: 17-30).

In this extract the participant points out how her emerging desire for a female teacher was distinct from any sense of identity – she fancied the 'person' rather than the 'anatomy'. It was only later that this form of desire became associated with a sexual orientation – an orientation towards people of the same gender - and one associated with 'abnormality'. Homosexuality carries a legacy of sexual perversion from its period of pathologisation and criminalisation during the early 1900s and, even in recent times which provide greater legal recognition for LGBT lives, the fear and stigma surrounding non-conformity remain. This is clear from both the participant's and her mother's reaction that she was 'not normal' and should have 'counselling'. In a similar example a male participant from Allsorts describes the process of associating 'gay' with gay:

I think I've always known [I was gay]. I'd never identify as being gay but I always knew that I fancied males, basically. Probably from about 5 or 6, even younger, I don't know. It wasn't until I was 15, 16 I started identifying as being gay – kind of made that link between fancying men and being gay. Before that ... I didn't really think of it as a, you know, from what it virtually meant it was more like 'that's gay' or 'this is gay', you know, horrible word, so my viewpoint, understanding of being gay, was a bit clouded (Allsorts, male, Int. 8, 23-30).

This participant outlines the way that the word 'gay' has become embedded in popular usage, particularly amongst adolescents, as a term of insult or as a reference for things deemed 'rubbish' or 'lame'. Despite claims from the BBC

that this usage should not be offensive to LGBT people (The Times, 2006), the judgement value that the term passes inevitable impacts on feelings of self worth for people who define themselves, or are labelled by others, as gay. This points to a need for educational policy and policy within national broadcasting to engage with the way this type of language demeans LGBT people and leads to negative consequences, particularly for young people who may not yet have access to positive models of LGBT lives that can counter these. For example, another male participant from Allsorts describes how he attempted to separate his feelings away from his sense of self to avoid the shame that the negative connotations of a 'gay' identity carries:

I knew I had those feelings and stuff but I didn't ever admit or label myself as gay because then I'd be, you know, admitting to what everyone was calling me and that was kind of, that disgusted me – I didn't want to become what they thought I was, that they'd made such a horrible thing out of (Allsorts, male, Int. 12: 97-101).

These types of feelings, sometimes described in terms of 'denial', are frequently seen as the result of minority stress and interpreted as a form of 'internalised homophobia' (Myers, 2003) Yet, it is not surprising that young people resist an identification practice that leads them to become the object of such derision – particularly when there is little effort to challenge derisive practices in mainstream institutions, such as the media. This process is exacerbated by the lack of positive representations of LGBT lives:

I: Can you tell me a little bit about that time when you first came out to someone?

P: Um, (laugh), it was actually my birthday. Um, I don't know why I thought it was necessary then but I think I just really wanted to tell someone because I thought, well I knew she'd be OK with it, but I just needed someone to affirm it to me and say, yes it's OK, because just thinking it over yourself thinking that's OK, that's OK, it's difficult because there are so many mixed messages around like, you see stuff in the press where it is not OK, and I really needed someone to say, no it's OK (Allsorts, female, Int. 11: 17-26).

None of the Allsorts participants described 'coming out' as a positive experience and their accounts were peppered with references to 'confusion', 'shame' and 'fear'. This can be summed up in the following quote:

I: Can you tell me about the first time you thought you might be gay?

P: ...it sort of confused me and I didn't quite know at the time if it was right or wrong. And slightly afraid at the time.

I: In what way?

P: Ah, in the way other people might judge me. Ah, fears of being bullied. Ah, basically people disowning me as well (Allsorts, male, Int. 7: 26-32).

One participant's account differed from the others in terms of stating that 'coming out' "wasn't a big ordeal". However, he highlights a key element for a

narrative account of coming out – that it is an ongoing process and that in each new situation or social encounter, the LGBT person faces a new source of potential rejection if they decide to be open about their identity:

...it was never really an ordeal for me, coming out, it was only probably later on when I came out with my dad that it started being an ordeal (Allsorts, male, Int. 8: 49-51).

Similarities in the process of identity formation were found in the accounts of MindOut participants, alongside some pertinent differences. In terms of the understanding of what it meant to be 'gay' participants also referred to feeling 'confused', 'different', 'afraid' and 'wrong' but more reference was made to closeted sexuality, sexual abuse and the relationship these might have to their ongoing mental health problems.

When I was in my early teens I realised I was gay... In about the second year at school, third year at school and I was aware I wasn't feeling very happy about being gay at that time

I: what made you realise that?

P: No positive images anywhere. Something that was laughed about, joked about. That is all it was.

I: How did that make you feel?

P: Afraid ... I didn't tell anybody I kept it as a secret. It was very important that nobody should know ... I wouldn't even describe it to my diary that I was gay in case anybody read it. I finally did admit it to the diary but it took a long time. I carried it from about the age of 12,13 right through until I was about 20 (MindOut, male, Int. 2: 18-21).

Like some of the earlier accounts from Allsorts members, this participant outlines the social context in which 'gay' is defined in terms of negative images and as a joke – a situation that is as relevant today as it was 30 years ago. In contrast to the Allsorts participants who all came out within a few years of initially exploring their sexuality this account points to an excruciating level of shame felt by the participant such that he was unable to 'admit' his secret even to himself in his diary. These types of fears were also relevant to a second participant who described the impact of a strict religious upbringing and the long-term effect it had on his mental health and ability to 'come out':

I was bought up in a very strict religious family...this was the late 60s, early 70s. So I didn't have much of a sexual education in that regard. I had a lot of friends who were girls but I never looked at them in the same way as I looked at (..) my own friends (..) in that area although as I said, at the same time I couldn't understand why I looked at them differently (..) you know. Why I was aroused by them (...) I thought there was something wrong with me which sort of led to the maybe a start of the mental health problems in the beginning...I became sort of self critical – I thought I was doing something wrong... Anyway I kept praying to God, nothing happened and the more I prayed, you know, I was still having these thoughts ...So for, I would say for most of my

teenage years and (...) for most I tell you I was about in my early 40s, I was a closet (...) gay person (MindOut, Int 4: 26, 37-46, 51-52, 56-58).

Similarly, the following participant shows that despite moving from a position of feeling confused and uncomfortable about her sexual orientation when she was 18 the 'coming out' process has not installed her with a sense of confidence in her sexuality or 'pride':

I probably find it easier to accept that I am gay and a few years ago I wasn't even able to say the word. So, in that sense, yes I feel more comfortable with that. But I'm still finding it extremely difficult to um (...) to talk about it with people ... it does mean being quite isolated and lonely.

I: how do you know who you can trust and you can't?

P: Um (...) well usually I won't introduce myself straight away as being gay. And, um, if they say something that makes me think they are not, um, (...) I mean I might be wrong but if I find these people quite judgemental and um, then I might start talking about some friends who are gay and see how they react to that. Um, and if I hear they are quite critical and not really accepting then, (...) I definitely will not talk about me (MindOut, female, Int. 9: 258-261, 266-272).

The central underpinning category that encompasses all the participants tentative accounts of 'coming out' appears to be fear of judgement – even when their own same-sex desire is not seen as problematic to the participant there is a general expectations that others will judge them negatively and reject them. The social context in which all people learn about which relationships are acceptable is heavily skewed to normative heterosexual formations with few positive models of LGBT lives to aspire to. This inevitably impacts on LGBT people's sense of self-worth and their ability to be 'out' and 'open' in their everyday interactions with friends, family, peers and acquaintances. Furthermore it also impacts on the responses made to LGBT people during the coming out process. In spaces of hesitancy, mis-recognition, shock and/or denial the LGBT person reads others' fear and embodies the rejection, however fleeting, as their own shame. As we have seen particularly in the accounts from MindOut, this can lead to a long-term disengagement with their own sexuality or a close monitoring of that part of their life.

A second difference between the two groups related to sexual abuse. No one at Allsorts mentioned sexual abuse during the interviews. This is not to imply that it was not a salient issue for some of the participants (youth workers at Allsorts report that a disproportionate number of young people exhibiting suicide and self-harm related behaviours and other mental health issues are also survivors of sexual abuse), but it was not something they chose to draw on while discussing their sexuality or suicidal behaviour in the interviews with researchers. In contrast, four of the seven participants from MindOut talked about or acknowledged experiences of sexual abuse during their interviews. For some this added another layer of 'confusion' in terms of working out why they felt different from their peers:

I: Is that when you thought you might be gay? (around 4 or 5)

P: At that age I didn't know what gay or straight or things or anything like that was. I knew that I was different but, being at that age where it is not talked about in earshot, it was a sort of feeling nervous, why do I feel like this and why do I feel that and what's going on about this and what's going on about that.

I: How did that make you feel?

P: Really confused. Really, really confused. It didn't help that my cousin was sexually abusing me as well (MindOut, male, Int. 1: 34, 37-47).

Experiences of sexual abuse can impact on people's subsequent understanding of their own sexuality and sexual behaviour and this can exacerbate any 'confusions' that people might have about their sexual orientation. This is particularly the case while stigma surrounds LGBT lives. Experiences of sexual abuse can also make it difficult to reflect on sexual relationships that exist outside of abusive practices, as the following participant explains.:

I think um, kind of the whole, whole sort of sexuality of any description and sexual relationships was really big, difficult to be for me um because of experiences of abuse. So, I just didn't, didn't go there, you know. It wasn't OK fullstop and I didn't you know didn't want to know. It was a world that was just – very frightening (MindOut, female, Int. 10: 116-120).

This participant outlined how her experience of abuse made any reflection on sexuality difficult for her up until the age 22. At this age she was subjected to further abuse from a woman. After she managed to extract herself from this situation it led to a period of personal distress, poor mental health, reflection and self-acknowledgement of a lesbian identity. It was seven years later before she 'came out' and began to talk to others about her sexuality. She explains the long process in terms of the negative responses from within the mental health system to her earlier discussion of lesbianism:

...I was quite entrenched in the mental health world in terms of living in residential places or having been in hospital or in centres or whatever, um, it was also something that I didn't feel able to talk about um in those settings because as soon as I did um, the times that I had kind of talked about it I'd been met with such sort of um hostility in a way I suppose and people kind of immediately saying oh well, that's a kind of reaction to the fact that you were abused as a child and doesn't mean anything and blah blah blah um, and that just made me angry because, you know, I don't know whether that's true or not but it didn't feel like that was relevant really. It's who I was for whatever reason and it almost felt that they were just adding it to my list of symptoms, do you know what I mean, it was something we would work through and deal with. That wasn't how I wanted it to be so they actually kept completely silent about um, any relationships that I had had, or things that were going on, which was quite hard because it was a big part of my life and

it just didn't feel safe to discuss it because I wasn't up for people criticising yet another thing (MindOut, female, Int. 10: 240-255).

This extract points to the particularly problematic aspect of the acknowledgement of same-sex desire within the mental health system and supports other qualitative reports that found the mental health system to be heterosexist and/or homophobic (King et al, 2003; PACE, 1998). Here the participant struggles to construct a legitimate sexual identity because the sexual abuse she had experienced during childhood was used as an explanation for her lesbianism. This highlights how the subsequent relationship patterns of those who are abused are subjected to particular scrutiny (Reavey & Warner, 2003). But, more than that, it illustrates the legacy of homosexuality as a developmental 'abnormality' that in this case emerged because of childhood sexual abuse. Heterosexism underpins this assumption as there would be no questioning or explaining her sexuality in terms of abuse if she was trying to form a heterosexual sexual identity.

Throughout the accounts we have seen how negative constructions of 'gay' impacted on these people's ability to form a positive self-identity within a heterosexist and homophobic climate and infer that this can lead LGBT people to internalise feelings of low self-worth and shame, alongside fears of physical abuse and/or rejection. The final extract provides one example of how this outcome is exacerbated by institution forms of discrimination, such as within the mental health system. It is this theme of 'discrimination' that is discussed in the next section in terms of how direct and indirect forms of discrimination on the basis of an LGBT identity relate to participants' suicidal feelings and intentions.

6.3 Relationship between LGBT discrimination and suicidal distress

Given the predominant social context of either silence or negativity surrounding LGBT lives researchers have started to point to 'discrimination' as a key element in explaining elevated rates of suicide amongst LGBT people. Discrimination is a broad term and can be defined in terms of legislative or every day practices. We have taken discrimination to include all aspects of behaviour that position LGBT lives in an inferior manner. In practical terms this includes physical and verbal assaults, bullying, failure to recognise or value same-sex relationships, ignorance about LGBT lives and lifestyle that leads to inappropriate questions and assumptions, poor service provision, etc. Recent changes to legislation in the UK mean LGBT people have more protection against discrimination in the workplace (Employment Equality (Sexual Orientation) Regulations, 2003), LGB people can register same-sex relationships through a civil partnership ceremony (Civil Partnership Act, 2005) and trans people have the right to change their gender on their birth certificate (Gender Recognition Act, 2004) However, everyday discrimination works in subtle ways to erode people's sense of self-worth and is frequently embedded within close relationships as well as institutions that are supposed to offer protection and support. It is these types of practices and their direct and indirect relationship to suicidality that we are interested in

exposing here. One participant from MindOut summed up this link between the impact of discriminatory practices and suicide amongst LGBT people:

I think there is definitely a link being doing yourself in and feeling shite because you're queer (MindOut, female, Int. 5: 1138-1139).

The form in which this link took place varied considerably between participants, rather than across the groups. For example, participants from both groups described explicit discriminatory events that pre-empted their suicide attempt(s), some from a very young age:

When I started taking overdoses the depression started.

I: When was that?

About 11. And then I went through school. It was quite a hard time... Horrible, I used to go home and used to try to kill myself" (MindOut, male, Int.1: 180-185, 194).

This male MindOut participant outlined a link between bullying at school and his suicide attempts. Accounts of physical and verbal abuse in school were common within the interviews, particularly from the Allsorts participants and half of them had experienced disrupted schooling. In a second account, quoted at length, a male participant from Allsorts describes in detail a specific event of homophobic bullying that resulted in an overdose:

Basically year 11 was the year when people started calling me gay a lot, queer boy, batty boy all this stupid names... every class I was going to it happening and basically at this time, ah, we were having our mock exams and I just came out of an exam and went to the hall to find out when my next exam was going to be and ah, there was a group of people from my actual form who started with the name calling and that, and (...) some of them was slightly pushing and shoving, not great physical abuse or anything, mainly verbal abuse, but I was just trying to concentrate on my exams at the time and to have someone do that, it really got to me and (...) I felt, at the time, I felt I could stick up to them because so many of my friends said if someone does that to turn around and hit them and they'll go away and (...) I went to hit one of the lads but I just couldn't bring myself to do it and of course it just got even worse – they started more of the name calling, laughing at me and I kind of felt humiliated and ashamed... and I ended up running out of school and went home and I thought the only way of not having to go back was basically to kill myself and I basically took I think 56 tablets, mainly paracetamol but I was on anti-depressants at the time as well and I took of few of them and basically whatever tablets I could find in the house" (Allsorts, male, Int. 7: 383-406).

Here again we see the impact of feelings of shame in relation to the suicidal event. Adolescence is a time when young people are attempting to establish independent identities. Despite his desire to solve the problem this participant was unable to defend himself, or cope with the behaviour of people in his 'own form' in a way that he felt he should be able to. Here, we see how sexuality

itself is not the issue but rather it is the perceived failure to cope with homophobic bullying that heightens the participants 'humiliation'. The resulting response is an attempt to take his life in order to avoid returning to the same situation, and escape feelings of shame.

For the participant who identified as transgendered physical and verbal attacks were almost commonplace in her narrative. After a brutal physical beating while living in B&B accommodation in London she decided to move to Brighton:

Well the last time I did try to kill myself was after I moved to Brighton, which was three and a half years ago. You see I naively thought that now I had left London and the heart of darkness, I thought that I would be safe – now that I was in Brighton. You know, I thought well this is the pink capital and I had been here just about 10 days and I was walking along Western Road in daytime and these youths came up and they just snatched my wig off the top of my head and they just ran off with it. You know, and when you think the wig cost £150 just a few days before, you know, then I was seriously upset, you know, and when I complained to the Police then there was the usual lack of interest in doing anything about it. You know. And then I realised I wasn't safe in Brighton and that I was never going to be safe again for the rest of my life. It might be much worse in London but the fact is that it wasn't safe in Brighton and that had been clearly demonstrated to me and therefore I was never again going to be safe so I thought well, I am absolutely worn out with all this and its never going to get any better, not in my lifetime, you know, and um (...) so yes, I decided to kill myself and I took a liberal amount of ah (...) one of the anti-depressants – I have forgotten which one it was – and but ah (...) somehow or other I was found and ah resuscitated (MindOut, transwoman, Int. 6: 616-634).

The emotional impact of this event is palpable. Not only does the participant experience the humiliation of having her wig torn from her head, it also shatters her dreams of building a new life – a liveable life – in a city that has an international reputation as a good place for LGBT people to reside. Again, the suicidal response is not the direct result of some pre-existing inner turmoil about her transgender status, rather it is the result of accumulative abuse that destroys an already withered sense of security, and a realisation of a complete lack of support from services she imagined might be there to protect her. This was a central concern for this participant as the discriminatory practices she experienced frequently took place in public and little support or understanding was subsequently available from public services, such as the police, housing or health services. For instance in the hospital after the suicide attempt 'one consultant asked me if I hadn't bought all this upon myself by choosing to go out wearing women's clothes' (641-642).

For most of our participants suicidal thoughts and actions were bound up in their experiences of the negative construction of LGBT lives rather than as a response to one particular event, or individualized distress over their identity

status. The factors discussed included relationship breakdown, homelessness, verbal/physical abuse, parental shame and the 'double stigma' of LGBT identity and ongoing mental health issues, and were tinged with accounts of homophobia, transphobia and heterosexism. For example homelessness arose for several of the participants because of the abuse they were encountering in the place they lived. In this extract the participant describes a transphobic assault that led to her leaving her accommodation:

I moved to Brighton and I was a homeless person in Brighton because I had to abandon everything. After the last time I was very badly beaten up these youths had stamped on my head, um, then, um, when I got out of hospital I just got ah two suitcases and threw what I could into them and I just got a one way ticket to Brighton (MindOut, transwomen, Int. 6: 517-522).

One of the Allsorts members describes the verbal homophobic abuse that occurred within his home from a father who he described as an alcoholic. This resulted in him staying away from home as often as possible, preferring to stay with strangers rather than return to the place he lived:

To begin with it was things like, oh is your bum sore, do you know what I mean, if I came home from Brighton, or, or been out with somebody or something – just little things like that. Then, obviously over time, he was an alcoholic as well, so obviously those comments would become more, more frequent, and you know, that led on to you know real emotional things and ..

I: like what?

P: ..big arguments and um it's a whole multitude of things – me staying away from home nights at a time and going for weekends away with random people. And just trying not to be there when I knew he was going to be there and when he was drinking to avoid any, you know, comments or arguments (Allsorts, male, Int. 8: 127-138).

This participant had moved from a Northern town after the break up of a relationship and had hoped to establish a relationship with his father who lived in the south-east. His father's response to his sexuality could be explained as homophobic, although the participant provided multiple reasons including alcoholism and political views as a way of explaining and tempering his actions. However, the final impact of these factors related in a suicidal episode:

It was just all the words, the comments, the nastiness, the bitterness, ... I'd just moved here, I didn't know anyone, I didn't know what I was doing here quite frankly. I think it was all that confusion amongst everything else that made me feel really unsure and suicidal (Allsorts, male, Int. 8: 384-387).

Relationship break ups were mentioned by several of the participants in the build up to suicidal episodes, particularly in terms of the support that was offered in their aftermath. For example, a male participant from MindOut felt

let down by the lack of support he received from his friends after his relationship ended:

I think part of why I felt suicidal is on the back of the fact that people don't really see gay relationships as significant (MindOut, male, Int. 2: 528-530).

In the changing legislative climate with people now able to register their same-sex relationships this may lead to a shift in public attitudes and greater recognition of their comparable emotional significance. Yet, the failure to recognize significant relationships often comes from within the immediate family and can heighten feelings of alienation and distress. For example, a male participant from Allsorts describes his mother's 'accepting' response to his sexuality:

I came out to my mum ... I think the first thing she said, oh I hope you don't move in with any men. I think that was the first thing she actually said. And, if I remember correctly I think she said, I don't mind but I don't want to have to hear about it basically. So she, she, she accepted in a sense but just didn't want to, you know, get into any details – she didn't want to know if I was going out with somebody or who I was going out with or what bars I went to – any details you know (Allsorts, male, Int. 8: 86-93).

If we reconsider how fear of rejection emerged as a theme in the coming out narratives we can understand why this type of response might be seen as 'accepting' - it doesn't emit horror or evicts the young person from the parent's life. However, it does silence and marginalize that person as it fails to recognize the centrality of sexuality, in terms of their identity, relationships and social life. If parents send a message that says 'I don't want to know about the details of your life' the son or daughter can feel alienated, unrecognised and lacking in core emotional support. This might be particularly hard to deal with in adolescence when they are less likely to hold other well-formed identities that are separate from their parents and that can maintain a sense of self-worth in the face of family disengagement. A negative response from parents can be understood in relation to their own sense of 'shame' that their child has breached cultural expectations and is therefore not 'normal'. These types of responses might emerge initially whether or not they have prior experience of LGBT lives through their own social networks and illustrate why 'minority stress' is a significant issue for some LGBT people. But, while parents should be aided in their own adjustment to the future trajectories of their children lives and their expectations of them, their early responses can have a profound effect on how young people make sense of themselves. As one participant from Allsorts describes:

...my parents aren't so understanding [about my sexuality]. Because they weren't brought up with it, so they are just like, they don't see it as being (...) not necessarily normal because my mum is like it's normal, it's fine, there's nothing wrong with it, but she has expectations of her kids growing up, meeting someone, getting married, having kids, big

house, everything – that is the vision she had um I have not done that so kind of the disappointment in the family I suppose, in some ways (...)

I: do you feel like a disappointment?

P: I have let her down (...) in her sense. I haven't let her down I know that because I'm not exactly doing anything wrong, I am just being me ... she does accept it, she just wishes it was a different way (Allsorts, Int.3: 153-166).

This is a pertinent account as it illustrates the difficulties some young people experience negotiating a positive sense of self in the context of relationships with parents and other family members who they feel they may have 'let down'. Disappointment and shame are easily read, despite the best efforts of significant others to be accepting, and these will inevitably impact on LGBT people's struggle for recognition and self-worth.

Other participants also pointed to negative reactions from friends who were embedded within support structures of 'the church'. The impact of the church upon development was particularly strong within the accounts of MindOut participants who made references to how religion constructs same-sex relationships as 'wrong':

Some of my close friends knew and were very very anti and basically told me, you know, that it wasn't OK and I had to um, had to kind of get over it and a couple of friends, um church friends, told me that they had been in same sex relationships and um, had realized that it wasn't OK and had kind of sorted it out and, look at me now sort of thing and I was kind of, oh man (MindOut, female, Int. 10: 151-156).

This extract acknowledges a particular position within some religions that same-sex desire offends morality and is a behaviour that can be modified. Growing up in this kind of environment can have profound long-term effects on mental health as the result of being indoctrinated into one belief system that others might interpret as discriminatory. As another MindOut participant explains:

I was bought up to believe that these things [same-sex relationships] were sinful, immoral (.....). So that was it, you know. Looking back on those years I think it has created a lot of (...) anxiety and, OK, it is easy to generalize and to paint all Christians with the one stick, or one brush, but my experience as I have found especially evangelical Christians as very narrow minded, bigoted (MindOut, male, Int. 4: 135-140).

Participants did not suggest that religion be totally discarded as a form of social support for LGBT people (one of the Allsorts participants spoke of the positive response he had received from his church in relation to his sexual orientation), but responses provided support for the widespread assumption amongst many LGBT people that religious practices are likely to discriminate against them. This theme emerged in several of the MindOut interviews as they attempted to live the 'contradiction' between being religious and being gay:

There was one guy I remembered, he was in the church I grew up in and I hadn't seen him for about a year or more before that and he recognized me and he was walking out the door and he saw me and I heard him say to his mates, "Gee, I thought he was Christian". And I thought to myself ... that's their attitude, you know. Gay people aren't Christians, you know. There is something dirty about it (MindOut, male, Int. 4: 152-157)

This contradiction was experienced most acutely by a female participant from MindOut who received unprecedented support from her religious friends for her mental health issues and yet felt profoundly rejected on the basis of her sexuality:

The people that are the most anti my sexuality are the people that basically kept me alive when I was really ill, who were there when I was suicidal, who um gave me somewhere to live when I was homeless and, you know, took me out of hospital and stuff for kind of three, three or four years basically where my family, my care givers, whatever went through hell and back with me and then it's like, I felt like I'd really kind of kicked the boot in because I'd gone and done the one thing that they were so adamant that I shouldn't do and wasn't OK – um (...) but it felt quite odd because the thing they kept telling me was that they were trying to show me I was OK and that they, um, despite all my experiences growing up [abuse] and stuff, that actually I mattered and that you know, they were going to stick by me and whatever but when it actually came to it, when I was really truly, they wouldn't accept it at all (MindOut, female, Int. 10: 180-192).

What this extract points to is the 'double stigma' that many of the MindOut participants have to negotiate when they frequently experience discrimination on the basis of both their mental health issues and their sexuality. Even if they felt supported on one account this was often undermined on the basis of the other, as this participant demonstrates. She goes on to interpret her family's response to her mental health problems and her sexual orientation in terms of shame and disappointment, as her sexuality was seen as an additional point of failure. More than that she also points to the stigma that comes from having a mental health problem within the LGBT community and the difficulties that result in forming relationships with other people:

I think, um, it feels quite hard to know how to meet people and have a relationship that's normal in some ways just because I've existed in the mental health system for so long and although I'm no longer um in it in lots of ways, um, I bear, you know, the scars of it and a big gap in my life is gone because of it and a lot of people, um, are really prejudiced about that, whether you like it or not, you know. Um, they think you're great until you take your jumper off and they see your scars [from self-harming] and suddenly they don't want to speak to you anymore and you're not quite, you know, you realize it's not um, you know, my mental health record it almost brings with it more prejudice in Brighton than my um sexuality would (MindOut, female, Int. 10: 332-341).

For others at MindOut their experiences of stigma were also more grounded in their mental health issues and the isolating effects this had. For example one participant spoke of the impact of depression on forming and maintaining relationships, while a second discussed the impact of their mental health on their ability to find employment. Stigma around mental health was less apparent in the Allsorts interviews as the participants were less likely to interpret their experiences in relation to ongoing mental health problems. However, one participant acknowledged his fear of being 'sectioned', and the implications of being labeled within the mental health system as a reason for not discussing his suicidal feelings with anyone, including his GP:

P: ...I was quite aware that if I said I was feeling suicidal he [GP] might section me and this that and the other ... I just didn't think it would help the problem at all because I knew that if I got taken away, or got sectioned or anything else, it would mean that I would still have to go back eventually and it would make it so much harder to come out of it again.

I: You'd have to go back where?

P: To my dad's

I: So what does section mean to you then? Why was that?

P: It just sounds horrible (laughs). Um, being taken away, even though I wanted to disappear I didn't want to admit to being mental, if you like, or depressed or suicidal or anything else really. I think I just didn't want to admit to it at the time. It was only when I realized that I could move away that I started telling people at Connexions [support service for 13-19 year olds] about what was going on – I felt really depressed, etc. But I don't think I ever admitted that I was feeling suicidal (Allsorts, male, Int. 8: 628-652).

One of the government's targets set out by the *Department of Health* is to reduce the number of deaths through suicide. Yet in this account GPs, as front line health providers, stall at the first hurdle in supporting suicidal individuals by not being able to offer an accessible service to discuss mental health difficulties because of the stigma that silences people. This participant's suicidal feelings developed in response to the verbal abuse he was experiencing at home, yet the extract illustrates how the stigma that surrounds being constructed as 'mental' is so resounding that it prevented him from seeking help. Moreover, it demonstrates that this is because the response from the mental health system would be to locate his suicidal distress as a problem within him, rather than as a response to the social situation in which he found himself (living with an abusive father). The implication of this would mean that the source of distress would not be removed, because once he was released from hospital he would have to return home with a label that would make it even more difficult to form an independent existence. Thus, it was only once he realized that he could find a way out of the situation himself that he felt confident to begin discussing his depression, although not his suicidal feelings, with people that could assist. Other young LGBT people may not be so resourceful.

In this section we have looked at the way discrimination impacts on LGBT mental health and have presented a case that suggests that suicidal distress is not the result of inherent individualized problems, but is the response by some LGBT people to institutionalised discriminatory practices – perpetuated through education, health, religion, media and the family. In the next section we look in detail at the influences, strategies and resources our participants drew on in order to cope with their suicidal feelings and intentions in the hope of making recommendations that can promote survival within LGBT communities.

6.4 Strategies and Resources for Survival in LGBT communities

Participants described a range of strategies and resources that they drew on in an attempt to survive their suicidal thoughts and feelings. These are discussed in terms of self-attributes, interpersonal connections and service provision. It is argued that effective suicide prevention strategies need to promote resourcefulness in all of these areas.

6.4(i) Self-attributes

In line with suicide intervention strategies that remind us that there is always a small part of some one that wants to live (e.g. ASIST), some of our participants explained their survival in terms of their own choice to live:

P: ...I could identify, not straight away but six months after my friend died that I was having this big struggle with my life. Was I going to go as well? Because my life had been a struggle. It has always been a struggle. And I chose to live.

I: Why was that. Why did you feel able to do that?

P: There is a lot about life, a lot about being alive I do like. Got passionate interests. (MindOut, male, Int. 2: 441-448).

Despite conflicting emotions defined in terms of a 'struggle with their life' this participant presents living as an active choice. Survival is not about being rescued or saved by others but as something that emanates from their own ability to tap into the aspects of life that they enjoy. In a similar fashion a second participant from MindOut also constructs her survival in terms of an active will to live:

I: How do you cope during these, and during that time when you wanted to take you own life, you wanted to kill yourself? How did you really cope during that time?

P: ... Um, I just kept reminding myself that I wanted to, I have an absolutely impeccable will to live, um and I purposely stay in this world because it's funny and I love it. I have a bath – um water is really grounding for me, um and often if I'm feeling really down the sooner I can get in the water the better um so I went in the bath and I stayed in the bath for quite a long time. And fair enough I was fantasising about cutting my wrists in the bath but I didn't – I kept kind of, I kept kind of thinking about this impeccable will to live. But yeah, I use my water

grounding techniques, I use breathing exercises that I have, um I cried a lot, I talk to my, I have like a rabbit – not a real rabbit like a teddy I guess, but a rabbit. We did have quite a lot of conversations that night. (MindOut, female, Int. 5: 942-957).

Alongside resources attributed to self-determination this participant describes a range of strategies that are used to moderate acute symptoms. The distress is still apparent in her account of ‘fantasising about cutting her wrists’, but ‘water grounding’ and ‘breathing exercises’, as well as ‘talking’ and ‘crying’, are cited as specific techniques for regulating her suicidal affect. These types of techniques were more frequently described in the accounts of participants from MindOut than Allsorts. This difference might be because MindOut operates as a support group with a greater focus on suicide prevention than Allsorts, but accessing routines that work for individuals were important in the accounts of participants from both MindOut and Allsorts:

I trained myself not to be hard. I sort of trained myself to do these things. To survive, you know what I mean. It was all about survival. And again, a routine of aah your way of surviving, and you find what works and just go with it, you know (MindOut, male, Int. 4: 231-234).

The only thing I can think of, ... it's just the fact of getting a routine going again. Finding something structured that you can just stick to so even when you are feeling crap, at least you're doing something (Allsorts, male, Int. 12: 676-678).

Both these participants pinpoint the need to establish a routine and find activities and techniques that are individually relevant and important to the suicidal person. In the final extract in this section a female participant from Allsorts demonstrates how her focus on music has a transformative effect on her emotional well-being to the extent that she had not harmed herself for over 2 years.

I've still got some scars on my arm and it says "why" and it means why am I not dead, why have I kept myself alive. And it is because I have a guitar and drums whatever. I have some music life in my life and it just kept me from hurting myself more I suppose. I am glad that I have that on my arm because I can look at it now and think I don't need to do that anymore (Allsorts, female, Int. 3: 338-343).

While many of the participants spoke of either their own strength of self or of their individual strategies for alleviating suicidal distress, self-efficacy was not the most dominant theme within the interviews. Rather, the dominant theme across all the interviews was the need to ‘connect’ or ‘feel connected’ and this is explored in detail in the next section.

6.4(ii) Interpersonal Connections

Connections were constructed in multiple ways but always with the intention of establishing a sense of belonging and reducing the isolation that was clearly linked to suicidal distress. Despite two participants (1 MindOut & 1 Allsorts) describing their family as supportive of their mental health problems, no one mentioned family or family members in terms of a resource for reducing feelings of isolation or suicidal thoughts and feelings. The need to feel connected to others was discussed in relation to 'talking' with friends and professionals as well as through accessing different support groups, in order to 'know that others cared'. For some this was the key difference in terms of survival. For one MindOut participant feeling connected worked by just being around other people in a simple activity such as being on the bus:

I: ...what are your coping measures on a day-to-day basis then?

P: ...Um, riding the buses, I get a bus ticket, I've got a cheap bus pass, get a bus pass and just ride the buses for as long as I need to so I can be around people, therefore I'm not isolated but not have to have any emotional contacts with people – that's been an absolute lifesaver ... just feeling part of something, even though I don't have to be an active part, I'm part of something bigger than me, and um yeah being with people therefore not alone, so that's been quite cool (MindOut, female, Int. 5: 989-998).

All participants mentioned 'talking' as central to feeling connected and alleviating suicidal feelings, yet there were different preferences amongst participants for talking to someone they knew or someone they didn't. For example, one participant found talking to *The Samaritans* useful, while others did not. This varied in terms of whether people were looking for immediate support with a situation or whether they were requiring some form of authentic connection to dissipate acute feelings of isolation. For example, a participant from Allsorts describes how useful he found speaking to a counsellor after his suicide attempt, rather than someone he knew who might be overly connected to the situation in which the suicide attempt arose. This highlights how for him 'talking' was seen as important in terms of finding perspective on the situation that precipitated his suicide attempt and learning that by discussing his worries he might have avoided the overdose:

I: What helped you at that time?

P: At that time the counselling sessions were quite supportive...I knew he [counsellor] knew nothing about me, he knew nothing about what had happened – so it was easiest to tell him what went on and how I was feeling because I knew that he wasn't connected to the school, he didn't know any of my friends, he didn't know my family and he, basically I knew he wasn't going to say anything to anyone. I found that a lot easier to get my feelings out in the open.

I: Why was that then? Why were you able to talk to him as a stranger?

P: I find personally, if someone is connected to the problem, or, is, either your mum, or parent or teachers or anything, they are sort of in that environment and they are sort of already involved and sometimes I

can feel that if they are already involved, if you tell them they can sometimes take a biased opinion whereas telling a complete stranger who knows nothing about you, nothing that has gone on, when you tell them they're just gonna, they just listen to you and (...) it enables basically yell it all out and get everything out of your system that you have wanted to for ages but you haven't had a chance to and personally I felt that was a positive thing for me – just getting it out. Because I'd been keeping it bottled up – I hadn't bothered telling anyone and by not telling anyone, which is one of the main reasons I probably took the overdose because if I'd told someone before then it might have helped me and if I had told basically someone before about how I was feeling, I might not have felt basically suicidal at that point. I wouldn't have had it all bottled up inside me.

I: So you said it was easier to talk to strangers. When you were bottling it up were you looking for people to tell or...

P: At the time I sort of, I think I was and I wasn't. I didn't (...) know of anyone I could tell at the time and I didn't want to tell anyone that I knew personally at the time basically I just (...) was, I was sort of worried that they if they thought I was being bullied because I was gay, they might think I was gay too. And, (...) I just sort of was trying to deal with it in my own way as well, I was trying to deal with it without dragging other people in. Because, at the time I think I saw it as a positive thing, whereas now I sort of realise that was a negative thing to do – to try and deal with it myself where really deep down I knew I couldn't. And, basically at the time I said I was seeing it as a positive thing, I thought I was being a big strong person – basically if I could sort it out, I didn't need anyone to help me sort of thing. And, when I look back at it now, I was like, it was a kind of stupid thing to do because by doing that, it just brought more weight on me and basically more pressure on myself. And, I think now, if I hadn't done that and kept it to myself then I might not have taken an overdose – I might not have felt suicidal (Allsorts, male, Int. 7: 419-465).

This extract has been quoted at length because it demonstrates several important points. First, it highlights the limitations of relying on personal attributes for avoiding and intervening in suicidal distress. This participant shows that people's self-attributions are not always accurate in terms of recognising what we are able to 'deal with'. He clearly outlines how he thought coping with the situation 'himself' showed 'strength' yet it brought 'more pressure' to the extent that he attempted to take his life. Thus, while we outlined in the earlier section that self-attributes are drawn on by participants to account for one resource in promoting survival, an over-emphasis on individual characteristics can be debilitating and serve the opposite effect. Secondly, this account is a pertinent example of the challenge to provide a safe environment in which young people can discuss homophobic bullying when they may not be able to discuss ideas about their own sexual orientation. This participant is reflecting from a position after coming out and is now reasonably positive about his identity as 'gay' having told his family and feeling connected to other young gay people at Allsorts. However, his account illustrates how the homophobic nature of the bullying he experienced at

school (as discussed earlier) restricted his ability to ask for help from any of the usual support structures for adolescents including teachers, family and friends. This is because he feared those he asked for help might also perceive him as gay – and they might also reject him. This suggests strategies that try to get young people to talk to others if they are feeling suicidal may not work if the reason they are feeling suicidal is unspeakable: as in this case where he is silenced because he is being bullied for being ‘gay’ and he worries he might be that very category. This account of needing to reach out to speak to someone requires confidence that they will receive a positive and supportive response from the person they turn to for assistance, as this participant did with his counsellor after the suicide attempt. Thus, to promote this type of action it requires a public acknowledgement that homophobic and transphobic bullying is unacceptable and that staff, pupils and parents will support young people irrespective of their sexual orientation.

In contrast, the following participant, who spoke openly about her eventual intention to talk her life, acknowledged it was connections with people she met through MindOut that had kept her alive by diminishing her acute sense of isolation and providing a sense of belonging:

I: What do you think has been the main things that have kept you alive?

P: People really. ... I mean last year was really really horrible and um, and then I started to come to MindOut and really it is one meeting a week when actually, as I said, I was really isolated – I could spend weeks without seeing anybody ... I guess what really helps me is um (...) is, knowing there is a place that I can (...) talk about how I feel with other people and actually with people who have, have, really understand, have been through the same thing and I have tried to phone the Samaritans before loads of times, especially at night, but its not the same really (laughs) (...) One because they don't know you and two because (...) what makes a difference to me is listening to other people and when you talk to the Samaritans, um, they just let you talk about how you are feeling. They don't necessarily give you sort of (...) I don't feel that I can connect with them because I don't know who's at the other end of the phone and I don't know whether they've experienced (...) being depressed or being gay or whatever it is and, they might not have any experience at all and, um, (...) and um, sometimes it's just meeting up for coffee and seeing somebody during the weekend and um, just feeling there is somebody there. Um, (...) and, (...) and I think what made a difference as well is the people I met here um, (...) because it's not only that I felt that I was lying about my sexuality and everything, it's also that I've never felt that I've fitted in (...) I'm not, you know, I said I'm not into clubbing and I'm not into, if you're not into the gay scene then it is really difficult to meet other people who are gay (MindOut, female, Int. 9: 673-680, 732-751).

This participant highlights the importance of ‘people’ in order to reduce her feelings of isolation. However, her isolation had been so acute she was not in

the position to go out and meet people by herself, resulting in weeks passing without seeing anyone. Yet, meeting 'people' in general is not a sufficient intervention into her suicidal distress. In order to feel connected she outlines the importance of both talking and listening to people that reflect and empathise with her experiences of mental health issues and non-normative sexuality. In this sense MindOut played a key role in facilitating connections that result in the ordinary and mundane friendships of the type that 'involve meeting up for coffee in the week' and can mean the difference between life and death for those without previous access to them. Thus, while interpersonal connection was the dominant theme within the interviews these were not necessarily connections that could be fostered on an individual basis. Both of these extracts pinpoint the importance of finding connections and a sense of belonging through services that can meet the needs of LGBT people in terms of mental health provision and understanding of sexuality and transgender issues. In the first quote we saw the need for LGBT sensitive, yet not specific, services and in the second we saw the important role that LGBT specific services play in creating the necessary connections between people who are isolated and marginalised from what is widely conceived as the 'gay scene' or LGBT community.

6.4(iii) The role of services

In this final section we focus in more detail at the role of services in supporting LGBT people who experience suicidal distress. Participants discussed a range of services including statutory mental health services, housing and fostering services, voluntary sector support groups and, unsurprisingly, the service they received from the group they were attending. There were also marked differences between the type of support sought by members of MindOut and those at Allsorts. For example, statutory mental health services were not mentioned by Allsorts members who were more likely to discuss experiences of counselling – which were found to be useful and spoken of positively. In contrast, MindOut service users had far greater experience of statutory mental health services. Some members acknowledged the positive impact of these services in terms of medication and providing a routine, particularly through day care hospital visits, but others provided a more negative account of the care they had received. One problem was actually being able to access the appropriate form of support through the GP:

P: I've seen quite a few GPs who – he was easy to talk to but their advice was basically to have a nice bubble bath in the evening (LAUGH) and you'll get better the next day.

I: So they didn't try and put you on anti-depressants at all?

P: Um, no. And um, then I (..) then I came to Brighton and (..) it was really getting worse and worse and I found everything so difficult to do and (..) I was just really scared – I just, I couldn't do it anymore. I just felt that I'd been like that for years and um, (..) I went to see the GP again and I said that I needed to talk to somebody, um. He told me that the waiting lists to see a counsellor was really long and it was probably best if I was if I went to see somebody private, which I did. And um, I started to see her about two or three years ago, um, (..) I'm not quite

sure that it helped me understand or change anything but it was just somebody that I could go and talk to once a week and (..) sometimes I could spend weeks without talking to anybody so she was really the only person that I would have and um, (..) and then she's the one who (..) who was a bit concerned and she talked to my GP and said that I would probably need some help and ah, (..) they put me on anti-depressants and (..) um, and I was feeling quite suicidal really and um, they then sent me, referred me to a psychiatrist (MindOut, female, Int. 9: 581-602).

This account demonstrates procedural issues in finding appropriate support within the mental health system. Another participant reiterated this concern in her account of the time it took to see a specialist after a suicide attempt as well as pointing to the lack of continuity in care and over emphasis on diagnosis rather than treatment or care:

P: [After a suicide attempt] I spent a few days in a general hospital and then I spent a week in Specialist Mental Health Hospital and (..) where it was pretty much made clear that the NHS didn't have anything to offer and I went back to out-patients appointments there a few times. Each time, well perhaps three or four times, each time there was a different person so there might have been continuity of paperwork but there was no continuity of care, there was no, you know, there was always a new SHO on each occasion...And they they firmly confused making assessments with treatment. You could go along, you know, you could go along to your GP and say I can't bear it, I don't want to live another minute and they would say well, we'll have to refer you to Specialist Mental Health Hospital so you then start dying of referralitis, you know, three or four months down the road you will get a letter saying you've got an appointment in three months time, so if you are still alive after six months, then you will go along and see somebody, who will make an assessment and that'll probably be it... Anyway, after approximately six months in total, I sort, I went to see the psychiatrist and (LAUGH) then he described Diazapan, Valium, right lasting 3 days, so it was almost as though the intervening period of 6 months, you know since I had had this severe panic attack (..) as though it hadn't happened, you know, as though he was giving me the treatment I should have been given (LAUGH) six months earlier. And I thought that was bizarre really, and (..) um, one of the reasons I suppose that I I feel (..) – on one hand you can look in med –lines and so forth and you can see wonderful research being done all over the place, you know, and how people have benefited from this treatment and that treatment but then the reality is you don't get any treatment here (MindOut, transwoman, Int. 6: 634-669).

Prompt access to mental health services and continuity in care would seem to be particularly important for the suicidal individual given the underlying need to form connections. Moreover, a mental health service perpetually in a process of assessment and diagnosis, rather than treatment and care, can only be failing those individuals that become reliant on its services. These are

generic issues for all patients of the mental health system and require review if the government is to meet its targets of promoting better mental health and continuing to reduce the number of deaths through suicide. However, as in previous studies (e.g. Pace, 1998; King et al, 2003b) some of our participants also spoke of abuse and homophobia or transphobia within the mental health system. For example, the following participant provides a damning account of the mental health system and her experiences within it, presenting it as a key factor in the perpetuation of her poor mental health:

P: ...and it was the mental health system I think that was just making me worse and worse and worse. Um, some of the things I experienced in within hospital and within the mental health system are absolutely horrendous. Um,

I: Like what?

P: I was abused by a psychiatrist when I was in hospital. Um, and as were a lot of other people and it has never been something, a couple of people have tried to um prosecute but because of labels of psychosis, because of drugs being given, blah, blah, blah, blah, you know, nothing's ever been, people have been dragged through the through the mud basically, their lives thrown back at them and ah, ended up in an even worse place than they were before. Um, just, don't know, like to have no, I think it's a huge shock to suddenly realise that you don't understand what's going on in your world – your world's just completely, doesn't make sense anymore and that you've got and that you've been sectioned, that you're being held in a locked ward in a hospital with someone watching you the whole time and you've got no rights any more. You can't even, you know, go to the toilet on your own. Someone standing there all the time and um, you know, you're not safe, you're not being looked after, you're being drugged to the hilt – every time you try and um, kind of have an idea or advocate yourself, it's just, just added to, it's like a symptom, you're being aggressive, you're being, you know, paranoid, you're being delusional, whatever and it's a load of rubbish – that's not what you're doing at all actually. You're trying to kind of, if people knew what was going on, but it was one big cover up the whole way through. Um, and if people thought you were getting too kind of clever if you like, they'd just drug you. So, it paid to keep your mouth shut (MindOut, female, Int. 10: 768-794).

This extract points to the damaging effect power differentials in the mental health system can have for those who are already in a vulnerable position and lack proper protection. It highlights psychiatric practice at its worst when it can be used as a form of social control since once somebody is placed within the mental health system any attempt to resist is interpreted as a symptom of the mental illness (Rosenhan, 1973). This has profound implications if a patient's attempts to prosecute for abuse are dismissed as 'irrational' because of the stigma that surrounds diagnoses of mental illness or disorder. Yet, this participant also experienced the effects of what she described as failures in accurate diagnosis by the attribution of her mental health problems, at discharge, to a relationship she had been having with a woman:

P: I was discharged from the mental health system, um, just over a week ago now, two weeks ago and even though I've got a history of six years of um, pretty severe kind of mental health stuff going on, the psychiatrist told me at discharge that my problem had obviously been a relationship that I was in in Brighton, with the woman that I was with, and that um, ending that relationship had obviously meant that now I was well again and that was my problem. It was a lesbian relationship that had made me ill, which is just a load of bollocks because you know, I was ill for years before I even knew this person existed let alone was in a relationship with her. But that, that's what it will say on my discharge, you know - cured by ending relationship (MindOut, female, Int. 10: 741-751).

Thus, it was not surprising that MindOut, and other voluntary mental health services, were constructed in an altogether more flattering light by the participants as crucial resources that helped them recover from their experiences with in the mental health system, in an environment that was positive about LGBT lives and helped them make crucial connections with other LGBT people. For many MindOut members this role was life saving. Allsorts' members also spoke highly of the role that their youth group had played in facilitating connections and friendships with other young people who identified as gay, generating a sense of community and providing them with a forum where they could discuss their own issues as well as contribute their views in a recognised public community forum (through a range of initiatives including this study). Some members also discussed other local services that were necessary for them to become more settled and secured. These services included Housing Services and the Albert Kennedy Trust fostering service. Several Allsorts members had experienced periods of homelessness, and one participant had been fostered by a lesbian couple:

I: What about, you're with foster parents now, how are they about it [sexuality]?

P: They're actually an LGBT thing – so um, they're a lesbian couple so it's all kind of really, everything's fine, it's really good. It does help sometimes when you come back and it's just (SIGH) had a really bad day, loads of people have been really homophobic or I've overheard some people being homophobic and that was annoying, so that's really good. (Allsorts, female, Int. 11: 105-111).

This extract demonstrates the positive effect that fostering by same-sex couples can have for young LGBT people. Myers (2003) detailed the impact of what he describes as 'minority stress' on young LGB people in particular. Here, the participant describes how her foster parents are able to help her deal with homophobic comments. Although it is an understated acknowledgement no other participant discussed going home and talking about homophobia with their family illustrating that lesbian and gay carers or mentors can provide a positive option for young, homeless LGBT people by providing supportive home environments and, to some extent, relieving the impact of 'minority stress'. The Albert Kennedy Trust was also mentioned by a

second participant who reported a less positive experience as he was not successful in his application to be housed with foster parents:

P: the second time that I went into hospital (after a suicide attempt) was a lot to do with the Albert Kennedy Trust. Um, when they said they were unable to be helped because I had signed a tenancy agreement compared to this other person, ...and their circumstances were nowhere near as drastic as they made out and I just think that it kind of defies their whole aim as a scheme to help young gay troubled teenagers if when they've only been operating in the city for a few of months and they only have one couple on a process that takes over six months – I think it's actually a year to vet a couple to get them ready to have them live with them, for them to come into a city, only just set and then get involved with people. I mean, of course I wasn't expecting everything to be alright with it and things like that but I just wished they'd sort of appreciated the fact that they weren't really equipped to deal with my problem, yet they took me on and in a sense I do feel I was given false hope ...all these wonderful things were spoken about and then the reality of it was they had one person who visited this place kind of every few months and one couple and god knows how many teenagers. And it's not fair for teenagers to have to compete on how drastic their situations are just for couples. I didn't want to be put in that position where I almost felt like I didn't deserve it or something like that. And to be honest I think like, I know so many young people who come here [to Brighton] and are moving about and having difficulties and a lot of it's to do with having to leave home and things. I think a lot of the problems to do with suicide and things is having nowhere to go, no-one you feel safe with and I think that does relate largely to housing (Allsorts, male, Int. 12: 751-780).

Here the participant describes his disappointment that he did not get housed with foster parents, and provides a typical picture of a voluntary organisation with good intentions that lacks sufficient funds and resources. However, he also suggests that for many young people housing is the crucial issue in preventing suicide – something that wider research findings discussed earlier in the report would corroborate. He also points out that this is particularly relevant to the local area. Given that the city Brighton & Hove is recognised as a 'gay capital' it is not surprising that LGBT move to the area looking for a better life. In this context, and the recent assessment of LGBT homelessness in Brighton & Hove (Cull et al, 2006), it is unfortunate that the Albert Kennedy Trust's funding has recently ended. This leaves a clear gap in service provision for young LGBT people in need and a missed opportunity for reducing minority stress through the role of mentoring or fostering by adult LGBT carers.

As a final reflection participants also mentioned some issues within their own voluntary groups. It should be stressed that overall participants were most positive about their experiences but two key issues arose, relating to 'crisis support' and 'transphobia'. While Allsorts members spoke of the positive impact the group had for forming friendships one participant raised the issue

of whether young people in 'crisis' would be able to access the group if they did not have prior knowledge of its existence:

P: ...everyone who comes here, well the majority of people who come here will come here through friends. How would someone struggling with their sexuality find out about it unless they already have a gay friend and um, they have a website which is kind of out of date and not really publicised on any of the posters they have in toilets or around town or anything – there's just a phone number, and it's meant to be a crisis centre. Yet you have to call and book an appointment before you come for the first time. And to me that seems too much of a structured procedure for someone who's in crisis (Allsorts, male, Int. 12: 708-717).

This is an interesting assertion as Allsorts does not operate as a 'crisis centre' but as a youth group for young LGBTU people. However, it does raise the important point of where do young people who are in 'crisis', potentially suicidal, confused about their sexuality, or experiencing homophobic abuse go? As we have seen already from MindOut participants, the process between identifying suicidal distress and receiving any treatment or appropriate care can be so long that it is surprising that many of these participants have managed to survive. The issue of 'crisis care' was also raised by MindOut participants: one female participant suggested that people needed support before they reached 'crisis' and these sentiments were reiterated by a male participant who described the difficulty in being able to make life saving connections once they were in crisis. Two other participants described a need for 'out of hours' support, particularly in evenings and the weekends:

My interest would be if there was a service which run from 12 o'clock in the afternoon all the way through until 9 o'clock in the morning around the whole night and the whole weekend. I think there would be less casual people trying to kill themselves. Because there is no service at that sort of time, personally me I feel vulnerable and if I feel down and it is on a Friday and it's past office hours and I have 48 hours, may be 36 hours before I can speak to somebody or reach somebody which I sometimes find a bit harsh. (MindOut, male, Int. 1: 290-296).

This participant points to how isolation and vulnerability increase at the time when he is unable to reach support services, such as MindOut and Allsorts, that he has found useful in the local area. The second female participant describes how her sense of connection has been improved in these more difficult hours through the use of online communities:

I: Have there been any other things that have kept you alive – coping mechanism that you can think of.

P: Um, the internet has been an invaluable resource. Um, at night times, one of my hardest times – it certainly used to be when I lived alone and I used to spend all night often on the internet talking to people you know the other side of the world who were up and making friends. (MindOut, female, Int. 10:796-807).

This suggests that there is a need for a crisis support system in the local area, incorporating facilities such as a late night phone line or online discussion boards – if people have access to internet services. Yet, as the participant from Allsorts pointed out it would need to be well publicised and maintained service to ensure access for a range of people who might be experiencing suicidal distress and be more or less comfortable about their sexuality or gender identity status.

The final issue that needs reflection occurs within the LGBT community itself, as well as outside of it. It was raised by the only transgendered participant who took part in the study, and marks out residual or explicit transphobia within LGBT support groups despite the best attempts of staff:

*P: ... I stopped going to Mind Out for about a year um, (...)
I Why was that?*

P: Well, it was a number of factors. One of was that ah, I was friendly with somebody who I met here who had schizophrenia and they became involved with other people who were sort of taking lots of drugs and drinking and stuff like this and they ah, began, to, ah, disintegrate really and (...) mistreated me, I would say. ... And also, you know, you know, you can gauge the community here - there are pockets of trans-phobia about for sure. Um, so, ah, ah, I thought well I wasn't really welcome here and ah, so I stopped coming. And then last summer, you know, I hadn't spoken to anybody for (...) six months or so, except from what one says in shops to buy something and um, my mental health became very very poor and ah, I decided, you know, I would take my own life and ah, (...) and (...) then I thought, I will talk about it with the doctor, I couldn't get to see doctor so I rung up Support Worker here at MindOut and um (...) she tried to get me admitted to Specialist hospital but they wouldn't take me. Anyway I started coming back to the groups here, um, and ah, I've been coming ever since (MindOut, transwoman, Int. 6: 731-765).

Social psychologists tell us that it can be notoriously difficult to change private attitudes, but a critical focus on the impact of social norms is necessary if we are to tackle negative societal constructions of LGBT lives. This applies as much to transphobia that exists within the LGBT community as it does to homophobia and heterosexism in wider society. We spoke at the beginning of the report about using the term LGBT because we want to provide an inclusive platform in order to understand the impact of marginalisation on lesbians, gay men, bisexual men and women, and transmen and transwomen (who may also identify as gay, lesbian or bisexual). We did not recruit any male or female participants who identified as bisexual or participants who identified as transmen. Yet, we assert as we did there that there are substantial similarities in the forms of alienation, isolation and discrimination experienced for LGBT people, while there also are matters that are particularly pertinent for any one group: Transphobia is one example. This requires that LGBT specific and sensitive services and service providers need to be cognisant of the differences within, as well as across, LGBT

communities. It also requires a concerted effort to address our own outstanding issues in relation to stigma around mental health, heterosexism, homophobia and transphobia in order to facilitate better community cohesion and more welcoming spaces for people of a range of LGBT identity categories.

7. Conclusion

This study outlines key themes that underpin the experience of suicidal distress amongst two groups of LGBT people: young people and those who identify as having mental health problems. We found that suicidal distress is associated with discriminatory practices of homophobia, transphobia and heterosexism that are embedded within institutions such as education, health, religion, media and the family, and that these practices made it difficult for participants to form positive self identities and good mental health. In order to promote survival in the LGBT community a review of existing services and crisis support is required. However, if we are to reduce the number of LGBT people who experience suicidal distress larger questions are demanded of the way social norms operate to marginalise and alienate LGBT people. Strategies and campaigns for challenging stigma about LGBT lives within dominate institutions are required, as are strategies for challenging the stigma that surrounds people talking openly about mental health issues, both inside and outside the LGBT community.

8. References

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