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Risk and Resilience Explored

The RaRE Research Report

LGB&T Mental Health - Risk and Resilience Explored

Nuno Nodin, Elizabeth Peel, Allan Tyler and Ian Rivers

Acknowledgments

We would like to thank the following for their contributions to the project:

Margaret Unwin, PACE Chief Executive Officer, and Ruth Overton, Head of Communications, for line managing the project and for their support, guidance and insight in regard to various aspects of project development and implementation.

Flávio Silva, Research Administrator, for the assistance provided throughout the project, including but not limited to assistance with the development of research instruments and with data collection, as well as with monitoring of recruitment for all phases of the research.

Tim Franks, former PACE Chief Executive Officer, for contributions to project conception, implementation and development, and for line managing it during its initial phases.

Maggie Lay, former Research Coordinator, for early planning, development and management of the project, particularly for conducting the literature review and coordinating the first phase qualitative study.

Emily Trip, Research Assistant, for contributing to data collection for the survey and assistance with planning, implementing and data cleaning for the second phase qualitative study.

Kiran Bains, Research Intern, for updating the literature review and for assistance in performing analyses of first qualitative phase data; Victoria Hotchin, Research Volunteer, and César Gonzalez, Research Intern, for assistance in performing analyses of first qualitative phase data; and Teemu Toivainen, Research Volunteer, for support in running survey data analyses.

Current and previous members of the project's Lay Panel, for their feedback and suggestions, as well as for assistance with data collection.

Participants in all phases of the study, for their time and for generously sharing their experiences.

Interviewers from the first and second phase qualitative studies, for their assistance in data collection.

Ander Arenaza, Adrian Cox, Tim Eastwood, Kate Emmett, Rose McLoughlin, Caroliz Pérez-Acevedo, Quay Tran, and other PACE members of staff, volunteers and interns for support and assistance in various phases of the research project.

Organisations which helped with participant recruitment, including B-eat, Millivres Prowler Group, Positive East, Terrance Higgins Trust, University of East London, amongst others.

And finally, The Big Lottery, for funding this project.

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Nuno Nodin, Elizabeth Peel, Allan Tyler and Ian Rivers

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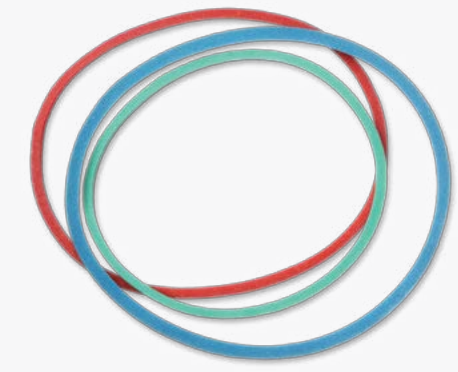
Participants said they wanted to help LGB&T young people who feel suicidal by sharing their experiences. They wanted to fight prejudice around mental health issues and help to normalise sexual and gender diversity.



Foreword

I am delighted to be able to present this report to you, which is the result of five years painstaking work. The RaRE research, funded with vision by the Big Lottery, has broken new ground for a small voluntary sector organisation like PACE. Our collaboration with some of the most qualified academics in the field, and the diligence of the RaRE research team, has enabled us to produce a piece of thoughtful research which expands on current knowledge about LGB&T mental health.

LGB&T mental health is poorer than that of the mainstream population as a result of the impacts of heteronormativity on LGB&T people's lives. Our research looked at three particular aspects: gay and bisexual men's body image, lesbian and bisexual women's relationship with alcohol, and suicide in young LGB&T people.

Over 2000 people completed our survey and participated in the in-depth interviews. The rich data they provided paints a vivid picture of what helps lesbians, gay men, bisexuals and Trans* people develop positive mental health as well as the factors that create risks to becoming a psychologically healthy human being.

The RaRE project was never just about finding out facts; the intention is that it should be used to inform and influence service providers and policy makers so that they are better able to provide for the broad mental health needs of the LGB&T community than is currently the case. PACE believes that developing more responsive mainstream services for LGB&T people should be a priority for all NHS and social care providers and we think there is a need for a national LGB&T mental health strategy, to enable providers to build their capacity to tackle specific LGB&T needs and better support LGB&T people.

We also believe there will continue to be a need for LGB&T-specific services provided by and within LGB&T organisations, even when the mainstream sector can honestly demonstrate it is meeting LGB&T people's needs.

I hope you will enjoy reading the report and that it will enable you to take some action in your particular area of work, in order to improve the outcomes for LGB&T people with mental health issues.

If you have any thoughts, observations, questions or comments we would be very pleased to hear your feedback.

With best wishes,

Margaret Unwin, PACE CEO

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Executive summary

The RaRE Study research project 2010 – 2015 is a 5-year collaboration between PACE, the LGBT+ mental health charity and an academic panel drawn from three UK universities. The study looked at risk and resilience factors for three mental health issues that affect LGBT+ people disproportionally:

1. Suicide attempts and self-harm for young LGBT+ people under 26
2. Alcohol misuse in lesbian and bisexual women
3. Body image issues for gay and bisexual men

Data was collected between 2011 and 2014, through two sets of interviews with 58 people in total and a national survey of 2078 people in England.

Key Findings – Suicide and Self-harm for Young LGB&T People

Young LGB and Trans[1] people under 26 are more likely to attempt suicide and to self-harm than their heterosexual and cisgender[2] peers.*

34%
of young LGB people had made at least one suicide attempt in their lives...

...as compared to

18%
of heterosexual young people

What Risk Factors did RaRE find?

People who attempted suicide while young reported factors that appear to correlate closely with suicidal thoughts or attempts. These were: negative experiences of coming out; homophobic and transphobic bullying; and struggles about being LGB or Trans* within the family, at school and in peer groups.

In addition, participants reported that a lack of awareness and training means responses from medical or professional staff can feel inadequate. Inclusive resources, which reflect the lives and issues of young LGB&T people, are sparse outside of LGBT+ specialist services.

1 'Trans*' will be used throughout the report as an umbrella term for people whose gender identity and/or gender expression diverges in some way from the sex they were assigned at birth.

2 'Cisgender' refers to all people whose gender matches the sex they were assigned at birth.

What Resilience Factors did RaRE find?

Participants reported that support and understanding from family and significant others helped them to develop self-worth. In addition, connection to other LGB&T people and communities create a sense of belonging, which helps build resilience.

Positive interventions and responses from medical and professional staff are crucial, to help young LGB&T people recover more quickly after a suicide attempt.

48%
of Trans* young people had made at least one suicide attempt in their lives...

...as compared to

26%
of cisgender young people

Key Findings – Alcohol misuse for lesbian and bisexual women

No significant differences in dependent alcohol use or hazardous drinking were found when comparing lesbian and bisexual women with heterosexual women. Some minor differences in patterns of drinking were found.

What Risk Factors did RaRE find?

The study found that the risk of problematic drinking amongst lesbian and bisexual women is often associated with prevailing heterosexism. It appears lesbian and bisexual women use alcohol in an attempt to manage feelings of fear, anxiety and guilt about their sexual orientation. Negative reactions from professionals can limit lesbian and bisexual women's engagement with treatment and support, including causing them to disengage with treatment altogether.

What Resilience Factors did RaRE find?

The study found that recovery from alcohol abuse is helped by good support from partners, family and others. It appears that an important strategy to regain control is creating life structures. Interaction with practitioners who are knowledgeable, aware and inclusive in their approach is key, as are LGBT-specific resources such as support groups.

Key Findings – Body image issues for gay and bisexual men

The study found that gay and bisexual men are more dissatisfied with their bodies and their health than heterosexual men.

What Risk Factors did RaRE find?

RaRE found that early experiences of 'feeling different' appear to create vulnerability and are a key factor in developing low self-worth for gay and bisexual men. Gay and bisexual men experience significant pressure to conform to the 'ideal' body type; they are also more sensitive towards social and media messages about this ideal when compared with heterosexual men. These messages are internalised from peers at school, family, media and other men on the scene.

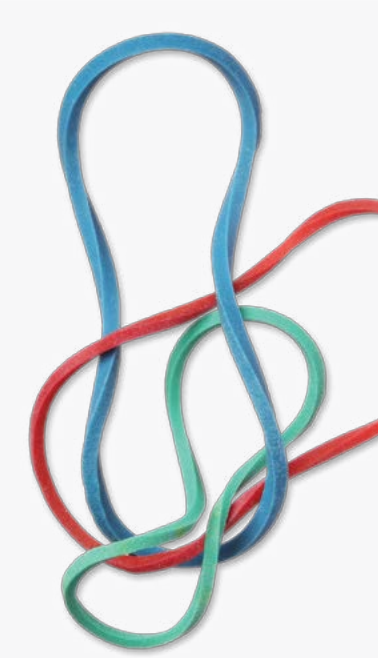
What Resilience Factors did RaRE find?

Gay and bisexual men reported that before they can make positive changes about their body image or eating concerns, they need to acknowledge that there is an issue and this is sometimes triggered by a crisis in their life. Self-motivation and support from people who understand is essential to recovery. Also important is more formal therapy, self-help and organised programmes, including specifically for gay and bisexual men.

Introduction

PACE, the LGBT+ mental health charity, was funded by the Big Lottery to undertake research into three mental health issues found to be more prevalent among lesbian, gay, bisexual and Trans* (LGB&T) people. These issues are:

- Attempted suicide and self-harm among LGB&T young people
- Drinking problems among lesbian and bisexual women
- Body image issues and eating concerns among gay and bisexual men



The study's main aims were to:

1. find out who is most at risk of developing the aforementioned health issues;
2. ascertain what the risk and protective factors are and whether and how these vary between LGB&T people and their heterosexual and cisgender counterparts;
3. identify common risk and protective factors for LGB&T people across the three health inequalities;
4. identify whether there is a need for a LGB&T-specific approach to mental health promotion capable of reducing the researched inequalities.

The desired outcomes of the RaRE study were improved targeting of services to LGB&T people at risk of developing mental health issues with a focus on the aforementioned three issues; earlier prevention initiatives; and more effective support for LGB&T people experiencing these problems.

The RaRE study was designed as a multi-phase study using a mixed-methods approach. In total there were five research phases to the project:

1. A stakeholders' survey to ascertain stakeholder issues and concerns regarding the problems under study (the current report will not cover the findings from this survey, a separate report of this phase was produced and is available on request; Lay & Silva, 2010);
2. An extensive and up to date literature review about LGB&T mental health research, specifically focusing on the three key issues under study;

3. First qualitative phase (P1Q): in-depth interviews of 35 LGB&T adults living in England with a history of the problems under study;

4. A comparative England-wide survey of 2078 LGB&T and non-LGB&T adults with and without a history of the problems under study to ascertain how sexual orientation and gender identity articulates with risk and resilience factors;

5. Second qualitative phase (P2Q): in-depth interviews with 23 LGB&T individuals with atypical risk and resilience profiles, i.e., those exposed to potential high risk but who did not suffer the expected negative mental health outcomes; and conversely those who developed a mental health issue but presented low or no risk exposure.

The RaRE Study was undertaken using the Community Based Participatory Research (CBPR) approach (Israel, Schulz, Parker & Beker, 1998; Speer & Christens, 2013). CBPR places an "emphasis on the participation of non-academic researchers in the process of creating knowledge" (Israel et al., 1998, p.177), often incorporating local and community specific theories, recognising the strengths and weaknesses of all those involved. It draws from critical theory and constructivist theories and uses qualitative and quantitative theory to better understand the phenomenon under study.

In the case of the RaRE study, PACE benefited from the support from academics from University of Worcester, Brunel University London and London South Bank University. However, a key feature of the RaRE study is the active engagement of volunteers within the community through a lay panel that operated as an advisory body to make sure research methods and materials, such as survey questions and dissemination materials, were appropriate and adjusted to the needs and interests of their target populations. Other volunteers and interns were also frequently involved in the development of the project, often being motivated by a combination of the desire to contribute to the LGB&T community and an interest in research and mental health.

The RaRE study was managed and coordinated by a researcher employed by PACE. The Coordinator was supported by a part time Project Administrator, temporary specialist workers at various stages and, as mentioned, a number of volunteers and interns assisting on various research and dissemination tasks. The project had an advisory panel consisting of the research team, three academic partners and lay members with an interest in the problems under study, engaging PACE's Chief Executive Officer and the Head of Communications at key stages in the project. This group was engaged in all aspects of decision making and quality assurance in accordance with the Community Based Participatory Research model.

This report starts with an overview of the literature review carried out which provided a background and informed the project. It then outlines the methodology used for the three phases of the research before presenting the key findings of all phases in the results section. The last section is a discussion of all phases of the research, weaving together common threads as well as highlighting divergent issues of the findings from the three mental health issues under study. The limitations of the study are exposed and future directions of the research suggested before ending with general conclusions and recommendations.

PACE and the research team recognise the diversity within the LGB&T+ community and the limitations of analysis in which bisexuals, Trans* people and people identifying with other sexual orientations and gender identities are not separated from lesbian and gay people. For the purposes of this report, survey responses from bisexual people were analysed together with those of lesbian and gay people (with the exception of some analysis of women's drinking behaviours) and only findings directly related to suicide and self-harm indicators are reported for Trans* individuals separately. This was done in order to limit this report in size and scope, considering it already covers a wide range of issues by using diverse methodologies.

However, the RaRE study will conduct further analyses and produce research outputs which will look into the findings within these broad categories of sexual orientation and gender identity more in detail.

Literature review

1. Aims and scope of the review

This literature review was undertaken to help define the terms, scope and parameters of the study; to identify relevant concepts and theories; to guide the choice of methodologies, such as sampling methods, instruments, and data analysis; to ascertain what is known about the nature and aetiology of the three health issues across heterosexual, cisgender, and LGB&T groups; and to provide a context into which to place the study's findings. It is not a comprehensive review of the literature or a critical analysis.

This review focused on papers published in psychology journals, although a broader range of research outputs from other disciplines were also briefly reviewed, such as from sociology, psychiatry and anthropology. In recognition of the impact of culture on these health issues the focus was principally on European, North-American and Australian publications. The search was limited to papers published within ten years of the commencement of the review (late 2010), although some particularly influential works from before 2000 were also reviewed. Other sources reviewed included UK Government policies and legislation and some relevant LGB&T publications.

2. Socio-political context for LGB&T people

Legislation and policy can impact greatly on LGB&T mental health. Britain has only fairly recently begun to address inequalities legally by improving the rights of LGB&T people in an attempt to counter discrimination. However, there is a cultural and historical background that influenced how many, particularly older, LGB&T people grew up in relation with their sexual orientation or gender identity.

Homosexual acts in private between men aged over twenty-one in private were decriminalised in 1967 in England and Wales, in 1981 in Scotland and 1982 in Northern Ireland. However, in 1988 the British Government made a regressive step in implementing Section 28 of the Local Government Act (1988). This made it illegal for a Local Authority to: 'intentionally promote homosexuality or promote the teaching in schools of the acceptability of homosexuality as a pretend family relationship.' The Act was eventually repealed in 2003 in England.

In 2004 the Civil Partnership Act was passed, which conferred similar rights as heterosexual couples to same-sex couples and, later, marriage

between same-sex partners was approved, in 2013 for England and Wales and in 2014 for Scotland. The Equalities Act of 2010 made it illegal to discriminate against anyone based on a range of characteristics, including sexual orientation and gender reassignment status.

Despite these improvements, LGB&T people continue to report a wide range of negative experiences related to discrimination and prejudice. There is evidence that these experiences link to the health inequalities being explored and may also constitute some of the barriers to addressing these inequalities.

3. Evidence of health inequalities in LGB&T people

The RaRE project was inspired by a meta-analysis by King et al. (2008) which evidenced inequalities in the experience of mental health issues by LGB&T people. Although it is generally now regarded that same-sex attraction is compatible with psychological health (King, 2004; McFarlane, 1998) LGB people have in fact been found to be at higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm when compared to heterosexual people (King et al., 2008). LGB people have double the risk of suicide attempts; the risk for depression and anxiety disorders over a period of twelve months or a lifetime were at least one and a half times higher in LGB people as was alcohol and other substance dependence over twelve months.

Research indicates that being LGB or having a Trans* identity is not in itself associated with mental distress and increased rates of mental illness, but that negative impact of transphobic, homophobic and heterosexist cultural norms that spur the discrimination, bullying, marginalisation and stigmatisation of LGB&T people may be. A term used to summarise the psychological effect of these social phenomena is 'minority stress' (Eisenberg & Wechsler, 2003; Meyer, 2003).

A brief review of the literature published in 2003-2009, conducted prior to the study found that although some research had been undertaken on the predictive and risk factors for these health issues, little research had explored resilience or protective factors. There had also been little research undertaken in the UK on LGB&T people's mental health compared to the United States (Chakraborty, McManus, Brugha, Bebbington & King, 2011).

4. Suicide and self-harm among young LGB&T people

There is evidence to suggest that LGB&T young people may be more vulnerable to suicidal ideation and attempts than their heterosexual counterparts (e.g. Clements-Nolle, Marx & Katz, 2008; Hatzenbuehler, 2011; Hatzenbuehler, Keyes & McLaughlin, 2011; Langhinrichsen-Rohling, Lamis & Malone, 2010; Mathy, 2003). For instance Shields, Whitaker, Glassman, Franks and Howard (2012), using data from a representative sample of LGB and heterosexual high school students in the US, found that LGB young people were 3.9 times more likely to make suicide plans, and 3.6 times more likely to attempt suicide. As death certificates do not record victim's sexual orientation, it is not possible to ascertain whether LGB&T people are more likely to die by suicide, although Plöderl et al. (2013) reviewed the literature and argued that this may well be the case.

Although completed suicide is more common in older LGB&T age groups, suicide attempts are more common among bisexual, homosexual and transgender young people (Mathy, 2003; Wang, Häusermann, Wydler, Mohler-Kuo & Weiss, 2012; Xavier, Honnold, & Bradford, 2007). Boeninger, Masyn, Feldman and Conger (2010) found mid adolescence (16/17 years of age) was a time of greatest risk for suicide attempt among adolescents with boys' risk remaining high longer than girls'. In one of the few studies focussing on Trans* young people using gender identity services in the NHS in the UK, similar results have been found in natal males versus natal females (Skagerberg, Parkinson & Carmichael, 2013).

4.1. Nomenclature of suicide

There is a range of terms used in clinical practice and research in relation to suicide including suicidal distress, suicidal ideation, suicidal behaviour (including suicide attempt, suicidal 'gesture' and parasuicide) and completed suicide. For the purpose of this study, we use O'Carroll et al's (1996) definition of suicide attempts as being: (a) self-initiated, potentially injurious behaviour; (b) presence of intent to die; and (c) non-fatal outcome (suicide being used only for cases in which death results). The term self-harm is used to denote the absence of the intent to die (Silverman, Berman, Sanddal, O'Carroll & Joiner, 2007a; 2007b).

4.2. Risk factors for suicide and self-harm

Risk factors have been defined as 'variables that are associated with an increased probability that an outcome will occur' (Van Orden et al., 2010, p.576) whereas causal processes explain an outcome.

A systematic review of the literature on suicide risk and protective factors (McLean, Maxwell, Platt, Harris & Jepson, 2008) found a number

of factors relevant to adolescents generally: sexual abuse, eating disorders, personality factors including, extroversion, neuroticism, impulsivity, irritability, anger, aggression, hostility, hopelessness and anxiety; attention deficit hyperactivity disorder (ADHD); and poor problem-solving skills. Although there is some overlap between general and sexual minority young people's suicide risk factors, we will focus on the latter on our review. Warner, et al. (2004) found in their study of LGB mental health, 'variables associated with attempted suicide were being female (OR1.7, 95% CI 1.2–2.5), having been attacked in the past 5 years (OR 1.4, 95% CI 1.1–1.9) and having been insulted at school (OR1.4, 95% CI 1.1–2.0)' (p.483).

4.2.1. Demographic factors

Some studies have suggested that young gay and bisexual males have higher rates of suicide attempts than lesbian and bisexual women (King et al., 2008; Remafedi et al.,1998). However, gender has not always been found to be significant for LGB young people (Blosnich & Bossarte, 2012; van Bergen, Bos, Lisdonk, Keusenkamp & Sandfort, 2013) and one study by Eisenberg and Resnick (2006) looking at sexually active young people has found that LB females had higher suicide attempts and ideation than GB male young people.

A study of lesbian and bisexual women found that emotional abuse by the family was also a significant predictor of suicide attempt risk.

Some research suggests that those who identify as bisexual (Needham & Austin, 2010; Plöderl, Kralovec & Fartacek, 2010), those questioning or unsure of their sexual orientation (Birkett, Espelage & Keonig, 2009; Lucassen et al., 2011; Zhao, Montoro, Igartua & Thombs, 2010) as well as those with attraction to both sexes may be at highest risk (e.g. Langhinrichsen-Rohling et al., 2010; Lucassen et al., 2011). However, some research has found no significant differences according to (sexual minority) identity (e.g. Hatzenbuehler, 2011). Finally, earlier age of same-sex attraction for LGB young people (Mustanski & Liu, 2013) and additionally an earlier identification as a sexual minority for lesbian and bisexual women (Corliss, Cochran, Mays, Greenland & Seeman, 2009) have been associated with attempting suicide. A study of adults (Plöderl, Kralovec & Fartacek, 2010) and another one of young people (Moon, Fornili & O'Briant, 2007) found that those with bisexual behaviour were more likely to attempt suicide with some intent to die than heterosexual participants.

4.2.2. Familial and social risk factors

A study of lesbian and bisexual women found that emotional abuse by the family was also a significant predictor of suicide attempt risk, though they did not focus on young people (Corliss et al., 2009). Family problems have also been linked to greater suicide ideation in LGB young adults by Blosnich and Bossarte (2012), and to suicide attempts

in their bisexual sample, who also reported a greater presence of family problems than any other group.

Adams, Dickinson and Asiasiga (2013) identified that mental health issues were stigmatised in LGB&T communities and that suicidal behaviour was seen as an almost acceptable way to deal with the experience of minority stress, which may impact the attitudes and behaviour of LGB&T young people in this regard.

4.2.3. Social isolation, exclusion and rejection

A study by Van Orden (2010) identified that, 'social isolation is one of the strongest and most reliable predictors of suicidal ideation, attempts, and lethal suicidal behavior across the lifespan' (p.582). Bisexual young people and those questioning their sexual orientation have been found to have less social support than other groups, which could be linked to greater suicide risk (Espelage, Aragon, Birkett & Keonig, 2008; Langhinrichsen-Rohling et al., 2010). Additionally, negative social support has been associated with greater risk of suicide attempt in LGB young people (Rosario, Schrimshaw & Hunter, 2005).

A study by Fenaughty and Harre (2003) identified coming out (disclosure particularly) as one of the most stressful experiences for gay young people. This may relate to rejection or fear of rejection, by friends and family which has also been shown to be a risk factor for suicide attempts particularly among LGB young people. Ryan (2009) found an eight-fold increased prevalence of reported suicide attempt among those that had experienced frequent rejecting behaviours by their parents or caregivers in adolescence compared with those whose parents were more accepting. Parental rejection in LGB young people contributed to their overrepresentation in those who are homeless (Ray, 2006). Additionally, Dahl and Galliher (2012) interviewed LGB&T young people brought up in a Christian religious context and found that they experienced increased social strain on relationships, as some people were rejected by family for religious reasons, similar to the findings of Reed and Valenti (2013) in their study with young black lesbians.

4.2.4. Discrimination and hostility

Homophobic, biphobic and transphobic hate crime is still a relevant problem in Britain today. A survey identified that one in every six gay, lesbian and bisexual people have been the victim of a hate crime or incident in the previous three years (Stonewall & Yougov, 2013). A study by Mays and Cochran (2001) found that discrimination perceived by LGB people may partially explain their greater psychiatric morbidity risk. King et al. (2008) speculated that hostility, stigma and discrimination experienced by LGB people contribute to the higher levels of psychiatric morbidity.

The suicide risk amongst transgender young people has received little attention. A study of correlates of life-threatening behaviours in American transgender young people found childhood gender non-conformity, negativity about their own transgender status, parental verbal abuse, parental physical abuse and two of three aspects of body esteem all to be more common in those who had a history of suicidal behaviours (D'Augelli et al., 2005). Indeed some research suggests it may be gender non-conformity rather than having an LGB&T identity per se that may confer greater vulnerability to suicidal ideation and attempts (Fitzpatrick, Euton, Jones & Schmidt, 2005; LeVasseur et al., 2013).

Several studies have suggested that LGB&T young people and adults are at higher risk of physical, emotional and sexual violence compared to heterosexuals, with increased risk of suicide ideation and attempts (Blosnich & Bossarte, 2012; Clements-Nolle et al., 2008; Roberts, Rosario, Corliss, Koenan & Austin, 2012a; Testa et al., 2012).

Several studies have suggested that LGB&T young people and adults are at higher risk of physical, emotional and sexual violence compared to heterosexuals.

A number of studies have identified that LGB&T students may also be more likely to experience victimisation and bullying at school, and linked this to increased depression, suicide ideation and attempts in these young people (Espelage et al., 2008; Hatzenbuehler & Keyes, 2011; Robinson & Espelage, 2012; van Bergen et al., 2013). Plöderl (2009) found that suicidal ideation was more frequent among both those students who were victims of bullying and students who bullied others.

4.2.5. Mental health problems

Several studies have linked increased prevalence of depression in sexual minority young people and transgender adults, and in turn associated this with increased suicide ideation and attempts (Clements-Nolle et al., 2008; Harris, 2013; Langhinrichsen-Rohling et al., 2010; Marshal, et al., 2011; Mustanski & Liu, 2013; Rosario et al., 2005). Unsurprisingly, this may also be associated with the increased prevalence of abuse, discrimination and victimisation, as well as social isolation in these young people (e.g. Marshal et al., 2011; Martin-Storey & Crosnoe, 2012; Mustanski & Liu, 2013). Similarly, increased anxiety and insecurity has also been identified as a risk factor for suicidality in LGB young people (Rosario et al., 2005; Straiton, Roen & Hjelmeland, 2012; Walker & Longmire-Avital, 2013).

Alcohol misuse has been identified as a suicide risk factor in sexual minority young people (Hatzenbuehler, 2011). A diagnosis of alcohol use disorder is associated with a high-risk for multiple suicide attempts and research highlights the need to target this group with suicide prevention initiatives (Boenisch et al., 2010). Additionally acute alcohol intoxication has been found to be associated with increased lethality of suicide attempt (Sher et al., 2009).

Kosky et al. (1990) reported that in the general adolescent population those with suicidal ideas were 'clinically indistinguishable' from those who attempt suicide. However, a review of the evidence by Haas et al. (2011) concluded that 'reported suicidal ideation does not appear to be a stable predictor of LGB suicidal behaviour' (p.19).

4.3. Suicide resilience

Psychological resilience has been described as the capacity of people to cope with stress and adversity.

Psychological resilience has been described as the capacity of people to cope with stress and adversity. Resilience may be seen as the ability of an individual to bounce back to a previous level of functioning, or being able to steel oneself against the effects of adversity and function better than expected in adverse circumstances. Resilience is usually understood as a process rather than a personality trait.

Resilience factors in relation to suicide are those that promote survival from suicidal behaviour in people exposed to risk (McLean et al., 2008). Very little research has been undertaken on factors that protect individuals from suicidality compared to those that put them at risk.

4.3.1. Demographic factors

Several factors may interact to put certain participants at reduced risk of suicide relative to other groups. For example Blosnich and Bossarte (2012) found that Black and Hispanic bisexual young people were at lower risk of self-harm, and Hispanic young people additionally at lower risk of suicide ideation than White participants. However, O'Donnell, Meyer and Schwartz (2011) found that these two ethnic groups had greater lifetime suicidality as adults, than White participants, which was not explained by depression or substance misuse. Nevertheless, there has been a paucity of research into LGB&T young people of colour, so it is difficult to draw any conclusions about what impact ethnicity has on suicide risk and resilience as arguably they may be at risk of being doubly oppressed due to ethnic and sexual orientation and/or gender minority status.

LGB young people with exclusively same-sex partners have been found to have a similar low risk of suicidality as the heterosexual comparison group (Eisenberg & Resnick, 2006), unlike identifying as LGB in itself which conferred greater suicide risk.

4.3.2. Psychological factors

Identity development has been argued by participants of some qualitative studies as key to resilience for LGB&T people (Dahl & Galliher, 2012; Harper, Brodsky & Bruce, 2012; Reed & Valenti, 2013; Singh, 2013; Singh, Hays & Watson, 2011), though this could take

considerable emotional investment in non-accepting contexts (such as a religious ones, e.g. Dahl & Galliher, 2012). This was achieved by some young people through identity exploration in a 'safe' space, then strengthened by investing in more difficult contexts, for example, by coming out or fighting prejudice in those contexts (Dahl & Galliher, 2012; Reed & Valenti, 2013). However, some participants also identified 'identity disclosure management' as important to stay resilient, by 'passing as straight' or taking extra care around homophobic people (Harper et al. 2012; Reed & Valenti, 2013).

Two studies found that having greater optimism and hope helped transgender people become more resilient to the stressors they faced (Moody & Smith, 2013; Singh et al., 2011). Moody and Smith (2013) also found that greater emotional stability was associated with lesser suicide ideation and behaviour.

Two studies found that having greater optimism and hope helped transgender people become more resilient to the stressors they faced.

Also related to this is the finding that greater instrumentality and personal agency may be protective, although again the research sampled adults only – the trans women and the general population respectively (Gonzalez, Bockting, Beckman & Duràn, 2012; Straiton et al., 2012). Interestingly, studies with LGT people of colour have shown that challenging heterosexism, self-advocacy and activism, as well as seeking support (i.e. mobilising personal resources) have been linked with increased resilience (Harper et al., 2012; Lehavot & Simoni, 2011; Reed & Valenti, 2013; Singh et al., 2011; Singh, 2013).

Greater self-care has been identified as a resilience factor by young gay males in one qualitative study (Harper et al., 2012), and Trans* adults in another (Singh et al., 2011). Participants in the latter also discussed the importance of embracing self-worth. Similarly, greater self-esteem has been identified as another potential protective factor against suicide risk in LGB young people by Rosario et al. (2005). In turn, recent research in LGB&T adults suggests that forgiveness, especially of the self, may enhance self-esteem (Greene & Britton, 2013).

4.3.3. Social support

Eisenberg and Resnick (2006) found that family connectedness, believing one is cared for by adults and feeling safe in school, improves resilience. Ryan, Russell, Huebner, Diaz and Sanchez (2010) similarly found that family acceptance is a buffer against suicidality in LGB&T young people, and this has been supported by other studies (DiFulvio, 2011; Espelage et al., 2008; Moody & Smith, 2013; Mustanski & Liu, 2013; Needham & Austin, 2010; Riley, Clemson, Sitharthan & Diamond, 2013). Participants in studies by DiFulvio (2011), Harper et al. (2012) and Reed and Valenti (2013) spoke about how social support by other key people, including family and friends, as well as certain individuals from within the LGB&T communities, helped them through acceptance and by encouraging them toward 'authenticity' and self-acceptance.

McCallum and McLaren (2010) studied LGB adolescents belonging to a young peoples group (for under 18 year olds) and found that having a sense of belonging to the general community was protective against suicidality but only so when young people had a greater sense of belonging to the LGB&T community.

In the US a growing number of schools have established a gay-straight alliance (GSA), and growing evidence suggests this may somewhat protect LGB&T students from suicidality (Poteat, Sinclair, DiGiovanni, Keonig & Russell, 2012). It has also been associated with an increased sense of high school belonging, decreased victimisation, depression and psychological distress, providing a safe space for LGB&T students and enabling them to challenge homophobic behaviour (Heck, Flentje & Cochran, 2011; Mayberry, Chenneville & Currie, 2013). Not surprisingly, the presence of inclusive anti-bullying and discrimination policies may also be protective as it is associated with lowered risk of suicide attempts in sexual minority young people, particularly gay and lesbian young people (Hatzenbuehler, 2011; Hatzenbuehler & Keyes, 2013).

4.3.4. Religiosity

Religiosity may have a complex relationship with suicide risk and resilience in LGB&T young people. Dahl and Galliher (2012) discussed how incorporating religious values into their identity, lifestyle and aspirations (e.g. through doing activities to help others, monogamy and importance of family) aided young people's resilience. Walker (2013) surveyed African American LGB adults and found that in those with high internalised homo-negativity, high religiosity was a protective factor for overall mental health.

5. Alcohol misuse among lesbian and bisexual women

Research using large population based samples has consistently demonstrated a higher frequency and intensity of alcohol use among lesbian and bisexual women in 'Western' industrialised societies, as well as among those with same-sex attraction and experience. A systematic review and meta-analysis of studies of mental disorders by King et al. (2008) reported a higher risk of alcohol and substance dependence in LGB people compared to their heterosexual counterparts. However, the risk of dependence was particularly acute in lesbian and bisexual women who had a four- fold relative risk of alcohol dependence over a twelve month period.

Large scale population-based studies documented that women who identify as lesbian or bisexual report higher levels of alcohol, tobacco and marijuana use than heterosexual women.

Rosario (2008) analysed a small number of large scale population-based studies that have consistently documented that women who identify as lesbian or bisexual (as well as women with same-sex attractions and same-sex sexual experience) report higher levels of alcohol, tobacco and marijuana use than heterosexual women. Albeit

Bloomfield, Wicki, Wilsnack, Hughes and Gmel (2011) found that lesbians in New Zealand and the US drink more than heterosexual women, but this did not hold in Great Britain.

The largest survey of women's health needs and experiences (over six thousand women) to have taken place outside the US was commissioned by Stonewall in the UK (Hunt & Fish, 2008). They reported that about 40% of lesbian and bisexual women drink alcohol three or more times a week compared with a quarter of women in general.

5.1. Terminology

The Diagnostic and Statistical Manual for Mental Disorders (DSM-5) defines a range of 'Addictions and Related Disorders' which includes alcohol use disorder. Contrary to the separation between abuse and dependence in the previous edition of the manual, these are now considered to be part of a spectrum that classifies substance use, including alcohol, according to the number of criteria met (American Psychiatric Association, 2013). The International Classification of Diseases-10 (ICD-10; World Health Organization, 1992) lists the following symptoms for alcohol dependence: withdrawal syndrome; using alcohol to relieve or avoid withdrawal symptoms; impaired control of drinking, or unsuccessful efforts to cut down use; neglect of normal activities; continuing to drink despite negative consequences; large amounts of time spent imbibing and/or recovering from use; and a compulsion to drink. If tolerance and withdrawal are present then drug dependence is associated with physical dependence.

Studies concerned with alcohol abuse have used a number of terms to describe it including: problem drinking, hazardous drinking, alcohol misuse, alcohol abuse, alcoholism, alcohol dependence, and alcohol use disorders (which subsume alcohol abuse and alcohol dependence). In the RaRE study we used the term 'problem drinking' in some of our participant recruitment materials. This term is the most inclusive and would therefore enable us to obtain a broad spectrum of narratives relating to problematic alcohol consumption. However, alternative terms, such as alcohol misuse and problematic drinking will also be used throughout the report as equivalents, and hazardous or dependent drinking will be used in the context of analyses in which specific instruments and criteria were used (following Hequembourg, Livingston & Parks, 2013).

5.2. Risk factors

5.2.1. Sexual orientation and gender conformity

Different studies have suggested that self-identity may be important, as lesbians, bisexual and heterosexual-identified women with same-sex partners were all found to be at higher risk of alcohol misuse than

their heterosexual counterparts, particularly heterosexual women with different sex partners (Ziyadeh et al., 2007; Drabble, Trocki, Hughes, Korcha & Lown, 2013). Further research also suggests that bisexual women may be at higher risk of alcohol misuse than lesbians (Drabble et al., 2013; Fredriksen-Goldsen, Kim, Barkan, Balsam and Mincer, 2010; Hughes, Szalacha, Johnson et al., 2010; Lanfear, Akins & Mosher, 2013).

A large US study (Cochran & Mays, 2009) comparing the prevalence of mental health problems between people of different sexual orientations found that lesbians were more frequently diagnosed with major depression than exclusively heterosexual women. In contrast, bisexual women were more likely than exclusively heterosexual women to meet criteria for several disorders, including alcohol dependency. Heterosexual women who had sex with other women had a greater prevalence of alcohol dependency than exclusively heterosexual women.

The degree of gender non-conformity amongst lesbian and bisexual women has been found to impact on their drinking patterns.

The degree of gender non-conformity amongst lesbian and bisexual women has been found to impact on their drinking patterns. For example, Rosario (2008) found that young lesbians with a more 'butch' self-presentation were found to use alcohol, tobacco and marijuana more frequently and to drink alcohol in greater volumes than young 'femme' women. Further research found that butch lesbian and bisexual women were more likely to be victimised, including by their families, which in turn was associated with greater substance misuse (Condit, Kitaji, Drabble & Trocki, 2011; Lehavot & Simoni, 2011).

5.2.2. Age

Following a review of longitudinal studies of alcohol consumption, Molander (2010) argued that there generally may be age-related decreases in drinking. Austin (2010) explored age differences in risk factors for problematic alcohol use among 1,141 self-identified lesbians. They found that the age group that used alcohol most frequently and intensively was the 19-29 age group (versus 30-49 and >50 year olds). However, in other studies lesbians reported drinking alcohol more heavily and later into old age than their heterosexual counterparts (reviewed by Pettinato, 2008).

Age may interact with other factors. Talley, Sher and Littlefield (2010) found that college students endorsing a minority sexual identity at the start of their college education reported greater frequency of binge drinking and drunkenness compared to their heterosexual counterparts, whereas those who only endorsed a sexual minority identification at the end did not.

Studies by Hughes, Johnson, Wilsnack and Szalacha (2007) and Ziyadeh et al. (2007) have found that parental or other adult heavier drinking at home were risk factors for greater alcohol abuse for sexual minority

women, but Hughes et al. (2007) also found that this was fully mediated by earlier age of drinking onset. Additionally, they found that those with earlier sexual debuts were also at increased risk of alcohol abuse.

5.2.3. Socio-economic status

Greater education, particularly having a college degree, has been found to be a risk factor for alcohol misuse in lesbian and bisexual women, as well as in other samples (e.g. Drabble et al., 2013). It may be that alcohol misuse is normalised at university, though people may also 'age-out' of drinking heavily (Lanfear et al., 2013).

The higher prevalence of alcohol use among older lesbians may be partially explained by their greater earnings. Lesbian women have been documented to earn more than heterosexual women irrespective of their marital status (Antecol, 2008). In contrast, a study focusing on younger participants found that having a yearly income below $37,000 was a risk factor for greater alcohol misuse in lesbian and bisexual women (Hughes, Szalacha & McNair, 2010, age range 25-30 yrs).

5.2.4. Mental health and self esteem

Greater perceived stress and poorer overall mental health has been linked to greater alcohol misuse in lesbian and bisexual women (Hughes et al., 2010), though it is equally possible that alcohol misuse can cause or exacerbate these issues. Research in LGB young people and sexual minority women suggests that higher distress is associated with increased alcohol misuse (Hughes et al., 2007; Newcomb et al., 2012).

Research in LGB young people and sexual minority women suggests that higher distress is associated with increased alcohol misuse.

King's (2008) meta-analysis of studies on mental health inequalities in LGB&T people found a higher 12-month and lifetime prevalence of anxiety in all LGB groups compared with heterosexuals. There is some evidence that social anxiety can lead to the use of alcohol as a coping strategy (Bacon, 2010). Social anxiety disorder was found in one study with the general population to precede alcohol dependence in almost four fifths (79.7%) of co-morbid cases (Schneier, 2010), helping to establish this as a causal risk factor.

Self-esteem appears to have a complex relationship with alcohol misuse in LB adolescent girls (Ziyadeh et al., 2007). Low academic self-esteem was associated with greater alcohol misuse, but so was high social self-esteem, which may be due to greater access to alcohol, such as in parties, whereas low social self-esteem and athletic self-esteem appeared to be protective.

5.2.5. 'Internalised homophobia' and heterosexism

LGB individuals have been considered to be at greater risk for alcohol abuse because of 'internalised homophobia'. Internalised homophobia has been defined as 'the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard' (Meyer & Dean, 1998, p. 161, cited by Span, 2009). However, little research has investigated the nature of the relationship between alcohol and internalised homophobia and the findings have been inconsistent (Span, 2009). For example, a study that explored age differences in problematic drinking concluded that similarly with heterosexual populations, depression and stress were strong predictors of problematic alcohol use among lesbians (Austin, 2010). Span (2009) found that men and women who reported experiencing little depression and internalised homophobia were those who drank most frequently. They suggested that these individuals may be least likely to seek psychological services (for depressive symptoms) and appear to be at lower risk for psychological problems but may have a greater risk of problematic drinking and alcohol use disorders (Span, 2009). A qualitative study that explored the impact of homophobia on young LGB people in the UK reported a coorelation between the distress arising from homophobia with suicide attempts, self-harm practices, risky sexual practices, and excessive alcohol consumption and drug-taking (McDermott, Roen & Scourfield, 2008).

Amadio's (2006) study explored the relationship between internalised heterosexism (IH) and alcohol consumption. Their results showed relationships between certain drinking issues and IH, but only in females. The positive association with IH in lesbians, but not gay men, was between the number of days participants reported being very high or drunk over the past year. In both genders, however, no association was found between binge or heavy drinking and IH, or in the number of days alcohol was consumed over the past year. Other studies have also found that increased IH is associated with increased alcohol misuse in LGB people (Hequembourg & Dearing, 2013) and sexual minority women (Lehavot & Simoni, 2011). Additionally Hequembourg and Dearing (2013) found that increased proneness to shame was also a risk factor for alcohol misuse, which may also be linked to internalised heterosexism and experiences of discrimination and victimisation in LB women.

5.2.6. Interpersonal rejection, discrimination and abuse

A study by Hughes, Szalacha, Johnson et al. (2010) found levels of 'hazardous drinking' among heterosexual women to be significantly lower than among sexual minority women. Using multivariate analysis, controlling for demographic characteristics and early onset of drinking, they reported significant differences in the level of hazardous drinking that could be attributed to the interactive effects of sexual identity and sexual victimisation.

A study by Wilsnack et al. (2008) found that exclusively heterosexual women had the lowest rates on all measures of hazardous drinking, and that these women also reported less childhood sexual abuse, less early alcohol use, and less depression. Bisexual women reported more hazardous drinking and depression than those who were mostly or exclusively lesbian. In line with that, McDermott et al. (2008) reported that the higher rate of childhood abuse in lesbian and bisexual women was a mediating factor in excess tobacco and alcohol use in adolescence relative to heterosexual women (McDermott et al., 2008). Drabble et al. (2013) additionally found that childhood physical abuse (CPA) also increased the risk of hazardous drinking, and that the presence of both childhood sexual abuse and CPA had a cumulative effect on alcohol misuse in the sexual minority group.

Bisexual women reported more hazardous drinking and depression than those who were mostly or exclusively lesbian.

It must be noted that lesbians and bisexual women may face multiple forms of intersectional discrimination – for instance related to ethnicity or age. Hence Condit et al. (2011) found that women of colour reported greater alcohol misuse after experiencing racial discrimination and due to awareness of racial discrimination in wider society. A study that explored the impact of multiple discrimination (including race/ethnicity, sexual orientation and gender) on mental health in the US (McLaughlin, 2010), found an increased incidence of psychiatric disorders (including substance abuse) among those who experienced discrimination, including racial discrimination in the past year. Further research by Lehavot and Simoni (2011) suggests that even when social support is taken into account LGB related victimisation remains a small but statistically significant risk factor for alcohol misuse in sexual minority women.

Few studies have examined the impact of institutional discrimination on the mental wellbeing of lesbian, gay or bisexual (LGB) people. A recent exception to this is a study undertaken by Hatzenbuehler (2010) that compared States in the US that had markers of institutional discrimination. They found the relationship between LGB status and psychiatric disorders (including alcohol problems) was 'significantly weaker' among those living in States with policies providing protection to LGB people (Hatzenbuehler, 2010, p.2279).

A qualitative study by Condit et al. (2011) sought to examine stressors which may lead to alcohol misuse in lesbians and bisexual women, who identified family rejection as a risk factor. These women had experienced rejection and a lack of support when coming out, a heteronormative silence regarding their identity, being forced out of their homes, as well as abuse and criticism.

Participants in Condit et al. (2011) also identified relationship dissolution as leading to greater alcohol misuse. However, some also identified alcohol misuse as a cause of their decisions to end previous relationships. This was also related to intimate partner violence (IPV), though establishing causality with regard to alcohol misuse and IPV

can be complex – i.e. alcohol misuse can precipitate incidents of IPV as well as experiencing IPV be a stressor for risky drinking (Lewis, Milletich, Kelley & Woody, 2012).

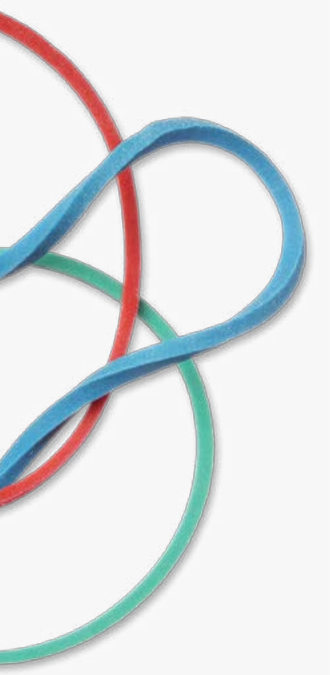
However as with most research in this area the cross-sectional designs of these studies preclude any firm conclusions about causality.

5.3. Resilience

5.3.1. Defiance and acceptance

Adopting a defiant 'out and proud' stance was reported to be an attempt by the LGB individuals interviewed in a study by Amadio (2006) to overcome the sense of shame their LGB status brought upon them. Alternatively Bowleg, Craig and Burkholder (2004) using a non-representative sample of African American lesbians found that having a strong lesbian identity predicted greater active coping.

Rosario (2009) found that rather than disclosure of a minority sexual orientation itself being associated with substance abuse, it is the number of accepting and rejecting responses to disclosure that are important in understanding substance abuse among LGB young people. They found that accepting reactions could act as a buffer against the effects of rejecting reactions in disclosure scenarios. Experiencing acceptance appears to be an important factor in building resilience to homo-negativity (and potentially alcohol use disorders). Ryan, Russell, Huebner, Diaz and Sanchez (2010) similarly found that family acceptance was protective against substance misuse in LGB young people.



Doty (2010) found that higher levels of sexual orientation support were associated with less emotional distress and acted as a buffer protecting against the impact of 'sexuality stress' on emotional distress amongst LGB young people.

Factors that may appear to bolster resilience may also act as a risk. A qualitative study found that socialising with other lesbians in gay venues provided a number of psychosocial benefits. However, participants described bar attendance as also having a health trade off, in that it exposed individuals to the temptation to drink (Gruskin, 2006). Participants in research by Condit et al. (2011) also identified the alcohol-centrism of activities in the LGB community as problematic, and some found it easier to abstain if going to a specific venue for a purpose (e.g. entertainment).

5.3.2. Guilt proneness and religiousness

Hequembourg and Dearing (2013) found that having increased guilt-proneness was negatively associated with alcohol misuse among LGB adults, and that lesbians had the greatest guilt-proneness of their sample.

One US study (Haber, 2007) explored the impact of religious affiliation on alcohol consumption amongst a large sample of daughters of alcoholic parents. They found that affiliation to religions that did not accept alcohol consumption as normal accounted for most of the protective influence of religious affiliation. Research by Rostosky, Danner and Riggle (2008), however, suggested that greater religiosity did have a protective effect against alcohol use and misuse in young heterosexual adults over time, but this was not the case for their LGB counterparts. The LGB sample also had lesser religious involvement, which may explain, to an extent, why they may not adhere to expectations regarding alcohol use.

5.3.3. Help seeking and treatment issues

A study that compared the treatment preferences and perceived barriers to seeking treatment by 'worried drinkers' of various sexual orientations (Green, 2011) reported few differences between genders or sexual orientations. However, heterosexual respondents considered stigma as a barrier more often than LGB respondents. Green speculated that this might be explained by LGB communities possibly having a more accepting view of psychotherapy than heterosexual communities. In support of this Grella, Greenwell, Mays and Cochran (2009), using a probability sample in California, found that lesbians and bisexual women were more likely to seek treatment for emotional and mental health problems than heterosexual women.

Wilsnack et al. (2008) suggested that the higher rates of childhood sexual abuse, early drinking, and depression among sexual minority women should be considered as important factors when clinicians are assessing and treating alcohol related problems or when developing prevention and early intervention strategies.

6. Body image issues, including eating concerns, among gay and bisexual men

Body image disorder in males has received far less scholarly attention in the past two decades.

The primary focus in research on body image has been on women and girls in relation to eating disorders (Thompson, Heinberg, Altabe & Tantleff-Dunn, 1999) and has resulted in an extensive scholarship. By comparison, body image disorder in males has received far less attention in the past two decades (McCabe, Ricciardelli & Karantzas, 2010) with only some of that research specifically examining gay and bisexual men's body image concerns or how these may differ from their

heterosexual counterparts. Definitions of 'body image' and approaches to its study are varied and the term 'body image' is often used to mean different things by different researchers (Cash, 2004). This can create confusion and variability across studies (Grogan, 1999). For many, the focus is entirely on perceptions of one's own body attractiveness and perceptions of body size, specifically thinness (Pruzinsky & Cash, 2004). Of particular concern to health practitioners in this context are issues around body satisfaction and body esteem, body image disorders, and associated spectrums of body dissatisfaction and risky behaviours.

Body image, as a concept, 'refers to the mental picture one has of his or her body at any given moment in time' (Kaiser, 1990, p.98) or 'a person's perceptions, thoughts, and feelings about his or her body [including] body size estimation (perceptions), evaluation of body attractiveness (thoughts), and emotions associated with body shape and size (feelings)' (Grogan, 1999, p.1). As part of the RaRE Study, there was a conscious effort to adopt and develop a definition of body image that encompassed contemporary usage that includes 'our experiences of our physical appearance [recognising] that embodiment entails more than self-perceived aesthetics' (Cash & Pruzinsky, 2004, p.510).

From a data-led definition that can be used across a range of health and social-care environments, the RaRE Study uses a theoretical position of embodiment that – as well as aesthetic considerations – includes levels of competence (e.g. physical fitness, athletic ability, kinesthetics) and experiences of the functioning body (e.g. sensation, perception, the ageing processes) which many conceptualisations of body image often fail to capture (Cash & Pruzinsky, 2004). To encourage engagement across a range of audiences at the various stages of design, data collection, analysis and dissemination, as well as to improve strategies of assessment (Thomson, 2004), the RaRE Study uses two specific foci: body satisfaction (and dissatisfaction; Tylka, 2011; Pruzinsky & Cash, 1990) and cognitive-behavioural investment (Thomson, 2004) such as drive for changes to muscularity or thinness (Kelley, Neufeld & Musher-Eizenman, 2010; Tod, Morrison & Edwards, 2012). Specific experiences of distress are discussed in relation to current theoretical models and the language of participants themselves, such as 'body dysmorphia', 'body esteem', and 'eating disorders' (Pruzinsky & Cash, 2004). This has allowed the data to be collected and analysed from 'cognitive-behavioural and feminist perspectives' whilst maintaining reflexivity about discursively constructing the medicalised body (Olivardia, 2004).

6.1. Body image disorders

Disturbances in body image have been defined as having three aspects: perceptual, attitudinal and behavioural (Thompson et al., 1999). There are a number of psychological/psychiatric diagnostic- type constructs and terms used to describe and define body image concerns. These

include body image dissatisfaction; body image disorder; body dysmorphic disorder (BDD); and muscle dysmorphia (MD), a sub-type of BDD. Whilst distinct, these constructs share some characteristics and it is important for the purposes of our study to clarify these terms and distinctions.

Lambrou, Veale and Wilson (2011) described people with body dysmorphic disorder (BDD) as having an unrealistic ideal as to how they should look. BDD symptoms include a preoccupation with the belief that a specific body part is defective or deformed in some way. The preoccupation is excessive enough to cause distress or significant functional impairment, such as in the social or employment sphere.

BDD is distinctive from the body shape dissatisfaction of anorexia nervosa or the body delusions of a psychotic disorder. BDD shares characteristics with obsessive compulsive disorder (OCD) but with some significant differences. According to a study by Phillips and Diaz (1997), BDD patients are more likely to have suicidal ideation and are at greater risk of developing major depression or social phobia than participants with OCD.

Muscle dysmorphia (MD) is defined as having a persistent belief that one's muscles may be small and insufficient, despite having enough muscularity. Along with a heightened drive for muscularity, men with MD tend to feel ashamed of their bodies, and hence avoid their bodies being exposed to others. They frequently compare their bodies with other men's and seek reassurance about their appearance (e.g. Chaney, 2008, Maida & Armstrong, 2005). These men also manifest symptoms of body dissatisfaction, body dysmorphic disorder and OCD, hostility, depression, anxiety, and perfectionism (Maida and Armstrong, 2005). A study that compared men with BDD who had either muscle dysmorphia (MD) or BDD without MD found greater psychopathology amongst those with muscle dysmorphia. This included higher rates of suicide attempt, higher rates of any substance use disorder, anabolic steroid abuse, and poorer quality of life (Pope, Pope, Menard & Fay, 2005).

Another relevant concept is that of body fat dissatisfaction. In many affluent societies there is a growing trend towards greater proportions of society experiencing being overweight or obese, both as adults and in childhood (Health and Social Care Information Centre, 2014; National Institute of Diabetes and Digestive and Kidney Diseases, 2012). Alongside that trend, dissatisfaction with body fat and pressures to attain a leaner body are also high. Even very young children express body fat dissatisfaction and it has been reported in boys as young as six (McCabe & Riciardelli, 2004). A study of 256 ethnically diverse, British boys and girls aged 11-14 years found that the majority were dissatisfied with their bodies in terms of fatness (Duncan, 2006), indicating that the issue is not only common for girls, but also for boys. A study by Bergeron and Tylka (2007) concluded that body fat dissatisfaction may be of great importance to males' psychological

well-being even after taking account of their 'drive for muscularity'. They also concluded that for men, body fat dissatisfaction is empirically distinct from the drive for muscularity.

To develop an ideal body type, people engage in body change behaviours such as dieting, binging and purging, exercise (which can be excessive to the point of injury) and the use of performance and body enhancing drugs including anabolic androgenic steroids (AAS), which are usually obtained illegally (Grieve, Truba & Bowsersox, 2009). Prolonged use of AAS in particular can pose potentially serious mental and physical health risks (Thiblin & Petersson, 2005).

6.2. Prevalence of body image issues

A specific desire to be more muscular is common in Western men. In the United States, for example, the vast majority of undergraduate males (up to 90%) in one study expressed this desire (Frederick, Buchanan, Sadehgi-Azar, Peplau & Haselton, 2007). At about the same time, Rief et al. (2006) reported a prevalence rate of BDD (as defined by DSM-IV) in the general population of 1.7%. However, they concluded that these reported rates are likely to underestimate the true prevalence as the study excluded those with weight concerns, some of whom may have had BDD.

Some studies have found that gay men have greater body dissatisfaction than heterosexual men (Peplau et al., 2009; Tiggemann, Martins & Kirkbride, 2007). Wrench and Knapp (2008) found that compared to their lesbian and bisexual counterparts they found significantly higher levels of body image fixation in gay and bisexual males as well as more negative attitudes towards and dislike of fat people, 'weight locus of control', discrimination against others' weight/ physique, and depression.

Compared to their heterosexual counterparts, gay men reported dieting more, being more fearful of becoming obese, and were more dissatisfied with their bodies generally as well as with their muscularity.

Additionally some evidence suggests that there may be a higher incidence of BDD amongst gay men compared to heterosexual men; however, an obvious tension is the omission of bisexual men, or the conflation of bisexual identity with either a gay or straight identity (Barker et al., 2012). For example, the following studies do not include bisexual men. Kaminski, Chapman, Haynes and Own (2005) found that compared to their heterosexual counterparts, gay men reported dieting more, being more fearful of becoming obese, and were more dissatisfied with their bodies generally as well as with their muscularity. They were also more likely to hold distorted beliefs about the importance of having an ideal physique. This has also been supported by others who also found that gay men were more pre-occupied with being overweight, had lower appearance evaluations and more negative feelings about their bodies (Lakkis, Ricciardelli & Williams, 1999; Peplau et al., 2009; Tiggemann et al., 2007).

Tiggemann et al. (2007) studied gay and bisexual men separately, and found that although they both had a thinner and more muscular ideal, gay men still had significantly thinner preferences than bisexuals and

rated themselves as the least muscular of the group. By contrast, Davids and Green (2011) found that body dissatisfaction levels in bisexual men were similar to those in gay men, so additionally such an inconsistency in findings may need to be further investigated.

6.3. Risks and predisposing factors

6.3.1. Personality and other associated factors

A literature review that explored studies of the psychopathology of BDD (Pavan, Simonato, Marini, Mazzoleni & Pavan, 2008) identified a wide range of factors that may predispose individuals to developing BDD. These include 'asthenia/ hyposthenia (lack of strength), a tendency toward self-criticism, insecurity, and perfectionism and OCD' (p.474). A study by Lambrou et al. (2011) reported that men with BDD have a more critical eye and greater appreciation of aesthetics than control groups, this ability being applied when evaluating their own appearance. They also found that individuals with BDD valued physical appearance three times more than control groups and that this may be to a dysfunctional degree.

Meyer, Blissett and Oldfield (2001) found that gay men who identified more with 'femininity' were more likely to restrict their diet. Another study by Lakkis et al. (1999) found more specifically that, after the influence of sexual orientation was controlled for in heterosexual and gay men, traits negatively associated with 'femininity' such as lower levels of assertiveness and self-esteem and greater expressions of passivity and dependence significantly predicted a higher drive for thinness, dietary restraint and bulimia.

6.3.2. Loneliness, poor self-esteem and shame

Studies have found associations between poor self-esteem, loneliness, and MD among gay and bisexual men (Chaney, 2008), between body dissatisfaction and body fat dissatisfaction and lower self-esteem in gay and bisexual men, and between poorer self-esteem and muscle dissatisfaction for gay men only (Tiggemann et al., 2007).

Downs (2005) posits that a sense of shame for simply 'being gay' thwarts gay men's development of an 'authentic' (self-accepting) self and results from difficulties living in a heterosexist culture that denigrates sexual minority people. He suggests that body dissatisfaction (and BDD) and the compulsive need to improve physical appearance is an expression of this internal shame.

A sense of shame for simply 'being gay' thwarts gay men's development of an 'authentic' self and results from difficulties living in a heterosexist culture that denigrates sexual minority people.

6.3.3. Bullying

Experiencing body-related comments in childhood is also a predictor of poor self-esteem in adult men. One study found a strong association between being a victim of childhood bullying and muscle dysmorphia

and concurrent anxiety, low self-esteem, and depressive and obsessive-compulsive symptoms in men (Wolke & Sapouna, 2008). Calogero, Park, Rahemtulla & Williams (2010) reported that it was the expectation of rejection for their appearance rather than actual rejection that causes the distress that may lead to behaviours associated with BDD.

6.3.4. Pressure to conform

Pressure to conform to culturally constructed body image ideals is known to contribute to the development of muscle dysmorphia (Grieve, Truba & Bowsersox, 2009) as well as to body dissatisfaction and body dysmorphia. A review of studies that explored the impact of the media on body ideals and body dissatisfaction found that young men were negatively affected by viewing idealized images of male bodies.

6.4. Prevention: resilience and risk reduction

Prevention of body image disorder has received little research attention compared to explorations of risk and predisposing factors. Prevention is not just about reducing or removing risk factors, such as bullying, but includes bolstering individuals' coping mechanisms for dealing with adversity and life's stresses. An aspect of coping is psychological resilience defined as, 'the capacity to recover from extremes of trauma and stress' (Atkinson, Martin & Rankin, 2009).

6.4.1. Better appearance evaluation and social comparison

Having a better appearance evaluation is unsurprisingly associated with better body image and thus may be protective against BDD (Peplau et al., 2009), possibly as it may also increase self-esteem; however, it is worth noting that better body image may equally be responsible for a better appearance evaluation, which cannot be tested in a cross-sectional survey.

Social comparison may also be protective against BDD (Davids & Green, 2011). This may be because it gives a person a 'reality check' for their body image ideals, and perception of their own attractiveness in comparison to other gay and bisexual men.

6.4.2. Positive identification with 'masculinity' and drive for muscularity

In a recent study, heterosexual men perceived their bodies to be less muscular and reported lower confidence in their physical abilities after they felt that their 'masculinity' had been threatened compared to men whose masculinity had been affirmed (Hunt, Gonsalkorale & Murray,

2013). However, when men were asked to report on anxiety related to appearance and intentions to increase muscularity following a threat to masculinity, results indicate that men reported less appearance-anxiety and drive for muscularity when threatened rather than affirmed. The relationship between appearance anxiety, drive for muscularity and attitudes to 'masculinity' requires further exploration, particularly where attention to appearance is often considered 'feminine', even – paradoxically – when related to muscularity. Complexity where gender-roles and sexual orientation intersect must also be considered, for example for bisexual or gay men.

In contrast, having greater drive for muscularity was found to be protective against body dissatisfaction in bisexual men (Tiggemann et al., 2007). In this study, the cohort of bisexual men sampled rated themselves as more muscular than the gay male sub-sample, and the gay men in the study had a thinner ideal, so what may aid resilience is a desired body image that is perceived to be more realistically achievable.

Rationale for the study

Previous research suggests that to a large extent risk seems to rise from exposure to external factors, while resilience may derive from a combination of a supportive environment, the acceptance of oneself and the attachment to the LGB&T community.

The reviewed literature highlights the challenges, as well as some opportunities, that LGB&T people face in their daily lives and in their communities in relation to their mental health. While the social and cultural environment has changed significantly in Britain over recent decades, there are indicators that LGB&T people still struggle with discrimination and abuse in various contexts, with the potential to contribute to the development of mental health problems. In fact, previous research suggests that to a large extent risk seems to rise from exposure to external (i.e. societal) factors, while resilience may derive from a combination of a supportive environment, the acceptance of oneself and the attachment to the LGB&T community.

However, while international research has highlighted some of these issues, little is known about mental health risk and resilience factors for LGB&T people living in Britain. Our study aimed to address this gap by gathering both qualitative and quantitative data and by using it to produce a detailed portrait of this reality.

The choice of the specific mental health issues under study was informed by previous research suggesting higher prevalence rates amongst LGB&T people (e.g., King et al., 2008) but also by the experience gathered from three decades of experience that PACE has as a charity providing support for the mental health needs of the LGB&T community. The RaRE study delivers evidence of that experience as a community sector organisation and also identifies priority intervention areas, adjusted to the real needs of the community, both at PACE and beyond.

While being quite different from each other (and despite the potential for morbidity overlaps between them), all three issues under study can cause severe suffering and negatively impact the LGB&T community as well as the families and friends of those affected. It is our understanding that increasing the knowledge about these issues will contribute to the improvement of the well-being of the LGB&T community and of society overall.

Methods

The RaRE study is a multi-phase study using a mixed-methods design drawing from both qualitative and quantitative methodological research approaches. This is done not with the aim of triangulation to avoid 'specious certainty' (Robson, 1993) but rather to provide 'complementary components' to the study.

The RaRE study is a multi-phase study using a mixed-methods design drawing from both qualitative and quantitative methodological research approaches.

Excluding the stakeholders survey, which was the very first phase of the project and that will not be covered by this report, there were three data collection phases, each one informing the next. All of them benefited from the extensive literature review conducted for the study (summarised for this report) and from the research team's expertise and feedback. All phases were cross-sectional.

The first of these phases was an exploratory qualitative study (P1Q) during which LGB&T people who experienced the mental health issues under study were recruited and interviewed about their lives and experiences of risk, resilience and recovery. The purpose of this phase was to gain insight into the lived experiences of these people so as to better understand which factors played a role in the development of their mental health issues and in their recovery.

The second phase was a national survey. The purpose of this survey was to collect data that would allow comparison of LGB&T and heterosexual & cisgender people's risk and resilience factors. Therefore, it was targeted at adults (ages 18+) of all sexual orientations and gender identities from across England.

The third phase of the study (P2Q) was qualitative and its purpose was to gather a more nuanced picture of the realities of LGB&T people's mental health. We were particularly interested in understanding atypical risk and resilience profiles, i.e., those who might have experienced traumatic experiences while growing up but did not develop mental health issues later in life, as well as those who did not have those types of experiences but did have mental health issues later in life, developing one of the three issues under study. Informally we called the first of the two subgroups the 'resilience' group and the second one the 'risk' group. Although the methodology for this phase will be presented in this report, no results from it will be presented or discussed here.

In this section we provide the relevant details of the methodology used for each of the research phases of the study.

1. Ethical approval

Ethical Approval for the RaRE Study as a whole was obtained from the Ethics Committee of Aston University in April 2010[3]. Additional Ethics approval for P2Q was obtained from Worcester University in December 2013.

2. First qualitative study (P1Q)

2.1. Selection criteria

To be included in this phase of the study, individuals had to be 18 years of age or older, identify as LGB or Trans*, have experience from one of the three mental health issues under study but have been in recovery from them at least five years prior to enrolment in the study. In the case of the suicide group, their first suicide attempt was to have occurred after they were aged from 12 years up to and including age 24. At least six years must have passed since their last serious attempt. The study specifically prioritised participants whose attempt had been life threatening whether or not it had been committed with intention to die.

2.2. Recruitment

Participants in this phase of the study were recruited through advertisements on LGB&T media, handout and poster distribution in specific locations in and around London, systematic and strategic emailing and follow up, and word of mouth. They then underwent an initial screening with the research coordinator to confirm they met selection criteria. If they did they were sent further information about the study and given a buffer period of no less than 48 hours. After this time they were contacted and asked if they were still available to participate in the interview. If they were, they were scheduled to come in for the interview.

Recruitment took place between July 2011 and March 2012.

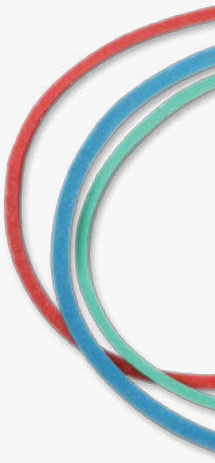
2.3. Data collection

In-depth, semi-structured interviews with LGB&T people with a history of issues under study were used to collect data. All participants were informed about the aims of the study, topics under study and potential

3 When the researched commenced Prof Elizabeth Peel was at Aston University, later having moved to University of Worcester.

risks of participating. Written consent was obtained prior to the interview. After giving consent, participants completed a demographic questionnaire. They were also given the option of withdrawing from the interview at any point without an explanation.

The interviews were carried out face-to-face or over the phone. All were audio recorded using a digital recorder. After the interviews took place the audio files were downloaded to a secure drive and deleted from the recording devices. Interviews were transcribed, checked for transcription errors and cleaned of identifiers.



2.4. Instruments

2.4.1. Demographic questionnaire

This questionnaire included a series of questions about demographic information, including sexual orientation and gender identity, for purposes of gathering descriptive information about the participants and about the sample for reporting purposes.

2.4.2. Interview guide

The interview guide was developed by the research team informed by the literature review and main research questions, therefore covering background factors that might have contributed to the development of the mental health issues under study, access to support and recovery factors, among others (Appendix 1). Altogether the guide included 11 questions organised thematically (e.g. 'What do you think may have played a part in causing your alcohol misuse issues or making it worse?', 'Can you think of anything that might have helped prevent your attempted suicide?') and included at the end the possibility for interviewees to add anything relevant they considered had not been covered in the interview.

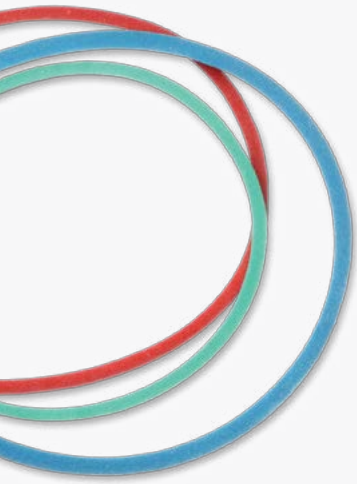
3. Quantitative study (Survey)

3.1. Selection criteria

Selection criteria for the RaRE study's survey included being aged 18 or older and living in England. Since comparisons between heterosexual & cisgender and LGB & Trans* people were to be made, people from all sexual orientations and gender identities were asked to take part. Publicity materials were designed taking that into account. Only completed surveys were included in the final dataset.

Since comparisons between heterosexual & cisgender and LGB & Trans* people were to be made, people from all sexual orientations and gender identities were asked to take part.

3.2. Survey Development



Initial versions of the survey were informed by the literature review, content analysis of interviews from the Phase 1 Qualitative Study (P1Q), other surveys evaluating similar issues and by research team expertise. There was a systematic and rigorous process of revision by different stakeholders: RaRE team, Academic Panel, Lay Panel and PACE colleagues. The final draft was pilot tested by an independent panel of volunteers recruited for the purpose. The survey was was programmed on Survey Monkey software and this process led to final adjustments to ensure it was simple to read and to complete. The online version was further tested by the study team, Academic and Lay Panel members as well as by other PACE staff members. There was then a final process by which the online version and the paper version of the survey were systematically compared and adjusted so that they mirrored each other, hence reaching a final version of the complete scale (Appendix 2).

Standardised components of the survey included the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988; binary scoring), the Multidimensional Scale of Perceived Social Support (MDSSPSS; Zimet, Dahlem, Zimet & Farley, 1988), Rosenberg's Self-esteem Scale (RSS; Rosenberg, 1965), the Importance of Gay/Bisexual Community Activities scale (IGBCA; Herek & Glunt, 1995; adapted by changing 'gay/bisexual' to 'LGBT') and the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders & Monteiro, 2001; Donovan, Kivlahan, Doyle, Longabaugh & Greenfield, 2006). Academic panel expertise and literature review informed questions about body image, self-harm and suicide as well as various other survey items.

For body image a new instrument was developed: the 16 item four point (Strongly disagree, Disagree, Agree and Strongly agree) RaRE Body Satisfaction Scale (RBSS), which asked participants how satisfied they were with various aspects of their bodies (e.g. their height, their faces, etc.) and body-related behaviours (how much they eat or exercise). An additional five point scale was developed which measured how participants rated the influence from various people (e.g. parents, siblings, childhood friends or classmates, people in the media, your doctor) and sources on the way they think about their bodies (from 'Had no influence at all' to 'Had a great influence', and including a 'Not applicable' option).

Both body image scales underwent a principal component analysis with Varimax rotation which identified two subfactors for each. For the RBSS, factor 1 was related to the bodily aspects that can be influenced through fitness (health, physical fitness, weight, body shape, body fat, muscularity, food, exercise); factor 2 was related with bodily features that could be seen as more fixed physical characteristics determined by the late teens and difficult or impossible to change later in life without cosmetic or surgical interventions (height, face and features, teeth, hair, body hair, genitals,

age). The item 'How much alcohol I drink' did not have loading on either of the factors and therefore was excluded. For the instrument about social influence on feelings about the body, factor 1 included people from the close social network and health professionals (parents/carers, siblings, friends, romantic partners), and factor 2 included the remaining, including people in the larger social environment (childhood friends and classmates, people in your daily life, people in your leisure time and people in the media).

Regarding suicide or self-harm, questions were developed that asked participants whether they had experienced or thought about either of those two behaviours in the previous year or ever in their lives.

3.3. Recruitment

Alongside the development of the survey, the RaRE study team developed a national recruitment strategy that would ensure widespread visibility and completion of the survey by a diverse range of people.

Calculations were made during initial phases of the study to determine sampling for each of the study phases. For the RaRE study national survey a minimum of 1200 participants was shown to be sufficient in order to perform all necessary statistical analyses. However, we targeted at recruiting a bigger sample in order to ensure inclusion of a diverse range participants, some of which are considered hard-to-reach groups (e.g. people from BME backgrounds, disabled people, older people). Recruitment took place between June and November 2013.

3.3.1. Emailing and partnerships

The first wave of recruitment consisted of an email to PACE staff members and volunteers asking them to forward information about the survey to their contact networks. This was followed by emailing PACE's partner organisations asking them to advertise the survey through their networks and resources, e.g. emailing their own contact lists, publicising the survey in their newsletters, etc. New partnerships were established by the RaRE study team with organisations that had a potential of reaching broad or strategic audiences. For those organisations that were willing to distribute print publicity materials to their clients, packages were sent that contained flyers and posters. Various other contact databases available at PACE were used in continuing emailing waves that publicised the survey. Unique Survey Monkey collector links were allocated to most of these organisations, allowing the monitoring of the recruitment that came through them.

3.3.2. Web advertising

Strategic websites were selected and contacted to assist with advertising of the survey through web banners, short news pieces in newsletters and other forms of online advertisement. Some of the types of websites used were women's and men's health and wellbeing organisations, LGB&T organisations, mental health related websites, etc. A series of promotional images were developed reflecting concepts of the study for the purpose of increasing visibility and in order to create a recognisable and consistent image for the study.

3.3.3. Social Media

Social media networks like Facebook and Twitter were used to recruit participants in two ways. On one hand, PACE's accounts on these websites were used to post regular messages with a link to the survey asking people to complete the survey as well as to share it with their networks. On the other hand, paid Facebook advertising campaigns proved to be very effective recruitment strategies in their ability to target specific groups that were underrepresented in the sample. Facebook's marketing tool allowed for targeting specific profiles of people to be exposed to our advert, this way targeting groups from which we had low numbers, as identified by our monitoring of the recruitment. Some of the groups that we targeted using this strategy were bisexual men, people in geographically remote areas, and others.

3.3.4. Events

Non-LGB&T as well as LGB&T specific events were selected for attendance by team members for study advertisement and survey collection. RaRE stalls where people could learn about the study, complete a survey and take flyers and posters were used at Black Pride 2013 and at two London universities' student fairs. Furthermore, flyers and posters were sent to LGB&T and health promotion events across the country to increase visibility of the project. RaRE team members also attended various conferences in 2013, where preliminary results of earlier phases of the project were presented, awareness was raised about the survey and people were presented with the web link and asked to complete the survey online.

3.3.5. Print advertising

At various stages of the recruitment phase print advertisement campaigns were carried out to increase visibility and to reach people that were not active on the Internet. Over 6,200 flyers and 215 posters were distributed in strategic places in the city of London, including in Soho, as well as in Brighton and at other smaller Pride events across

England. Electronic versions of the survey were also sent out via email so that recipients could print and distribute them (postcards were emailed out 19 times and posters 82 times). Additionally, press releases were also sent out to 18 general and LGB&T specific media outlets. study that allowed identification ofin

3.4. Recruitment monitoring

Each recruitment method was allocated a unique collector link on Survey Monkey, hence allowing monitoring and informing the refinement of the recruitment strategy in two ways. One of them was to verify the success of the strategies used so that ineffective ones could be tweaked and made more efficient or abandoned. The other way that monitoring was used was to check whether specific subgroups of interest were falling behind in representation, e.g. bisexual men or women with a history of alcohol abuse. If that was the case, new strategies were devised to target those subgroups. New strategies were assigned new collector links to monitor their effectiveness.

3.5. Informed Consent

Completed surveys were accepted only if participants had ticked the informed consent box in the first part of the survey. The informed consent sheet consisted of information about the study topic, source of funding, which organisation was running the study and confidentiality. It explained the options people had to withdraw from the study and the risks and benefits of being involved.

4. Second qualitative study (P2Q)

4.1. Selection criteria

For this phase of the research we were interested in interviewing individuals who had experienced traumatic events while growing up but who did not develop mental health issues later in life (the 'resilience' group); as well as those who did not experienced traumatic events growing up but did develop mental health issues (the 'risk' group). For the second group we were also interested in interviewing individuals who, meeting those criteria, also developed one of the three key mental health issues of the study: had attempted suicide while growing up (identifying as LGB or Trans*); had abused alcohol (identifying as a lesbian, gay or bisexual woman); and had excessive body image preoccupations (identifying as a gay or bisexual man).

To participate in the study all individuals had to be 18 years of age or older.

4.2. Recruitment

In the first phase of the recruitment process individuals who had participated in the survey and had provided their contact details and given agreement to taking part in the following phase of the research (P2Q) were contacted in several waves. This continued throughout the recruitment process. However this method proved insufficient to recruit the targeted number of participants (n=20). For that reason, alternative methods of participant recruitment were devised. Posters and leaflets were distributed across key London locations; emails were sent out and social media resources were used to recruit additional participants. Paid Facebook campaigns targeted at specific segments of the population (e.g. lesbian and bisexual women living in London with an interest in alcohol or in alcoholic anonymous support groups) generated additional participants.

Monitoring was used throughout the recruitment process to ensure diversity in the sample with regard to gender, sexual orientation, ethnicity and age. When the recruitment target was reached, a further effort was made to achieve a similar number of participants per mental health issue in the 'risk' subset of the sample. A total of 23 participants were recruited in this way.

Recruitment took place between February and April 2014.

4.3. Procedures

A recruitment survey was created, developed and made available online. The purpose of this survey was to collect information from people available to participate in the study in order to identify those who fited the selection criteria stated above. People who showed an interest in participating in the study were directed to the survey and asked to complete it. The data collected in this way was regularly downloaded and subjected to a standardised filtering process that excluded those whose replies indicated they did not fit the criteria. The research coordinator then checked the remaining participants and if they did match the selection criteria they were shortlisted for telephone screening. A member of the research team then telephoned the potential participant and asked a standardised series of questions intended to confirm their suitability to the study goals. If they were suitable, they were sent further information about the study via email and given 48 hours to reflect on their further participation in the study. After 48 hours they were contacted again and asked if they were still available to participate in the study and, if they were, they were scheduled for interview.

Interviews were carried out face-to-face or by telephone. In both cases written consent was obtained prior to the start of the interview. The interviews were semi-structured, with the interviewers being

instructed to ask the main questions in the guide but also to explore other relevant aspects of the interviewees' experience and perceptions as appropriate. The interviews were recorded using a digital recorder (two recorders, in the case of face-to-face interviews). Interviewers were always debriefed about the interviews with a member of the research team after the interview took place. This allowed the identification of any practical, ethical or scientific issues that had been identified, allowing for additional measures to be put in place to address them, if and when needed. The audio files and transcription processing procedures were similar to those undertaken for P1Q.

4.4. Instruments

4.4.1. Recruitment instruments

Several instruments were created and used to recruit P2Q participants. These will be briefly outlined here, but full details and the instruments used are available from the research team.

Pre-recruitment survey: this online survey was linked with the main study survey and asked participants a series of questions to ascertain their suitability and also their availability for participation in P2Q. At the end of the paper version of the survey participants were provided with details about P2Q and asked to leave their email addresses if they were available to participate in it. Both these forms of P2Q pre-recruitment lasted during all of the survey's recruitment process, from June to November 2013.

Recruitment survey: this online survey was a more detailed and expanded version of the previous one and used upon launch of recruitment for P2Q. Many of the questions it included (e.g. those to ascertain body image issues or suicide attempt experience) were either copied or adapted from the main study survey. It also included more detailed questions about participant's availability and contact details. It was available from February to April 2014.

Inclusion Criteria Assessment Tool: this instrument was used as a guide during telephone interviews to confirm whether shortlisted individuals met the selection criteria. It asked similar questions about traumatic experiences while growing up and later in life, as well as about experience of the mental health issues under study. As necessary interviewees were asked to self-define their concept of the topics under study (e.g. excessive alcohol use or traumatic events), but ultimately allowing for interviewer expertise to make a decision about inviting participants for enrolment in the study. This instrument was used throughout the recruitment process for P2Q, from February to April 2014.

4.4.2. Interview guide

Four interview guides were developed, one for each of the subgroups of interest for this phase of the research: one for the 'resilience' group and three for the 'risk' groups (Appendix 3). These were adapted to the research interests of each subgroup and, in the case of the 'risk' subgroup, to the mental health issues experienced by participants. However, all of the guides included a common set of questions that covered key issues under study, and all of the three of the 'risk' subgroup had a similar structure.

All interview guides were developed by the research team informed by the literature review and main research questions.

All interview guides were developed by the research team informed by the literature review and main research questions.

5. Analysis

5.1. Qualitative studies

All interviews underwent a process of thematic analysis, conducted as per Braun and Clarke's (2006) guidelines. The transcripts were first coded in sequence using a data-driven approach, identifying new codes based on the content of the interviews and guided by the research questions. Codes identified later in the process were added to earlier interviews where applicable.

When all interviews had been coded, the codes were examined, evaluated for similarity, and grouped together in structure, with tentative names assigned to the code groups. Codes with few source references were moved, merged, renamed or deleted after close re-reading of the code content. The code sets were then further grouped into overarching potential themes, and separated into risk and resilience factors, informed by scientific literature on the topics of analysis.

The model emerging from this process was then streamlined by examining the meaning of the central codes and the relationships between them, and then further reducing the model to overarching central themes.

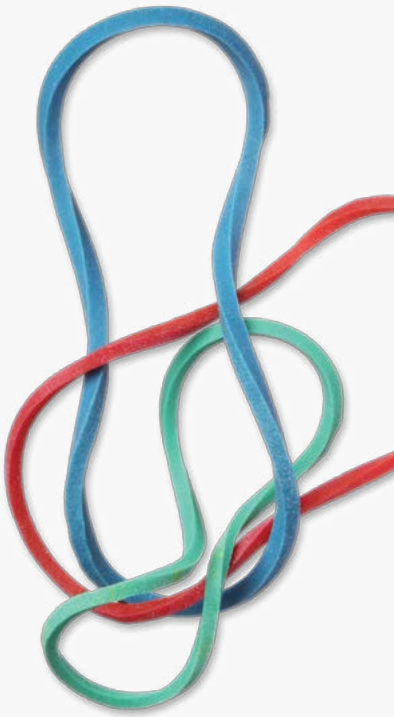
For confidentiality and reporting purposes all participants were assigned aliases.

5.2. Quantitative study

For descriptive statistics, Chi-Square analyses were carried out for comparisons of all the categorical variables; ANOVAs or T-tests were used for comparisons of the continuous variables, as appropriate. A significance level of .05 was used as the threshold for all analyses; however, some marginally significant results are also reported, where they seem to be particularly pertinent to the issues under study.

For identifying the risk and resilience factors, backward stepwise logistic regressions were used in order to raise statistically significant risk or resilience factors predicting the outcome (Menard, 2010). This procedure is commonly used in exploratory research, including in psychiatric research, and has been used in sexual minorities mental health research (Paul et al., 2002). The more relaxed significance level of .1 when excluding the variables instead of the conventional .05 was used since too strict criteria may eliminate predictors that may be significant when all the other irrelevant predictors are removed (Paul et al., 2002). For variables with many outcome values (more than 5), quartiles were used to reduce the number of outcomes choices to four; this prevents empty cells when calculating regression coefficients. These variables were age as well as the total scores for the MDSSPSS, the GHQ-12 and the RSS.

Variables to include in each of the models were only selected after extensive literature review on identified risk and resilience factors for each of the three topics being researched. In the first step of the regressions, all the variables were added to the model. In the second step all the non-significant variables ($p>.1$) were removed and the regressions ran again. In the third step, the sample was split between hetero and LGB+ participants in order to compare whether there were differences between the variables explaining the outcome.



Results

1. The study samples

1.1. P1Q sample

A total of 35 individuals (15 females; 19 males; one genderqueer) who met the selection criteria were interviewed for this phase of the research. Their average age was 38.6 years (SD=7.5). In terms of sexual orientation: two identified as bisexual, 17 as gay, 11 as lesbian and five as 'other' (e.g. queer or questioning). Two identified as being trans* (one as a trans women and one as trans man). Just over a quarter (25.7%) indicated they had a disability. The majority identified as being white (91.3%).

Of the total sample, the majority (n=17, of which 10 males and sevenfemales) including both cisgender and trans* participants were recruited and took part in the study due to their experiences of suicide while young. Nine gay and bisexual men were recruited due to their experiences of body image issues and nine lesbian and bisexual women were recruited due to their experiences of alcohol misuse.

Twenty-three interviews were conducted face-to-face and the remaining 12 over the phone for reasons such as simplifying access for participants and for allowing inclusion of participants living outside of London and with limited ability to travel.

1.2. The survey sample

Between June and November 2013, a total of 2,078 valid surveys were collected. Of all participants, 700 (36.5%) identified as heterosexual, and 1,320 (63.5%) as LGB+, of which 29.9% were gay, 16.8% lesbians, 16.7% bisexual and 2.8% identified with having an alternative sexual orientation (e.g. pansexual, asexual, queer).

The average age of LGB+ identified participants was 38.3 years (SD=12.3) and of heterosexuals 37.2 (SD=13.5); this difference was not statistically significant. There were more female participants in the heterosexual sample (75.7%) than in the LGB+ sample (42.9%), and more participants who identified with having an alternative gender (e.g. genderqueer, FAAB or female assigned at birth, etc.) in the LGB+ sample (3.7%) than in the heterosexual sample (0.9%). In both groups the percentage of non-white identified participants (LGB+ = 12.9%; Het= 15%) was similar to that of the English national population (approx. 15%; Office for National Statistics, 2011).

More GLB participants indicated they were single (45.8%) when compared with heterosexuals (34.1%). With regard to disability, significantly more GLB+ participants (18.6%) considered themselves to have a disability when compared with heterosexuals (10%).

Significantly more GLB+ participants (18.6%) considered themselves to have a disability when compared with heterosexuals (10%).

In total, 120 participants from the RaRE survey sample identified as Trans*. There are significantly more Trans* participants who did not identify as having a female or a male gender identity (45%) when compared with cisgender participants (0.9%). The average age of Trans* identified participants was 38.4 (SD=13.3) which is not statistically different from the average age of the cisgender identified participants (37.7; SD =12.7). Less Trans* participants identify as being BME (10.8%) when compared with cisgender participants (14%), however, this difference is not statistically significant.

More Trans* participants i ndicated being single (54.2%) when compared with cisgender participants (41.3%). Also significantly more Trans* participants considered themselves to be disabled (33.3%) compared with cisgender participants (14.8%).

In terms of overall geographical distribution, London was the region with the most participants (43.9%), but all other regions of England were represented in the sample with the smallest representation being from the North East (4.3% or 89 participants).

Details about the demographics of the survey sample can be found in Appendix 4.

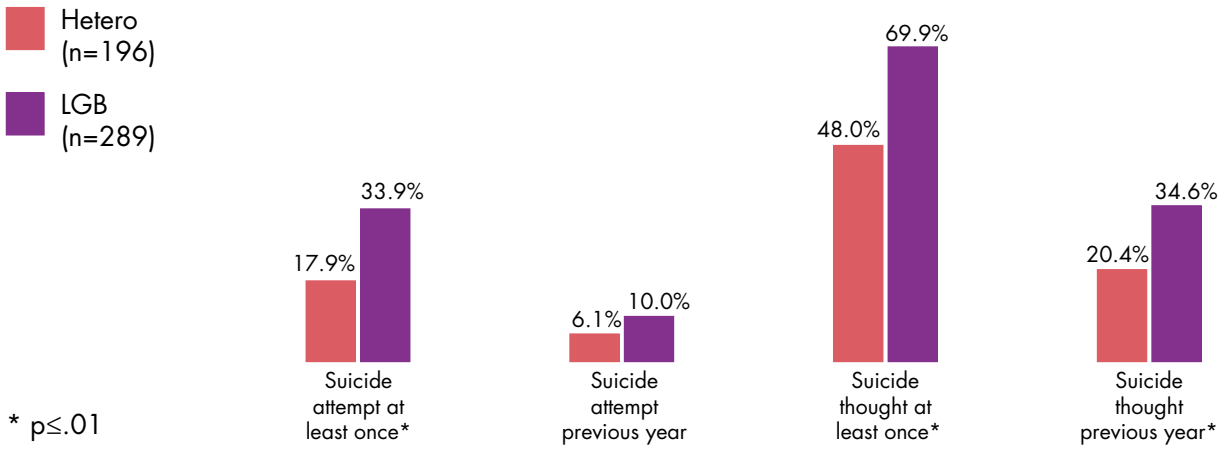
1.3. P2Q sample

A total of 23 individuals (13 females, nine males and one 'other') who met the selection criteria were interviewed for this phase of the study. The average age of participants was 36.2 (SD=11.5). In terms of sexual orientation, eight identified as lesbian, seven as gay, five as bisexual and two as 'other'. Two identified as being trans* (one a trans woman and another a crossdresser heterosexual man). Of the total sample, 10 matched the inclusion criteria and were interviewed due to their experiences fitting into the 'resilience' subgroup (five females, four males and one 'other'), including both trans* identified participants; of the 'risk' subgroup, five were recruited due to their experiences of suicide and self-harm (four females and one male), four gay and bisexual men due to their experiences of body image issues and four lesbian and bisexual women due to their experiences of alcohol misuse.

The majority of participants in the sample identified as white (91.3%); two identified as having a disability. In terms of geographic distribution, the majority lived in London (12), with the remaining participants being distributed across the rest of England.

We conducted 11 interviews face to face and the remaining 12 over the phone.

Figure 1 - Comparing suicide indicators LGB vs hetero young people



2. Findings

2.1. Suicide and self-harm among young LGB&T people

2.1.1. Descriptives

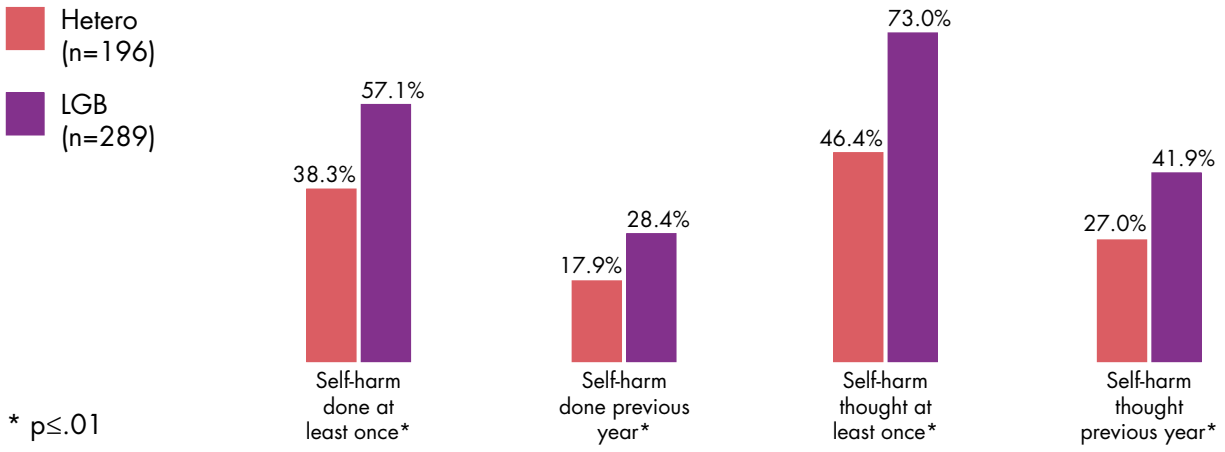
In the subset of survey participants aged 26 and under (n=485), when compared with their heterosexual counterparts by using Chi-Square analyses, LGB[4] young people have significantly higher rates of lifetime suicide attempts, as well as of lifetime and previous year suicide ideation (Figures 1 & 2). For the same subset, young LGB participants have significantly higher rates of lifetime and previous year self-harm ideation and experiences. The only non-significant result for this group of comparisons is for suicide attempt in the previous year.

In the subset of participants aged 26 and under (n=485), when compared with their cisgender counterparts, Trans* individuals have significantly higher rates of both lifetime and previous year suicide attempts and ideation. For the same subset, young Trans* participants have significantly higher rates of lifetime and previous year self-harm ideation and experiences[5] (Figures 3 & 4).

4 This analysis excludes participants identified as having an "other" sexual orientation.

5 Sexual orientation was not controlled in this analysis, and therefore both groups will include participants who identify as LGB or heterosexual.

Figure 2 - Comparing self-harm indicators LGB vs hetero young people



2.1.2. Predictors of suicide and self-harm indicators for young LGB people

Suicide attempt

A backward stepwise logistic regression was performed to ascertain the effects of self-esteem, family support (two variables were used for this purpose: 'I get emotional help and support from my family' and 'My family is willing to help me make decisions' from a Likert scale, converted into quartiles to allow inclusion in the model) and income on the likelihood that young LGB+[6] young people have attempted suicide. The logistic regression model was statistically significant ($\chi^2(4, n=218) = 36.89, p<.001$) and explained between 15.6% (Cox and Snell R square) and 21.7% (Nagelkerke R square) of the variance and correctly

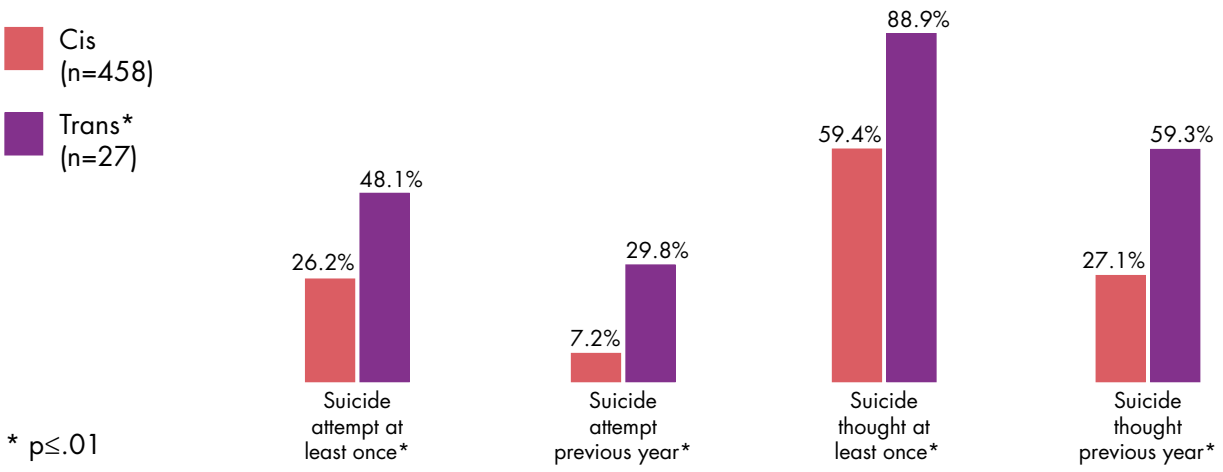
Table 1 - Predictors of suicide attempt for young LGB people

LGB+	Hetero
Self-esteem (—)	Self-esteem (—)
Income (—)	Income (—)
Perception of family helping to make decisions (—)	

Note – A plus or minus sign indicates the direction of the relationship found between the independent variable (suicide attempt) and the predictors listed

6 Includes all participants not identifying as heterosexual, including 'other', but does not control for gender identity due to low numbers of young Trans* participants in the sample.

Figure 3 - Comparing suicide indicators Cis vs Trans* young people



classified 71.1% of cases. Lower levels of income (β -.319, p<.005), self-esteem (β -.582, p<.001) and family support on decision making (β -.488, p<.01) were associated with an increased likelihood of making a suicide attempt. Emotional help and support from family was not found to be significant.

For young heterosexual people, the logistic regression model was also statistically significant ($\chi^2(4, n=146) = 36.41$, p<.001) and explained between 22.1% (Cox and Snell R square) and 36.3% (Nagelkerke R square) of the variance and correctly classified 82.9% of cases. For this group it was found that lower levels of income (β -.400, p<.05) and self-esteem (β -1.193, p<.001) were associated with an increased likelihood of suicide attempts. None of the family support measures were found to be significant in this model.

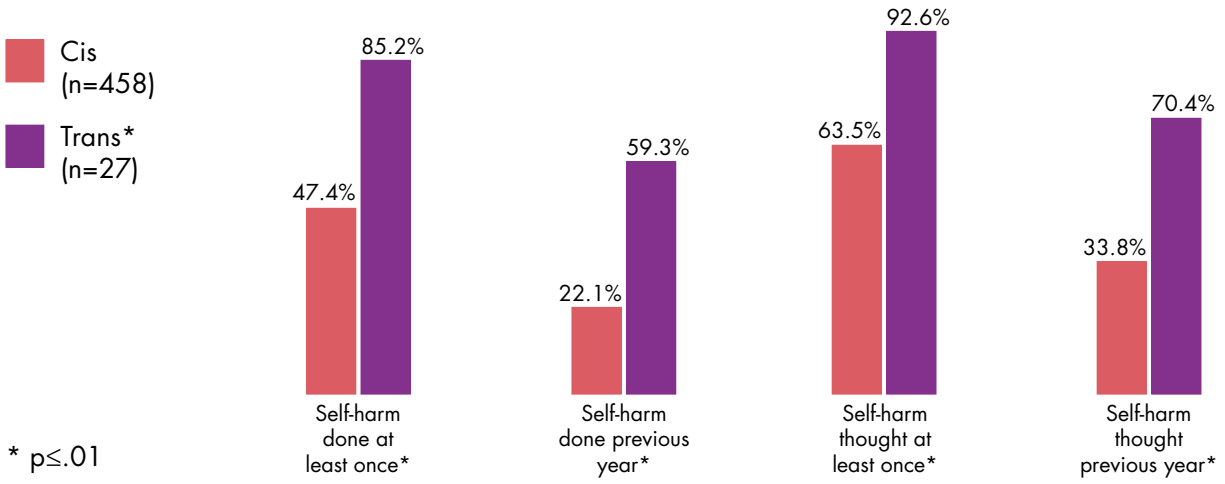
Table 2 - Predictors of suicide ideation for young LGB people

LGB+	Hetero
Self-esteem (—)	Self-esteem (—) Income (—) Social support (—) Consider themselves to have been different (—)

Suicide ideation

A backward stepwise logistic regression was performed to ascertain the effects of self-esteem, income, social support, relevance of faith or believe and perception of having been different while growing up on the likelihood that young heterosexual and LGB+ young people have

Figure 4 - Comparing self-harm indicators Cis vs Trans* young people



had suicidal ideation. The logistic regression model was statistically significant ($\chi^2(5, n=217) = 42.03$, $p<.001$) and explained between 17.6% (Cox and Snell R square) and 25% (Nagelkerke R square) of the variance and correctly classified 76% of cases. Lower levels of self-esteem (β -.754, $p<.001$) were associated with an increased likelihood of having experienced suicidal ideation. None of the other variables in the model were statistically significant (decreased income was marginally significant, β -.193, $p<.08$).

For young heterosexual people, the logistic regression model was also statistically significant ($\chi^2(5, n=144) = 63.09$, $p<.001$) and explained between 35.5% (Cox and Snell R square) and 47.3% (Nagelkerke R square) of the variance and correctly classified 78.5% of cases. Lower levels of self-esteem (β -.728, $p<.001$), income (β -.277, $p<.05$), social support (β -.767, $p<.001$) and not having been considered different when growing up (β -1.046, $p<.05$) were associated with an increased likelihood of having experienced suicidal ideation. Faith or belief was not significant in the model.

Self-harm experience

A backward stepwise logistic regression was performed to ascertain the effects of self-esteem, family support (two variables were used for this purpose: 'I get emotional help and support from my family' and 'I can talk about my problems with my family' from a Likert scale, converted into quartiles to allow inclusion in the model), relevance of faith or belief at home while growing up and income on the likelihood that LGB+ young people would have experience of self-harming. The logistic regression model was statistically significant ($\chi^2(5, n=218) = 46.20$, $p<.001$) and explained between 19.1% (Cox and Snell R square) and 25.6% (Nagelkerke R square) of the variance and correctly classified

Table 3 - Predictors of self-harm experience for young LGB people

LGB+	Hetero
Self-esteem (—)	Self-esteem (—)
Perception of being able to talk to family about problems (—)	Perception of being able to talk to family about problems (—)
Perception of getting emotional support from family (+)	
Importance of faith or belief at home while growing up (+)	
Income (—)	

71.6% of cases. All variables were significant in the model. Lower levels of self-esteem (β -.738, p<.001), income (β -.23, p<.02) and a perception of being less able to talk with family members about problems (β -.489, p<.02) was associated with an increased likelihood of having self-harmed. The greater importance of faith or belief at home while growing up (β .281, p<.02) and perception of getting emotional support from family (β .365, p<.05) also increased the likelihood of having self-harmed.

For young heterosexual people, the logistic regression model was also found to be statistically significant ($\chi^2(5, n=146) = 49.34$, p<.001) and explained between 28.7% (Cox and Snell R square) and 38.5% (Nagelkerke R square) of the variance and correctly classified 76% of cases. For this group it was found that lower levels of self-esteem (β -1.068, p<.001) and a perception of being less able to talk to family about problems (β -.606, p<.01) were associated with an increased likelihood of self-harm.

Table 4 - Predictors of self-harm ideation for young LGB people

LGB+	Hetero
Self-esteem (—)	Self-esteem (—)
	Perception of being able to talk to family about problems (—)

Self-harm ideation

A backward stepwise logistic regression was performed to ascertain the effects of self-esteem, being able to talk about problems with family and having been considered to be different while growing up on the likelihood that LGB+ young people have thought about self-harming. The logistic regression model was statistically significant ($\chi^2(3, n=287) = 45.82$, p<.001) and explained between 14.8% (Cox and Snell R square) and 21.4% (Nagelkerke R square) of the variance and correctly classified 74.2% of cases. Lower levels of self-esteem (β -.867, p<.001) were

associated with an increased likelihood of self-harm ideation. None of the other two variables in the model were statistically significant.

For young heterosexual people, the logistic regression model was also statistically significant ($\chi^2(3, n=193) = 83.15, p<.001$) and explained between 35% (Cox and Snell R square) and 46.8% (Nagelkerke R square) of the variance and correctly classified 80.3% of cases. Lower levels of self-esteem (β -1.268, $p<.001$) and a perception of being less able to talk about problems with family (β -.292, $p<.05$) were associated with an increased likelihood of having thought about self-harm. Perception of being different while growing up was not found to be statistically significant in this model.

No regression analyses were possible between Trans* and cisgender young people due to low number of participants in the former group. Additional findings about the Trans* sub-sample of the survey will be reported in further publications from the RaRE Study.

2.1.3. Qualitative results (P1Q)

Brief description of the subsample

For P1Q of the research 17 people (six females, 10 males and one genderqueer) were interviewed due to their experiences of attempted suicide while young. One identified as bisexual, nine as gay, four as lesbian and three as 'other'. Their average age was 37.5 years (SD=8.1). The majority identified as white (13), indicated not having any religion (12) and being single (11). Four indicated being disabled.

Risk issues

There is strong evidence to suggest that cumulative factors for suicidality among LGB&T young people are closely related to negative experiences from others associated with coming out. Furthermore, all the interviewees, with one exception, experienced homophobic or transphobic distress while growing up. With that particular exception, there are indications that becoming aware of being LGB or T translated into periods of difficulty and uncertainty.

The narratives of most of our interviewees are marked by constant struggles in the face of homophobic or transphobic realities, generally experienced in the interviewees' family network, schools and circle of peers. As we go on to show, this was particularly the case in interactions with individuals with strong religious or heterosexist backgrounds. Moreover, having a distant relationship with their family increased the levels of anguish among our interviewees when young at the crucial moment when they were coming to terms with their sexual orientation.

Most of the participants in this phase of the study experienced homophobic bullying while they were at school.

Most of the participants in this phase of the study experienced homophobic bullying while they were at school. The consequences of this form of bullying can be dramatic: Sirus, a 28 year old gay man originally from Southern Europe, attempted suicide when he was only eleven years old. Others suffered abuse on the basis of a perception of their gender identity rather than because of their sexual orientation. In this respect, the two Trans* individuals interviewed for this research, Nicky, age 36, and Maureen, age 26, were both victims of bullying for their gender non-conformity. Both tried to conform to the pressures they were put under by trying to 'pass' for their gender assigned at birth, but this did not deflect the bullying.

A sense of incomprehension about the way they were treated led our interviewees to feel isolated and to suffer from low self-esteem. In order to face these adverse scenarios, they implemented behaviours such as drinking, truancy, smoking, self-harming, binge-eating, not talking to anyone, crying and attempted at performing normative gender, pretending to be who they were not.

Based on our evidence, to a large extent, LGB&T young people suicidality seems to be predicted by a tortuous coming out experience and it is possible to identify certain triggers that can lead to suicide ideation and attempts. It appears that homophobia or transphobia might lead to suicidal ideation, but specific triggers may precipitate the act itself. These triggers may be of an emotional nature, as was the case with Ian (52, gay), who attempted suicide at the age of 18, after the death of his mother from cancer:

'I just felt that that [suicide] was the only solution, and there was nobody to– well I wasn't prepared to speak to anyone about it.' (Ian)

I was gay and growing up in a very hostile environment; there was a lot of conflict with my father about it. [...] There was a lot of aggression, a lot of homophobic stuff coming at me from my father [...] And this was like in a climate where I guess there were no gay positive role models, I didn't know any other gay people, I thought there was something wrong with me and I remember feeling that really strongly [...]. It's complicated because round about the same time, my mum in my first year of university died so the whole thing culminated in it. But, I know sort of prior to– anything sort of happened to mum, I had a lot of negative self-harm thinking that was in place, all through my teenage years really. And I just felt that that [suicide] was the only solution, and there was nobody to– well I wasn't prepared to speak to anyone about it. (Ian)

Maureen, a trans-woman originally from Eastern Europe, was raised in a hostile environment, bullied in her social circle, physically abused by her stepfather, and reprimanded by her mother because of being Trans*. The escape she found from this reality was attempting suicide at the age of 20, after drinking.

I couldn't go to my parents. I wanted to become self-sufficient, which– it wasn't happening. Nobody to talk to, the community boxing you up

and they're just not happy with you. I couldn't live my life, they started all the time boxing me in; no, you are not a girl, and you can't live as a girl [...] I got very depressed with everything and then I saw the fast moving car, then I saw another one straight after so I decided to jump underneath it. (Maureen)

All interviewees but one considered the medical or professional response they received just after their suicide attempt to be inadequate. In some cases they could not open up, finding barriers to express their emotions to health professionals, but also health professionals being unprepared for dealing with their specific needs; in other cases, there was an inappropriate response from professionals. Ryan (45, gay), who attempted suicide when he was 24, remembered reading his psychiatrist's report as he left it accidentally on his desk: "this dishevelled young man smelling slightly of alcohol" and "with effeminate tendencies". An opportune and adequate intervention not only could have helped our interviewees to have a more prompt recovery from their suicide crisis, but also more opportunity to have a less traumatic and scarring coming out process.

Recovery and resilience

When asked about the circumstances that could have helped the participants in our study to prevent their suicidality all pointed out particular issues related to their own experiences and challenges as LGB&T young people. These related to issues of rejection or fear of rejection by lovers, peers, friends and most importantly family. Difficult coming out experiences increased strain on young people's social networks and their mental health, a situation aggravated by the lack of appropriate resources and support.

A lack of awareness and training around issues particularly relevant to LGB&T young people as hindering mental health service provision for this group during their suicide crisis.

Our findings suggest a lack of awareness and training around issues particularly relevant to LGB&T young people as hindering mental health service provision for this group during their suicide crisis. In effect, some of the people we interviewed said that the professional help they received in schools, hospitals, and general consultant practices was totally inadequate, while others highlighted the need for early and opportune interventions including LGB&T specific services. In relation to this, some interviewees expressed that family understanding regarding their sexual orientation, and feeling safe in school would have had a positive impact on their well-being.

Interacting with other LGB&T people made a significant positive impact on their lives.

It should be noted that for most interviewees, the help and support they received was obtained by connecting with significant others and by embracing self-worth. In some cases, this support came from their family in the aftermath of their suicide attempt, and in other cases interacting with other LGB&T people made a significant positive impact on their lives. Esther (32, queer), who suffered homophobic bullying after coming out at school and attempted suicide at age 17, remembered her first LGB&T pride in London:

I was very aware that I was part of the stereotype, the depressed gay teenager and so it was nice to be around people that weren't that and it was just nice to be around so many LGB&T people all in one go and people having a nice time. It felt good. [...] I had a lot of people kind of telling me, including my mum in particular, "oh you're destined to be lonely" and "those types of relationships never work" and I guess going there made me realise- actually "you're talking crap". (Esther)

Having a sense of belonging to the LGB&T community can be protective against suicidality, by strengthening individual identity and possibly making young people feel part of a collective identity. However, not all our interviewees had this opportunity. For some, in depth planning was required: waiting to become an adult and leave the family home, while in the meantime focusing on school or hobbies. For example, Ian found refuge in reading novels by gay writers, while Robin, a 33 year old gay/queer man, focused on figure skating practices. Interestingly, all our interviewees, by sharing their experiences with us reported seeking to help LGB&T young people who feel suicidal. Their view was that by doing so, they not only support other LGB&T people, but also fight prejudice around mental health issues, and normalise sexual diversity.

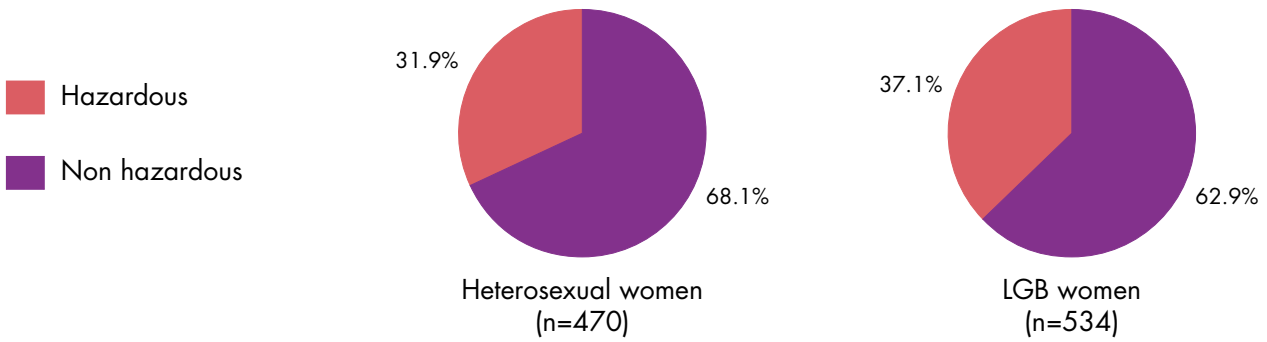
2.2. Alcohol misuse among lesbian and bisexual women

2.2.1. Descriptives

There are no significant differences in our survey sample between levels of hazardous or dependent alcohol use as measured by the AUDIT between heterosexual women (n=470) and LGB women (n=534) (Chi-Square analyses; Figures 5 & 7). Comparisons were also run by breaking down the LGB group (bisexual vs lesbian and gay identified women), but even then no differences were found between these and heterosexual women (Figures 6 & 8).

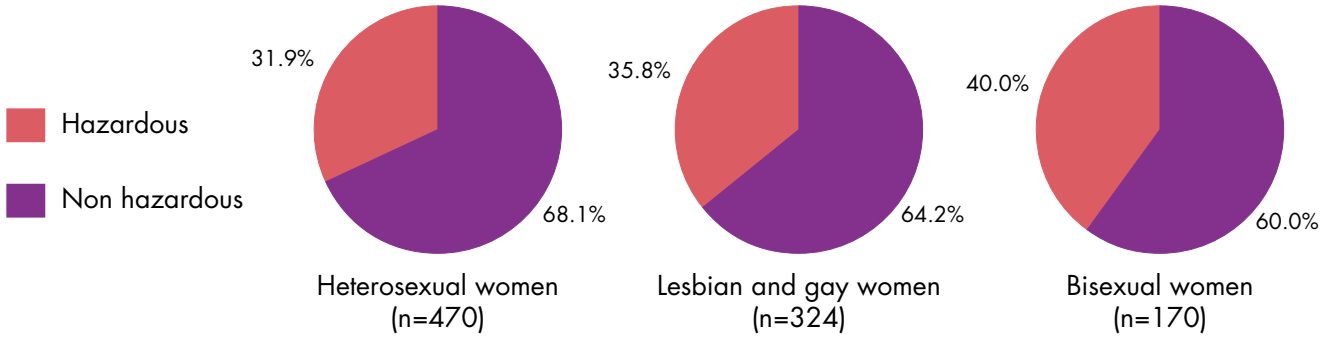
However there were significant differences in patterns of frequency of drinking to intoxication amongst the women (Figure 9), the data suggesting that more LGB women drink once a month (17.5%) when compared with heterosexual women (13.7%) and that more heterosexual women (36.2%) never drink when compared with LGB women (27.8%) (Figure 9). When separating bisexual women from lesbian and gay women (Figure 10) there are marginally significant differences, with bisexual women drinking more once a month and 2/3 times a month, particularly when compared with heterosexual women; significantly more heterosexual women indicating never drinking when compared with LG women; and more LG women indicating never drinking when compared with bisexual women (Figure 10). However, in both analyses the effect size was small or very small, respectively.

Figure 5 - Hazardous alcohol use (LGB vs Heterosexual women)



$\chi^2(1, n=1004) = 2.72, p<.10$ (n.s.)

Figure 6 - Hazardous alcohol use (LG vs Bisexual vs Heterosexual women)



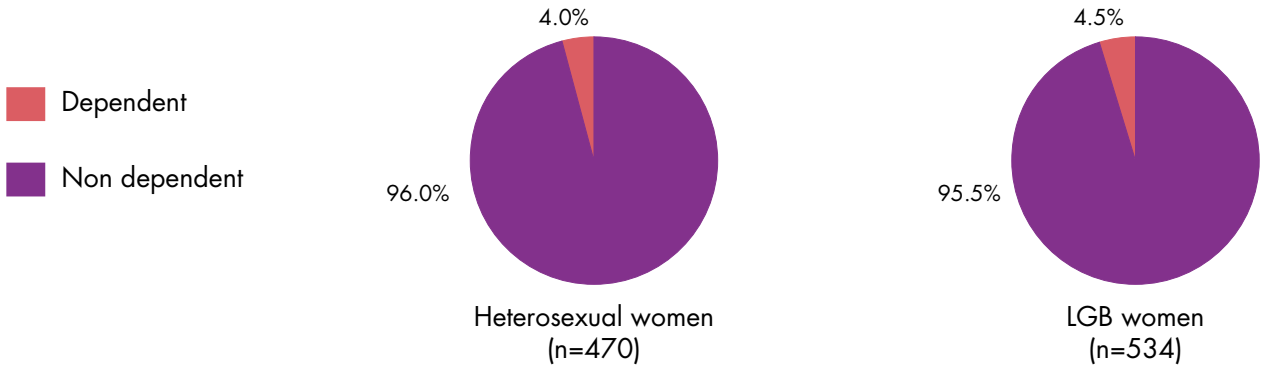
$\chi^2(2, n=964) = 3.89, p<.14$ (n.s.)

2.2.2. Predictors of hazardous alcohol use for lesbian and bisexual women

A backward stepwise logistic regression was performed to ascertain the effects of age, general health (GHQ-12), importance of faith or belief and size of the place of origin (town or city, suburb, small town or rural area) on the likelihood that lesbian and bisexual women would have a hazardous pattern of alcohol use (AUDIT). The logistic regression model was statistically significant ($\chi^2(6, n=555) = 42.28, p<.001$) and explained between 7.3% (Cox and Snell R square) and 10% (Nagelkerke R square) of the variance and correctly classified 66.8% of cases. Being of a younger age (β -.315, $p<.001$), lower levels of self-reported well-being[7] (β .219, $p<.01$) and the increased relevance of faith or belief currently (β .147, $p<.05$) were associated with an increased likelihood of hazardous drinking. Additionally, living in a small town (β -.523, $p<.05$) or

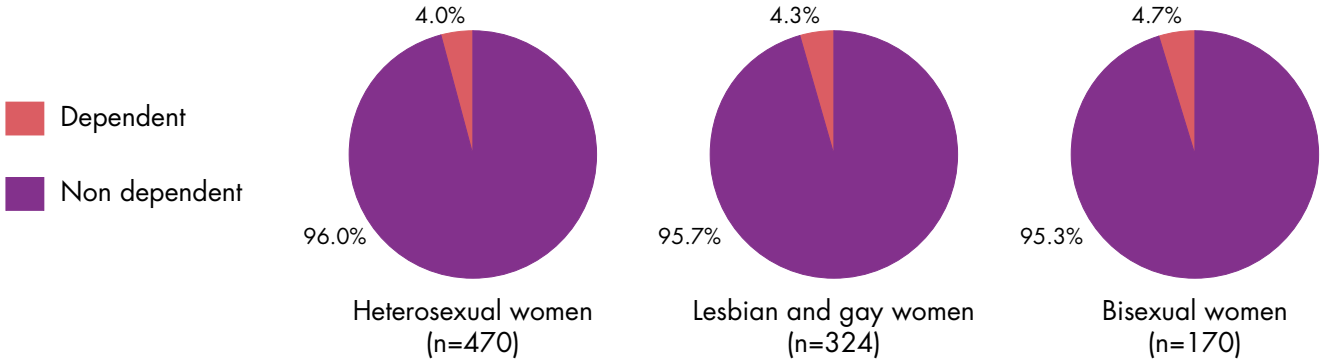
7 Higher scores on the GHQ-12 denote poorer health/well-being.

Figure 7 - Dependent alcohol use (LGB vs Heterosexual women)



$\chi^2(1, n=1004) = .04, p<.84$ (n.s.)

Figure 8 - Dependent alcohol use (LG vs Bisexual vs Heterosexual women)



$\chi^2(2, n=964) = 0.14, p=.93$ (n.s.)

Table 5 - Predictors of hazardous alcohol use for lesbian and bisexual women

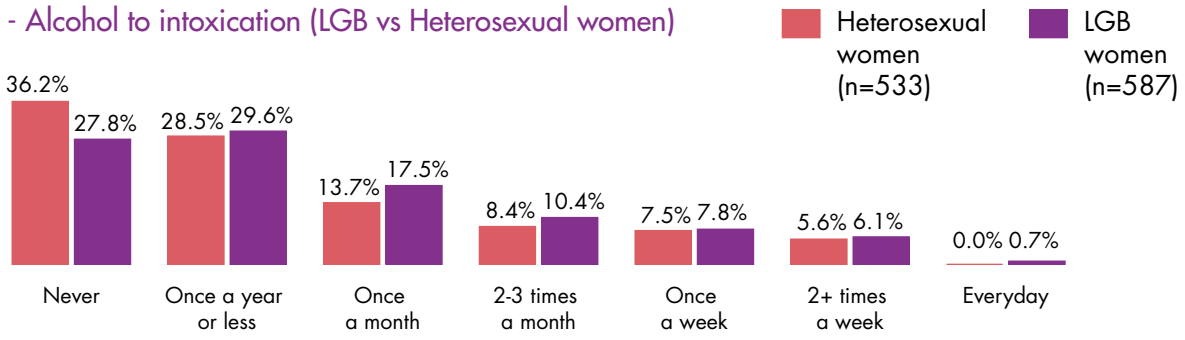
LGB+	Hetero
Age (—)	Age (—)
General health/well-being (—)	General health/well-being (—)
Current relevance of faith or belief (+)	Current relevance of faith or belief (+)
Living in small town or suburb (—)	

suburb (β -.802, p<.01) was associated with a decrease in the likelihood of hazardous drinking[8].

For heterosexual women, the logistic regression model was also statistically significant ($\chi^2(6, n=469) = 31.79, p<.001$) and explained

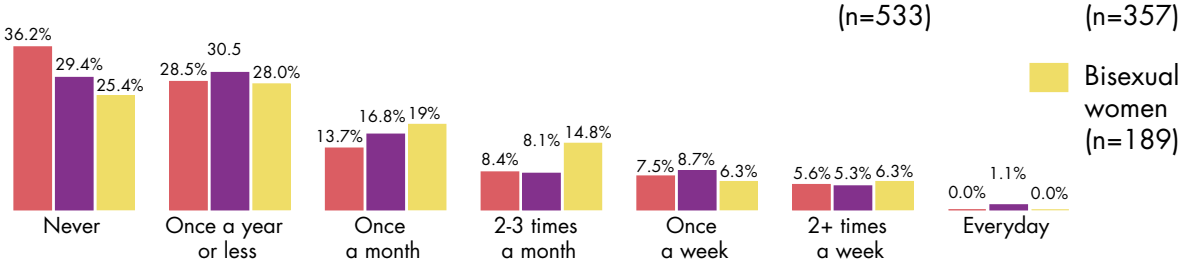
8 Living in a large town or city was used as the reference category.

Figure 9 - Alcohol to intoxication (LGB vs Heterosexual women)



χ^2(6, n=1120) = 13.93, p=.03, Cramer's V=.11

Figure 10 - Alcohol to intoxication (LG vs B vs Heterosexual women)



χ^2(12, n=1079) = 25.88, p=.01, Cramer's V=.01

between 6.6% (Cox and Snell R square) and 9.2% (Nagelkerke R square) of the variance and correctly classified 68.9% of cases. For this group it was found that being of a younger age (β -.290, p<.001) lower levels of self-reported well-being (β .251, p<.01) and the increased relevance of faith or belief currently (β .242, p<.005) were associated with an increased likelihood of hazardous drinking. None of the other variables in the model were statistically significant.

2.2.3. Qualitative results (P1Q)

Brief description of the subsample

During P1Q of the research 9 women (one of which identifying as 'female/genderqueer') were interviewed due to their experiences of problem drinking. Seven identified as lesbian, one as gay, and one as queer. Their average age was 39.6 years (SD=6.5). All identified as white; six indicated not being religious and being single. Two indicated having a disability.

Risk factors

For the lesbian, bisexual and queer women we interviewed in relation to problematic alcohol use, drinking seemed to have developed as a consequence of a number of factors. Many of these factors related to a social and family culture of heavy drinking, sometimes marked by a relaxed attitude towards alcohol and some of its negative consequences and by a permissive or even reinforcing approach to early onset of drinking within the family. For many participants, this context is later reinforced by exposure to environments where drinking plays an important role in socialising, such as when going out with work colleagues, and by pub culture in general, as described by Linda (35, lesbian):

> *[A]nd the other thing is work drinks, it's always work drinks it's never work coffee. And I had a couple of colleagues who'd constantly question "what are you drinking?" and look at me odd, you know "a pint of Coke?!" So that's difficult, it's almost like there's something wrong with you if you don't drink. Because I smoke but I don't drink and people just can't understand that at all. It's like "why don't you quit smoking and carry on drinking?" you know. Because my smoking doesn't affect everybody in my life, I can go outside and smoke. (Linda)*

Traumatic experiences were another set of reasons provided by some of the participants to explain their problematic alcohol use. These experiences were of a varied nature and occurred at different periods of their lives, from childhood to adulthood. Some of these experiences were associated with growing up in families where the young people faced particular challenges, e.g. having a parent suffering from mental health issues or from alcoholism; or having supported a friend through cancer, amongst others. Two participants suffered from a sexual assault. In both cases the assault happened while they were drunk, but then they continued to use alcohol to manage the intense anxiety caused by the incidents. Julie (33, lesbian), was assaulted by a male taxi driver on her birthday while travelling abroad:

> *I was struggling with what had happened and not being able to remember it and the fact I was drunk when it happened so then when I got really drunk, which I was doing all the time, I was getting a lot of anxiety and stress and guilt about doing it in pretty much every situation but it was the only way... I had a dependency so I kept doing it. (Julie)*

Jane (40, lesbian), was sexually assaulted by a woman while under the effect of alcohol. She subsequently developed depression and attempted suicide as a consequence of the experience and considers it to have affected her ability to form stable and lasting relationships in the future.

Alcohol was often used as an unhealthy mechanism to deal with negative feelings, such as guilt and depression and to boost confidence. Some participants talked of using alcohol as a 'coping strategy', for instance to help them be able to feel interesting and relaxed when socialising. Others, like Siobhan (50, lesbian), described alcohol as a 'crutch':

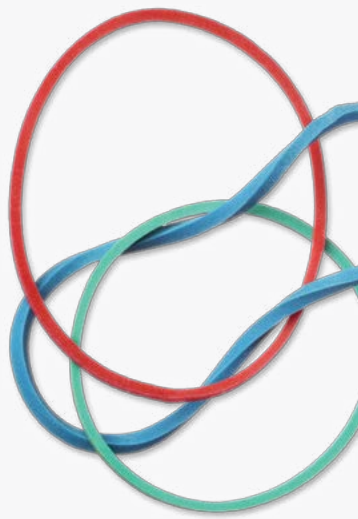
I think I just learned to use it as a crutch to support me when times got emotionally tough and yeah I just woke up to realise what I was doing wasn't healthy. It probably means I'll do it again at some point but I hope not, that is my hope. I do drink still but not to excess, to oblivion. (Siobhan)

This theme of using alcohol to manage uncomfortable or unwanted feelings is particularly significant in relation to concerns around same sex attraction. This was often the case during adolescence and young adulthood when these women were first becoming aware of their sexuality and sometimes linking with feared reactions to their coming out. Simone (36, lesbian), talks about her experience:

Q: And what sort of other things do you think may have played a part or made it worse along the way?

Simone: I don't know for sure but I think that the additional pressure of growing up and sort of knowing that being gay was not considered to be a good thing may have intensified that: the need to push down difficult stuff. (Simone)

A few participants also talk about how they used alcohol specifically to deal with family expectations and pressures around their sexuality, as well as with the anxieties caused by the possibility of disclosure. Marian, a 30 year old 'gay' women, described how she was only able to tell her brother that she was dating a woman while she was drunk, and for Yvonne (43, lesbian), drinking helped her cope with the guilt following her coming out to her family:



Q: How do you think being a lesbian may have affected your alcohol problems?

Yvonne: I felt at the time my parents, or my mother, was alive I'd broken her spirit and her hope for me as a young woman because there was a lot of peer pressure surrounding me getting married and having grandkids, so the white wedding and everything like that. So when I did come out there was the disappointment. I'd let my parents down and having to deal with their excuses of why I might be a lesbian. So again it's upsetting and guilt and I didn't live up to their expectations so drink again basically blanked all that out. So I can deal with it as long as I've got a drink. I think that's basically it. (Yvonne)

Several of the women also discussed how the gay and lesbian scene is heavily based around consumption of alcohol, therefore alcohol plays a dual role in enabling community attachment and a sense of belonging, at the same time as reinforcing a continued pattern of drinking. Claire (44, lesbian), found the gay scene an accepting environment where the sight of a woman drinking heavily was not judged harshly:

British culture and attitude to alcohol [is unhelpful]. It's encouraged. The media encourage it, it's everywhere. It's how we socialise. The gay scene is awful for it. There are pills everywhere. Women especially are heavy drinkers. It's perfectly normal to drink pints in a gay club and it certainly wasn't when I went to heterosexual clubs. But I could easily order pints and nobody would give me a second look in a gay club, whereas heterosexuals had to look dainty and have half a lager. But it was a big drinking culture on the gay scene so that was my experience of it. So you can blend in and not stand out too much as well on that scene and it suited me. (Claire)

'But I could easily order pints and nobody would give me a second look in a gay club, whereas heterosexuals had to look dainty and have half a lager.' (Claire)

Recovery and resilience

For many of our interviewees, recovery from alcohol abuse was a long process marked by struggles to control or to stop drinking and often impacted by the support, or lack thereof, received from partners, family members and other people. This support was frequently mentioned as one of the most relevant aspects of the recovery process, alongside the gain of a sense of control over their drinking and their lives. Formal help, such as that provided by therapists and self-help groups, was also key in this process, although barriers, both real and perceived, to disclosing intimate matters, particularly their sexual orientation, sometimes tempered the engagement with these structured sources of support.

The first steps towards recovery were often acknowledging the problem and seeking help. Both these occurred as a consequence of their own reflexions and actions, as well as from pressures and incentives from supportive family members and partners. For several of the interviewees it was their partner or sometimes isolated more distant family member who provided much needed support that helped them to stop problematic drinking. Close friends also proved helpful around the practical aspects of recovery:

Q: What other things have you found helpful along the way?

Simone: [Pause] I have had friends listening to me and accepting me when I said: "I don't drink anymore, I can't drink" - friends agreeing to meet me in cafes to begin with rather than pubs and clubs. My family not pouring me wine" (Simone)

Family and partners also played a part as internal motivators, with some of the women discussing how becoming aware of the impact of their behaviour on those close to them was relevant in their decision to stop drinking. The turning point, in some cases, was associated with 'hitting rock bottom' or with a revelation of sorts ('waking up'). One woman talked about needing 'incredible will power' in order to be able to recover. In all cases the language used reveals an arduous, often long, process.

As many found that a lack of control in certain aspects of life had led to alcohol abuse, conversely a few also discussed how regaining control and incorporating structure into their lives became an important strategy in recovery. This sometimes involved not stopping drinking altogether but developing strict rules of when drinking could happen.

Participants accessed various kinds of formal help but sometimes engagement with the treatment process was limited by a variety of issues. Important among these was an uneasiness or unwillingness to discuss some of the issues that were closely linked with the problematic drinking in the first place, such as experiences of abuse and struggles in coming to terms with their own sexual orientation. Some were altogether unable to disclose having a drinking problem to mental health professionals. Others had negative reactions and experiences from the professionals they disclosed their bisexual or lesbian identity to, leading to the abandonment of the treatment altogether.

I went to my GP and said I was really, really miserable. I actually told her, she was one of the first people that I told that I was a lesbian which was a bit hard for me and she suggested that I see a psychiatrist. So she put me in touch with the community mental health team and they at that time diagnosed me as having a borderline personality disorder, which I really don't think I have. I think at the time I was very confused about my sexuality and that is something that was never really addressed in those early days. (Isabell, 45, queer)

Sometimes engagement with the treatment process was limited by an uneasiness or unwillingness to discuss some of the issues that were closely linked with the problematic drinking in the first place, such as experiences of abuse and struggles in coming to terms with their sexual orientation.

CBT was generally considered to be helpful, but alternative forms of support such as Buddhism, meditation, yoga, mindfulness, spirituality were also mentioned by some. However, most of the interviewees eventually found helpful support in specialised units and help groups, some of which were LGB&T specific, providing a sense of community support in the recovery process not found elsewhere.

[I]t was really important to go to a lesbian and gay [AA meeting] because I realised I carried some shame about my own sexuality – internalised homophobia – and needed to be with other gay people before I mentioned relationships or mention[ed] a girlfriend in a straight or mainstream meeting of Alcoholics Anonymous. It took me a couple of years to get to the point where I could mention my girlfriend and not give a shit. (Simone)

Others accessed 12-steps programmes and groups, and some had mixed views about this support. For some it provided the help they needed, giving them alternative types of social support in the recovery process. For Yvonne, referring back to the AA programme allows her to stay 'on the tracks' even years after stopping drinking. However, others did not appreciate the 'religious' component to the 12-steps programme and considered it to be unhelpful overall.

Q: Sure, and you also mentioned that it sounds like AA has been an important support for you.

Marian: It has – I have a love-hate relationship with AA to be honest. It has been amazing in that there is somewhere to go and great people. It is just wonderful to have all these meetings where people are so supportive and all round lovely and if you live in London it's brilliant but I do find some of them – I don't find the spirituality hard, but they say it is about spirituality rather than God but actually God is a big part of AA and I am an atheist and I still struggle with that. (Marian, 30, gay)

Additional support from family, partners, friends and from formal resources that helped them gain a sense of control in their lives and to control their previous drinking patterns, participants mentioned a range of additional strategies that contributed to recovery and to keeping a balanced life. Claire (44, lesbian) used music and reading as relevant sources of insight into what she was experiencing in specific moments of her recovery. Linda learned to play the drums and changed careers:

Q: So after the Smart help and the CBT and the new relationship, you found things to make you feel as a good as the alcohol did, as a coping strategy?

Linda: I did yeah. I've bought a drum kit; I'm learning to play drums. And I just, I left the Home Office and I'm now committed to starting a new career as a carer, you know more giving I guess. I think the only thing that would make me go back to drink now is if I decided life wasn't worth living and I can't see that happening because that's such a drop from where I am now. I don't think I'd ever fool myself into thinking that drink would make life better, I'd have to want to die to start drinking again. (Linda)

All of the women interviewed were able to recover from their problematic drinking and move on. Their narratives, thoughmarked by deeply troubled experiences, illustrated a sense of hope, and the possibility of recovery.

2.3. Body image issues (including eating concerns) among gay and bisexual men

2.3.1. Descriptives

The gay and bisexual men (n=721) were compared with the heterosexual men (n=165) in our survey sample on a number of items about different features of their bodies (e.g. their muscularity, body fat, or genitals) and about behaviours that may affect their bodies (e.g. how much they eat, drink, or exercise). Comparisons were made by dichotomising all items of the RBSS (strongly disagree and disagree vs strongly agree and agree) and then by running Chi-Square analyses.

When compared with the heterosexual men, the gay and bisexual men presented higher percentages of dissatisfaction (replying to disagreeing or strongly disagreeing with being satisfied) across all categories presented (Table 6). The majority of these differences are statistically significant (highlighted in the table). The only items for which comparisons were not significant were those regarding health, physical fitness, face and features, teeth and amount of alcohol consumed.

Table 6 - Disagrees or strongly disagrees with being satisfied with features of their bodies and behaviour affecting the body, by sexual orientation (men only)

Items	Hetero (n=165)	GB (n=721)
a. My health	36.4%	42.7%
b. My physical fitness	53.9%	60.9%
c. My weight*	45.5%	59.6%
d. My height**	9.1%	16.5%
e. My body shape*	40.0%	59.2%
f. My face and features (eyes, ears, nose)	18.8%	25.1%
g. My teeth	38.8%	44.5%
h. My hair**	23.0%	32.6%
i. My body hair**	20.6%	30.8%
j. My genitals**	20.0%	29.1%
k. My age*	15.8%	29.8%
l. My body fat*	46.1%	61.7%
m. My muscularity*	40.6%	58.1%
n. How much I eat**	32.1%	44.8%
o. How much alcohol I drink	24.8%	26.4%
p. How much I exercise**	52.7%	62.7%

* p<.001 ** p<.02

2.3.2. Predictors of body image dissatisfaction for gay and bisexual men

A backward stepwise logistic regression was performed to ascertain the effects of self-esteem, self-perceived masculinity and social influences to thinking about one's body (e.g. people in their daily lives, people they encountered in their leisure activities, the media, and friends and classmates from their childhood) on the likelihood that gay and bisexual men would be dissatisfied with their bodies. The logistic regression model was statistically significant ($\chi^2(3, n=728) = 104.01$, $p<.001$) and explained between 13.3% (Cox and Snell R square) and 17.8% (Nagelkerke R square) of the variance and correctly classified 66.6% of cases. Lower levels of self-esteem (β -.633, $p<.001$) and the increased influence of others (in society at large) on feelings about the body (β .254, $p<.001$) were associated with an increased likelihood of men being dissatisfied with their bodies. Self-perceived masculinity was not found to be statistically significant in the model.

Table 7 - Predictors of body image dissatisfaction for gay and bisexual men

LGB+	Hetero
Self-esteem (—) Influence from social environment (people in daily life, leisure time, media & childhood friends and classmates) (+)	Self-esteem (—)

For heterosexual men, the logistic regression model was also statistically significant ($\chi^2(3, n=163) = 25.58$, $p<.001$) and explained between 14.5% (Cox and Snell R square) and 19.8% (Nagelkerke R square) of the variance and correctly classified 68.1% of cases. Lower levels of self-esteem (β -.750, $p<.001$) were associated with an increased likelihood of these men being dissatisfied with their bodies. None of the other variables in the model were statistically significant.

2.3.3. Qualitative results

Brief description of the subsample

For P1Q of the research, nine men were interviewed due to their experiences of body image issues (including eating concerns). Seven identified as gay, one as bisexual, and one as 'other'. Average age was 39.6 years (SD=7.9). The majority identified as white (8), indicated not having any religion (8) and being single (6). Three indicated having a disability.

Risk factors

Analysis of this subsample of participants suggests that the vulnerability created by early experiences of feeling different appears to be a key factor in the development of feelings of low self-worth, as well as a susceptibility to outside pressures to conform to a masculine body ideal. As a result, participants reported engaging in compensatory and escapist strategies to reduce these negative feelings. While the experience of feeling different may be common to many LGB&T people, for the gay men participating in our study the unique pressures regarding policing of the masculine body seemed to have resulted in forms of body control and abuse.

All participants in this phase of the study speak about negative experiences of 'feeling different' from a young age, deriving from a variety of experiences, most commonly remembered as negative relationships with parents or family members and the experience of bullying or rejection by peers at school. For some, it emerged through a self-consciousness related to perceived physical differences or difficulties. The experience of 'feeling different' often proceeded – as well as coincided with – participants' explicit awareness of their sexual orientation, with homophobic messages received through the media and wider society contributing to their negative feelings. David (51, gay), describes a feeling of alienation from his parents associated with his interests in typically non-masculine activities.

> *There was a huge elephant in the room about me, because they thought I was not interested in anything boyish from a young age. I wanted to do something arty which was out of the ordinary. And so I just felt that I was not right, a sort of cuckoo in the nest really. (David)*

Many participants were deeply impacted by bullying at school, which often centred on their physical appearance as well as their sexuality, resulting in a lasting insecurity around these areas. In addition, many participants had few or no friends with which to share their experiences, and felt a general sense of rejection from their peers.

Many participants were deeply impacted by bullying at school, which often centred on their physical appearance as well as their sexuality, resulting in a lasting insecurity around these areas.

Messages about masculine body ideals were experienced by all participants via peers at school as children, and later in adulthood through mainstream and LGBT-specific media, and in the gay scene, especially in the context of clubbing culture. The pressure to 'look good' was pervasive and, in many cases, destructive for participants' self-worth. The overall feeling described was oppressive and regulatory, with participants having a sense of being pushed out of environments where their body did not fit the prescribed dimensions. A key experience for all participants was that of 'comparing bodies' – evaluating their own body in relation to that of their partner, other desirable men or simply the image of men presented within LGBT or mainstream media. Many participants described this as a unique aspect of same-sex relationships; the complication of being attracted to an

idealised masculine body while also feeling their own body judged against this standard. Alan (43, gay), describes how comparing bodies with his partner impacted on his self-worth:

I got into a relationship with a guy, it lasted a very long time, who...and it's really weird, I don't kind of know how it happened, who actually had a very good, I thought who had a really good body, much better than mine... There was something about the way he looked that was just a way of me feeling bad about myself. You know...I think that kind of made it worse in a funny sort of strange kind of fucked up kind of way. (Alan)

Many participants commented on the lack of sexual minority male role models presented in mainstream media, singling out stereotypical examples who conformed to a slim and muscular body type. Some were critical of the unrealistic images seen in mainstream magazines and of the lack of variety in representations of body types when it came to LGBT specific media. Growing up, John (28, gay), felt unable to identify with the body types of gay men he saw represented in the media: 'Well I actually understood what I might be part of but then there was no one in there who related to me because they were all slim... I just didn't feel I fitted into it'. He also saw the media as influential in determining viewers' feelings of self-worth and encouraging conformity to a body ideal.

Most participants described negative experiences with regard to judgement of bodies within the gay scene, particularly when clubbing. Alan talked about the difficulty in avoiding messages about the body within gay culture and how this impacted the expression of his sexuality:

It really affected my ability to be gay. Because gay is all about how you look. And it was quite a difficulty there and tension there and the whole kind of you know, "look good with your shirt off" kind of culture and the whole Boyz magazine and the gay clubbing magazine and all of that lifestyle... (Alan)

'I've gone to bars where you go in and basically the muscle boys, if you're not a muscle boy, will not even notice you. And they spill pints on you, they don't even say sorry and there's this real kind of arrogance.' (Trevor)

Some participants reflected on similarities with the experiences of bullying they had at school, and described the pressure to conform by other gay and bisexual men to be a form of bullying in itself. Trevor, (39, gay), described the pressures he feels going out on the gay scene:

I've gone to bars where you go in and basically the muscle boys, if you're not a muscle boy, will not even notice you. And they spill pints on you, they don't even say sorry and there's this real kind of arrogance and then I get, I feel victimised so then I get very angry. So I hate going to places like that. (Trevor)

These common, early experiences of feeling different that men associated with the negative messages received from parents and peers, combined with later negative messages about the body received

through mainstream and LGBT-specific media and culture, were highlighted by participants who had gone on to struggle with a very low sense of self-worth. Many directly reported low self-esteem, while others, particularly those who were victims of bullying, described a deep sense of shame about themselves and their bodies. Most participants in this phase of the study described a strong need for approval and acceptance from their peers and many referred to not feeling 'good enough' as they were.

Finally, participants found it difficult to speak about their problems, which added to the perception of a lack of adequate support targeted to men, especially sexual minority men. Some described being unable to relate to the information available on body disorders, which was targeted primarily at girls and women rather than men. Those who did approach health services for assistance often experienced long delays waiting for therapy, and then found their concerns to be poorly understood or superficially treated.

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Resilience and recovery factors

For participants who had suffered from body disorders as a result of their difficult early life experiences, the resilience to overcome their problems emerged at a later stage in life after considerable damage had already taken place. For most participants, change was a gradual process, requiring impetus from within. They described experiences of personal crises, acknowledgement that they had a problem, self-reflection and a desire for change in their life as motivating factors.

With some exceptions, internal motivation seemed to be the key driver in participants attempting to find help. Support was found through personal relationships, therapy and organised programmes, sometimes targeted specifically at gay and bisexual men. Some participants relied on self-help guidance or independently generated strategies for solving their problems, describing a sense of self-reliance.

Many participants described going through an internal process of coming to terms with the extent of their problems and wanting to overcome them. Carl, a 40 year old man identifying his sexual orientation as 'other', had developed an understanding of body image disorders and steroid abuse in men through his work. He found that he then was able to 'address that in myself, rather than go out and pump iron and do all these things'.

A number of participants described having reached a personal crisis point, after enduring years of psychological distress. Immediately following the breakdown, these participants accessed treatment, mostly medical, and not always successfully. In all cases though, the experience appeared to serve as a precipitating factor in seeking or being open to receiving more effective support in the future.

Many participants described a point at which they consciously made a decision to change, marking the start of their recovery process. Trevor suffered a nervous breakdown where he 'lost pretty much everything' and made the decision to change his life:

> *I think it came from being at my lowest that I've ever been and I actually took a leap of faith in myself and said, "If I don't look at these things now it's never going to get any better... I was in a very, very bad state and something in me just said you have to let go of all of this and let it come up, let it surface and when it surfaces it needs to be looked at and you might not like what you look at but you've got to do it. (Trevor)*

Almost all participants described a supportive relationship where someone had helped them in overcoming their problems, whether this was with a family member, partner, friend, or another supportive person.

The help participants sought and found came in different forms. For many, counselling and support programmes and groups were beneficial. For other participants, talking to family and friends or others who understood body image concerns was beneficial. Some found that being self-reliant was the most effective tool for recovery, while others used outside sources including self-help literature.

Almost all participants described a supportive relationship where someone had helped them in overcoming their problems, either with a family member, partner, friend, or another supportive person. In many cases, participants found speaking with others who had experienced a similar problem to be especially helpful, and sometimes this was useful in leading them towards other forms of support.

Simon's flatmates had noticed his eating disorder and were 'dropping subtle hints' until he became aware of the extent of the problem. He was then able to turn to these people for support in overcoming the disorder. 'After that I reached out to them and spoke to them and said I can't actually stop because I got to a point where I thought I was in control of the eating thing but I realised that I wasn't' (Simon, 28, bisexual). His friends then helped him to develop a strategy to deal with his eating problem.

Most participants undertook some form of therapy as treatment for their body image concerns. Whilst not all experiences were successful in aiding recovery, in those that were participants described key aspects of recovery as including identification with other members of the support group or a process of identification with the therapist. Support groups targeted specifically toward gay and bisexual men were mentioned as helpful by participants who had accessed them. Along with reporting that they had learned to see themselves and their behaviour from a new perspective, the men in this phase of the study reported that experiences with targeted support led to increased self-esteem and greater self-acceptance. For some this was possible by allowing themselves to feel vulnerable around others who had gone through similar experiences.

Some participants explicitly rejected outside support, preferring to rely on their own resources in achieving recovery; however, most of these efforts followed or coincided with other forms of therapy. Some found strategies to manage their problems directly or prevent them from resurfacing, for instance by adopting techniques or practices to change their mind-set and focus. After his decision to stop drinking and improve his physical health, Asad (39, gay, Pakistani) developed a strategy of noticing the positive and important aspects of his day to day life, through journal writing:

> *I started to write a gratitude list for want of a better phrase and making a point of looking for the great things that are happening in life, from the benign to the super exciting and I guess gradually over time that readjusted the focus – how I viewed the world around me and myself and where I could fit into that world round me. It almost became a little like a drug because as I did that better and better things started happening. (Asad)*

For most participants, some form of self-acceptance had emerged over time, through the course of self-reflection and analysis, or following support and a sense of acceptance from various others.

'I started to write a gratitude list for want of a better phrase and making a point of looking for the great things that are happening in life, from the benign to the super exciting and I guess gradually over time that readjusted the focus.' (Asad)

Discussion

Suicide and self-harm

Findings from the RaRE Study survey show significant differences between the rates of previous year and lifetime suicide attempt and ideation, as well as of self-harm experience and ideation when comparing LGB and heterosexual young people and when comparing Trans* and cisgender young people in our sample. Across all comparisons both LGB and Trans* young people were shown to have higher rates of the majority of indicators, in some cases with double or more of the rates of their comparison groups. The only exception to this pattern regards previous year suicide attempts when comparing young LGB and heterosexual participants, in which despite the higher rate for those identifying as LGB, the differences were not significant. Nevertheless, the lifetime rates of suicide attempts for LGB young people are almost twice as high as those of young heterosexual respondents. This could mean that attempted suicide might happen more often at younger ages, later levelling out as young people get older, for instance, due to establishing ties and obtaining support from the LGB&T community, as suggested by previous research (Harper et al., 2012; Reed & Valenti, 2013; McCallum & McLaren, 2010). Of note however is that suicide ideation remains significantly higher amongst LGB young people in our sample, including within the year previous to the survey, which is consistent with findings by Haas et al. (2011) according to which suicidal ideation and behaviour seem to be unrelated.

All rates of young Trans* people in our sample are particularly high when compared with their cisgender counterparts, with about half reporting lifetime suicide attempts and over 80% indicating lifetime suicide ideation and self-harm ideation and experience. These findings are consistent with findings that suggest increased suicide risk for Trans* young people (D'Augelli et al., 2005; Wang et al., 2012; Xavier et al., 2007), possibly associated with gender non-conformity (Fitzpatrick et al., 2005; LeVasseur et al., 2013). Taken together, the above findings seem to suggest that sexual and gender minority young people still experience significantly more self-harm and suicidal distress than their non-minority counterparts.

Regression analyses allowed insight into some of the factors that are associated with this reality for both LGB and heterosexual people alike (numbers of young Trans* participants in our sample did not provide enough power for regression analyses for this subset of participants). A noteworthy, albeit unsurprising, finding is that for young people

regardless of sexual orientation low self-esteem is a significant predictor of suicide attempt and self-harm ideation and experience. Whereas the reasons underlying the low self-esteem might be different for heterosexuals, for LGB young people this may be associated with shame-proneness and greater internalised heterosexism as suggested by the study by Greene and Britton (2013), with the reverse picture, that of forgiveness of the self, contributing to enhance self-esteem amongst LGB&T adults (Rosario et al., 2005).

Some aspects of family support, or lack thereof, were also identified as relevant in our analyses. For young LGB people a low perception of family helping them to make decisions is a predictor of suicide attempt. This finding potentially links with fears and experiences of rejection or hostility related with coming out to parents and others, which have been shown to be associated with suicide risk in this group (Espelage et al., 2008; Langhinrichsen-Rohling et al., 2010; Ryan et al., 2009; Rosario et al., 2005).

A more complex picture is that associated with the self-harm experience, for which we found as predictors both a high perception of getting emotional support from family and a low perception of being able to talk to family about problems. Taken in conjunction with the high importance of faith or belief at home while growing up as another of the predictors, the picture is that of emotionally expressive but potentially conservative family environments which limit young LGB people's perception of being able to talk about issues that may concern them, such as their sexuality. In turn, this might lead them to use unhealthy strategies for dealing with emotional distress, such as self-harming. As mentioned above, other research has already reported on the influence of negative family support or reactions to coming out, but some has also specifically focused on LGB young people being rejected by their families due to holding particular religious beliefs (Dahl & Galliher, 2012; Reed & Valenti, 2013).

Taken in conjunction with the high importance of faith or belief at home while growing up, the picture is that of emotionally expressive but potentially conservative family environment which limits young LGB people's perception of being able to talk about issues that may concern them, such as their sexuality.

Low income was shown to be a predictor of suicide attempt and self-harm experience for LGB and heterosexuals alike, as it was for suicide ideation for heterosexuals alone. This finding is not consistent with research which has shown that for lesbian and gay identified young adults, family socioeconomic status was a protective factor for suicide attempt (Ryan et al., 2010). However, for young LGB people financial resources might be relevant in order to become more independent from their families with lack of finances being associated with having to remain in environments which do not allow for the expression of their sexual orientation.

The findings from the first qualitative phase of this research, in which LGB&T people who attempted suicide when young were interviewed about their experiences, largely corroborate and amplify the findings from the survey, as just discussed. Problematic coming out experiences due to the reactions of family and others were identified as key risk

factors for suicidality, leading to a negative impact on feelings of self-worth. These negative experiences were potentially more impactful within heterosexist or religious contexts, increasing the strain our participants experienced while young and their feelings about their sexual orientation. Additionally specific factors were identified as triggering suicidal incidents, particularly those associated with increased emotional strain, such as the death of a loved one or being the victim of violence, on a background of pre-existing distress. The experience of negative reactions from others seem to be particularly intense in the case of the Trans* individuals interviewed for which repeated experiences of transphobic bullying and violence may help understand the significantly high rates of suicide attempts and self-harm found in this group.

Also significant are the experiences of dealing with health professionals, who can demonstrate a lack of appropriate knowledge, even prejudice. This in turn impacted on processes of recovery, even if it lead some to make decisions not to try and attempt suicide in the future so as not to experience any of that again.

Alcohol misuse

Comparisons within our survey sample between heterosexual and LB women in levels of hazardous and dependent alcohol use revealed no significant differences between these two groups. This finding is contrary to the research that suggests higher patterns of problematic drinking amongst lesbian and bisexual women (e.g. King et al., 2008; Rosario, 2008), which informed the inclusion of this specific topic in the current research. However, another comparative study had also reported such a difference to exist in other countries (US and New Zealand) but not in Great Britain (Bloomfield et al., 2011). A recent UK study had also suggested higher levels of problematic patterns of drinking for LGB people (Buffin, Roy, Williams & Yorston, 2012), albeit using an external dataset (British Crime Survey) for comparisons with the general population. It may be the case that in the UK the pub and drinking culture contributes to the levelling out of problematic drinking in women regardless of sexual orientation, making it different in the UK, in comparison with other countries where this issue has been studied.

It may be the case that in the UK the pub and drinking culture contributes to the levelling out of problematic drinking across the feminine population regardless of sexual orientation.

Only minor differences were found between specific patterns of drinking, with LB women being more likely to drink to intoxication once a month and less likely to never drink when compared with heterosexual women. This finding is consistent with findings according to which LB women have slightly different patterns in their frequency of drinking than heterosexual women (e.g. according to Hunt and Fish, 2008, about 40% of lesbian and bisexual women drink alcohol three or more times a week compared with a quarter of women in general) but is not significant overall and does not add to our understanding of problematic drinking amongst sexual minority women.

For this topic we also decided to break comparative analyses down further, as according to some studies, sexual orientation and identity may be a relevant factor associated with alcohol misuse in women, with bisexual women more at risk of having alcohol-related issues (Drabble et al., 2013; Fredriksen-Goldsen et al., 2010; Hughes, Szalacha, Johnson et al., 2010; Lanfear, Akins & Mosher, 2013). However, in our analyses, even when separating lesbian and bisexual women, the lack of differences between sub-groups of women remained. Considering that we did not control for sexual behaviour, it may be the case that a significant number of women in our sample who identify as heterosexual had same-sex partners, a group identified with increased risk of alcohol misuse (Ziyadeh et al., 2007; Drabble et al., 2013), hence potentially confounding the findings.

Our regression analyses confirmed other studies' findings that age is a relevant factor for alcohol use (e.g. Austin, 2010; Molander, 2010), with younger age associated with higher rates of drinking. However, this was found to be a common factor for heterosexual, as well as for lesbian and bisexual women, which again from our quantitative analyses suggests more commonality, rather than dissimilar patterns, between women, whatever their sexual orientation. As suggested by others, drinking at younger ages might be associated with drinking culture at university which would be common for lesbian and bisexual as well as for heterosexual women (Drabble et al., 2013; Lanfear et al., 2013); otherwise coming of age rituals and leisure activities for younger people, common across the sexual orientation spectrum, are heavily associated with alcohol consumption, despite potentially with nuances between groups that might not necessarily have been captured by using a survey method (more on this below when discussing the qualitative findings).

Two other variables to come out as significant predictors of hazardous alcohol use for both groups were low general health/well-being and high current relevance of faith or belief. With regard to the first of these two, it is a somewhat unsurprising finding, considering the significant association that alcohol misuse has been shown to have with poor mental health for sexual minorities (Hughes et al., 2007; Hughes, Szalacha & McNair, 2010; King, 2008; Newcomb et al., 2012) as well as for the general population (Schneier, 2010). This relationship seems to be two-sided, with poor mental health potentially leading to alcohol use and with alcohol use causing deteriorating mental health and well-being.

The link between the high relevance of religion and problematic drinking for both groups studied is potentially a more challenging one to contextualise, considering for instance the findings by Rostosky et al. 2008), suggesting greater religiosity has a protective effect against alcohol use and misuse for heterosexual but not for LGB young adults. In our sample, not only does this effect seem to be reversed, with greater relevance of religion associated with greater

levels of hazardous drinking for LGB women, but a similar effect is also found for heterosexual women. One potential explanation in the case of lesbian, gay and bisexual women is that a more active involvement with religion is the cause of distress due to many religious contexts not being accepting of sexual diversity, hence generating a conflict between sexual identities and religious beliefs that might be temporarily relieved by drinking. For heterosexual women there might be other sources of influence to justify this finding that are unrelated with sexual orientation, however being beyond the scope of our study.

The only factor found to be specific for sexual minority women was in relation to the place where they live, with living in a suburb or small town being associated with a lower likelihood of drinking hazardously.

The only factor found to be specific for sexual minority women in the regression analyses was in relation to the place where they live, with living in a suburb or small town being associated with a lower likelihood of drinking hazardously. Larger urban contexts are more likely to provide the leisure resources, such as bars and clubs, where lesbian, gay and bisexual women gather and socialise, with large availability of alcohol and peer-pressure to drink, which might help justify this finding.

Of note, the effect sizes for the regression analyses for these groups were low, and therefore both the findings and their interpretations should be made with caution.

The findings from the first qualitative study corroborate some of these results and interpretations, while providing a more nuanced perspective on the factors associated with problematic drinking for sexual minority women. Thematic analysis of the interviews suggested that family as well as social condoning of drinking associated with negative or traumatic experiences both at home and in other contexts were some of the earliest and most relevant factors to set the path for alcohol misuse as a teenager and an adult. Alcohol was also described as a crutch to deal with negative emotions or experiences and to feel more confident. Associated with this theme but specific to this group was the use of alcohol to mitigate anxieties surrounding their sexuality in the context of a repressive environment or one that expected them to be heterosexual, particularly while young. Additionally, the theme of alcohol being an important part in some LGB social environments, particularly in the scene, was also identified in the analysis.

Alcohol was also described to be used as a crutch to deal with negative emotions or experiences and to feel more confident.

Recovery was often described as a challenging process, sometimes marked by relapses, and heavily based on support received from partners, family members and others in more formal structures, such as self-help groups and therapy. Sexual orientation sometimes affected women's ability to fully engage with these resources. This was either due to concerns of the reactions of professionals if they were to disclose their sexual orientation, which as explained above, often linked closely with the reasons behind drinking, or to the women's experiences of inappropriate responses from professionals upon disclosure.

Support from LGB&T specific organisations and resources were often mentioned as valued sources of support and key to successful recovery processes. Additional strategies, such as mindfulness, yoga or finding means of self-expression were considered helpful, as was regaining a sense of control over their lives, something that was lost during times of excessive drinking.

Body image and eating concerns

The RaRE Study developed an instrument that explores satisfaction and attitudes to change across a diverse range of bodily sites to understand health and physical concerns for men. Findings identified that more than half of all men (gay, bisexual and heterosexual) expressed dissatisfaction with their physical fitness and how much they exercise. On six out of the 16 item RaRE Body Satisfaction Scale (RBSS), dissatisfaction was reported by approximately 60% of all gay and bisexual men. More than 60% of GB men disagreed or strongly disagreed that they were satisfied with 'How much I exercise', 'My body fat', and 'Physical fitness' and just under 60% of GB men indicated dissatisfaction with 'My weight', 'My body shape', and 'Muscularity'. By comparison, men who identified as heterosexual expressed satisfaction in greater numbers, with more than half agreeing or strongly agreeing to all of the items except 'My physical fitness' and 'How much I exercise'. In fact, compared to heterosexual men, GB men expressed dissatisfaction in greater numbers to statistical significance on 11 of the 16 items.

More than half of all men (gay, bisexual and heterosexual) expressed dissatisfaction with their physical fitness and how much they exercise.

These findings are not surprising when considering the research that has highlighted the concerns that men in general have in regard to their bodies, for instance, by expressing a desire to be more muscular (Frederick et al., 2007) and also the research which has evidenced gay men's higher tendency to be dissatisfied with their bodies when compared with heterosexual men (Kaminski et al., 2005; Peplau et al., 2009; Tiggemann et al., 2007).

Regression analysis identified as a unique predictor of gay and bisexual men's body dissatisfaction, a high relevance placed on the influence from the social environment in the ways they feel about their bodies. This suggests that sexual minority men may be more susceptible to images of bodily ideals seen in the media, but also to real men around them, including in gyms and in other daily contexts. This is contrary to findings by Davis and Green (2011) who found that social comparison may protect against the development of body image problems. However, their study focused on pathological expressions of excessive preoccupation with the body such as BDD, which was not specifically targeted by our research. It may be that our participants are more susceptible to the pressures to conform, such as those found in specific spaces that are aimed at gay and bisexual men.

Regression analysis identified as unique predictor of gay and bisexual men's body dissatisfaction a high relevance placed on the influence from the social environment in the ways they feel about their bodies.

Some of these findings and hypotheses are corroborated by our qualitative findings. According to these, early experiences of bullying and of feeling different within the family and amongst peers were key factors in the development of low self-worth, as well as in creating a susceptibility towards pressures to conform to a masculine body ideal for the gay and bisexual men interviewed. The resilience and recovery factors identified were a combination of finding motivation to change, along with connecting with sources of help, such as personal relationships, therapy, organised programmes, eventually leading to self-acceptance. Between the risk and the resilience findings, there is a triangulation that suggests the existence of contrasting themes that open up interesting paths for increasing the understanding around body dissatisfaction for gay and bisexual men. For example, low self-worth is a risk factor and self-acceptance is a factor of resilience. In contrast, high self-worth offsets risk and lack of self-acceptance hinders resilience to negative feelings, thoughts and behaviours related to one's own body. Importantly and with implications for intervention, our findings indicate that resilience can be developed throughout the person's lifespan, whether as preventative or as part of an intervention to distress and harm.

Body image has an impact on how people think, feel, and behave, as well as being impacted by thought, feelings and behaviours. This applies to all people, regardless of gender and sexual orientation. Research that has explored and developed our understandings of body image has mosty focussed on cisgender girls and women (e.g. Thompson et al., 1999), a pattern which is repeated in popular culture and media; however, boys and men are also subject to the materiality of the body, as are people who may identify their gender differently to the codas of 'male' and 'female'.

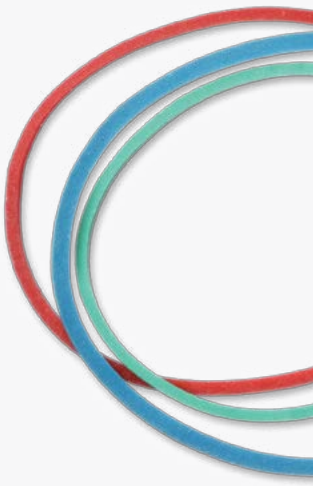
Similarities and differences between genders – and within genders – are constantly reproduced in English culture and society, no less within our systems of social welfare and healthcare. As sexual orientation is defined in terms of gendered bodies (e.g. heterosexual, bisexual, same-sex), patterns of similarities and differences can be seen between (and within) groupings related to people's genders and sexual orientations.

Ongoing analysis within the RaRE Study will include an analysis of the data for gay men and bisexual men separately, where initial analysis has been produced for 'gay and bisexual men' as a single group.

General discussion

Our findings suggest that while some similarities may exist between the risk and resilience factors of LBG people and those of heterosexual people (with less information to discuss if the same might apply in relation with Trans* people when compared with cisgender people), there is evidenced that a range of unique factors strongly influence the experiences of mental

health and well-being for sexual minority people. More often than not these are a consequence of negative reactions or of the expectation of such reactions from significant others, such as family and friends, as well as from health professionals. Additionally, experiences of discrimination, bullying and violence associated with their sexual orientation and gender identity seem to be commonplace and came across as impacting the well-being of many of those who took part in our research, leading to feelings of loneliness and isolation, often being associated with the development of poor mental health in its various guises. The analyses we carried out of Trans* people seem to suggest that this group is particularly vulnerable to this set of circumstances due to the transphobic reactions they are often exposed to in various contexts, including within the family.

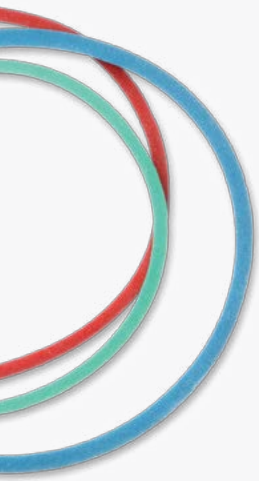


Self-esteem particularly was identified as a relevant aspect associated with the issues studied, both in quantitative and in qualitative analyses. To a certain extent this is unsurprising, considering the amount of evidence suggesting that low self-esteem is strongly associated with mental health (e.g. Chaney, 2008; Rosario et al., 2005; Tiggemann et al., 2007). However, despite this knowledge, the recurrent presence of low self-esteem as an important predictor of issues such as self-harm, alcohol use or body dissatisfaction in our findings suggests that greater awareness and interventions to boost young people's self-esteem might still play an important role in the prevention of emotional distress both during younger ages and later in life. Despite the fact that self-esteem was found in many cases to be a relevant factor for heterosexuals and for LGB people alike, our qualitative findings provide insight into what might be specific of the latter. For many of those interviewed, experiences of bullying, discrimination, isolation and loneliness, among others closely link with the development of feelings of low self-worth which in turn contribute to experiences of poor mental health.

Many of those interviewed stated that finding help was not an easy process and often required overcoming emotional barriers (e.g. concerns around the potential reactions of professionals to disclosing their sexual orientation) and practical ones, such as lack of appropriate reactions to issues specific to sexual minorities or the sheer lack of LGB&T support, considered a relevant need for many. On the other hand, the support from those participants referred to as close to them, such as partners, friends and family members as well as sensible professionals or other formal resources (e.g. support groups and specialised units) were considered keys to the recovery process despite the challenges faced.

Limitations of the study

The RaRE Study used a robust and systematic approach to the understanding of three key mental health issues that affect the LGB&T community, involving a wide range of stakeholders and various research and data collection phases. However, the choice of specific issues comes at the expense of disregarding other relevant mental



health issues that also affect the LGB&T community, such as drug use, depression or anxiety, which in our analyses could only be accounted for in rough and approximate ways (for instance, when participants mentioned them in the context of open questions in the survey or when asked about experiences of mental health as part of the P2Q recruitment process). A wider look at the context and at the interactions existing between various mental health conditions that affect LGB&T people continues to be relevant and should not be disregarded.

There were also challenges in combining the three topic areas as they span a range of health issues, although the research did identify commonalities in terms of risk and resilience patterns and frameworks.

Another limitation of the research, particularly regarding the results presented and discussed in this report, is the lack of more findings for specific sexual orientation and gender identity groups, including but not limited to bisexual and Trans* people. These groups often have specificities in regards to their experiences around mental health that require more detailed analyses and larger debates. These analyses go beyond the original scope of the RaRE research project as it was designed in 2009. In order to keep manageable the size and the breadth of this document we decided to report here only what was then planned. However, further analyses will be conducted and research outputs produced making use of all the data collected.

The recruitment processes for all three phases of the research were purposely strategic and focused on specific populations of interest, more so in the case of the qualitative studies, but also for the national survey for which there was a need to include enough numbers of participants from smaller and harder to access groups (e.g. bisexual men, older people, disabled people) to allow some of the analyses of interest. Furthermore, given the nature of PACE and also of the topic of the research, it is possible that there is a disproportion amongst research participants of people with experience of or who are sensitive towards mental health issues, as well as of people with an LGB&T community attachment. It is also possible that the survey attracted heterosexual people who are sympathetic towards the LGB&T community, even if the publicity materials for the survey were designed to minimise their sexual minority focus. This potential bias is suggested, for instance, in the rates of suicide experience and ideation for the heterosexual cohort, which are higher than expected when compared with those of the general population (The NHS Information Centre for Health and Social Care, 2009).

Ultimately our findings can only be considered valid for our samples and are also subject to the specificities of the social and cultural contexts where the research was conducted.

Conclusions

The RaRE Study was able to gather significant evidence about specific mental health issues that affect LGB&T people. It used a Community Based Participatory Research, which had the strength of bringing together the community knowledge and sensitivity with the expertise and rigour of academia in addressing delicate but relevant topics. Despite addressing mental health issues, the project had an important focus on factors that may contribute to recovery and resilience, hence keeping a positive outlook at the multiple and sometimes creative ways that people find to obtain and maintain a sense of well-being. Further findings and analyses will provide more detail and additional insights, as well as recommendations in regard to the mental health needs of LGB&T people.

Also importantly, the project's survey collected data from a large group of heterosexual people, which allowed for comparisons to be made within the same sample, increasing the reliability of the findings from that phase of the study. The use of a mixed methods approach further contributed to a nuanced portrait of the topics under analysis.

The study has corroborated previous research that suggests poorer mental health for people who identify with a minority sexual orientation or gender identity, but it has found specific areas for which this might not necessarily be the case (e.g. problematic alcohol use amongst lesbian and bisexual women when compared with heterosexual women). It also identified a range of factors that seem to contribute or that are strongly associated with the mental health issues studied, thus adding to a better understanding of the support and interventions needed for this population.

Recommendations

In relation to the general findings of the research, there are a number of recommendations:

- Training and awareness of health professionals is essential to ensure appropriate care to the mental health and other health care needs of people of various sexual orientations and gender identities
- General and mental health services should ensure that they are proactive in their efforts to be LGB&T friendly, both physically and virtually, thus assuring their sexual minority users that it is safe to disclose their sexual orientation or gender identity without concerns of being treated inappropriately by members of staff
- Sexual diversity awareness and training should be implemented in all schools, for staff and students alike, thus creating inclusive educational environments that do not tolerate discrimination or homophobic, biphobic or transphobic bullying of any sort
- Confidence and self-esteem support should be made available for young LGB&T people at risk, allowing them to develop skills that are key to helping them withstand adverse circumstances and prevent the development of mental health issues as they grow up
- There is a need for more LGB&T specific social environments that do not centre around alcohol and that offer alternatives to the pub and drinking culture
- Mainstream as well as LGB&T specific media need to become more inclusive of diverse representations of the male body which go beyond conventions of beauty and fitness
- Family support is a key factor for recovery from many mental health issues that affect LGB&T people; more awareness and information needs to be provided, for instance through media campaigns and increased visibility of sexual minority people, for the purpose of achieving a more inclusive and accepting society

Glossary

Alcohol abuse – A pattern of excessive alcohol consumption which has a significant impact on the performance of activities such as working, attending school, childcare, amongst others.

Alcohol dependency – A range of behaviours, thoughts, feelings and physical symptoms associated with continuous alcohol use. Typically, someone who is dependent on alcohol will want to continue drinking despite the negative effects or consequences associated with this behaviour.

Asexual – A person whose identity is non-sexually oriented. They may have 'emotional orientations' towards same-sex or different-sex others, or not. This is a contemporary and emerging self-identification.

Biphobia – A range of negative attitudes, feelings and behaviours towards bisexuality and bisexual people as a social group or as individuals.

Bisexual – A person who has an emotional and/or sexual attraction toward more than one gender.

Body dysmorphic disorder (BDD) – A condition in which people develop an unrealistic ideal as to how they should look. BDD symptoms include a preoccupation with the belief that a specific body part is defective or deformed in some way.

Body fat dissatisfaction – A feeling of being dissatisfied with the amount of fat in one's body.

Cisgender – A person whose gender identity is the same as the sex they were assigned at birth; someone who is not Trans*.

Coming out – Refers to the experiences of some, but not all, LGBT people as they explore or disclose their sexual orientation and/or their gender identity.

Diagnostic and Statistical Manual for Mental Disorders (DSM-5) - The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders. This manual is published by the American Psychiatric Association and includes extensive descriptions, definitions and diagnostic criteria (amongst other information) for mental disorders.

Discrimination – Detrimental treatment experienced on the grounds of some aspect of a person's identity or presentation.

Gay – Most commonly refers to men who have an emotional and/or sexual attraction to men. However, some Lesbians identify as "Gay" or "Gay Women".

Gay-Straight alliance – School and university-based organizations, common in the US, intended to provide a safe, supportive environment for sexual minority students, members of staff and their straight allies.

Hate crime – A crime committed on the basis of the actual or perceived ethnicity, religion, gender identity, disability, age or sexual orientation of a person.

Heteronormativity – The belief that heterosexuality is the only 'natural' and 'normal' expression of human sexual orientation and that it is inherently superior (and healthier) to other types of sexual orientation.

Heterosexual – An individual who has an emotional and/or sexual attraction to persons of the other gender. Heterosexual people are sometimes referred to as 'straight'.

Homophobia – A range of negative attitudes, feelings and behaviours toward homosexuality or towards people who are identified or perceived as being lesbian and gay; although sometimes it is also used in the context of similar reactions towards bisexual or transgender people.

Homosexual – A term mostly used by external authorities (e.g. doctors, police, newspaper writers) to refer to an individual who has a sexual and/or emotional attraction towards persons of the same sex. This term is often now rejected by LGBT people as being too clinical and the terms 'lesbian', 'gay' or 'queer' are preferred.

International Classification of Diseases (ICD-10) – The 10th edition of a medical classification list produced by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases, including mental health issues.

Instrumentality – A personality trait associated with being objective and focused in a competitive way, and to easily be able to make decisions; it is sometimes associated with a stereotypical masculine identity.

Lesbian – A woman who has an emotional and/or sexual attraction to other women.

LGB&T – Acronyms for lesbian, gay, bisexual and Trans*. Increasingly including 'Q' for Questioning and/or Queer (LGBTQ) and 'I' to include Intersex (LGBTQQI).

Minority Stress – The psychological effect on LGB&T people of transphobic, biphobic, homophobic and heterosexist cultural norms that spur the discrimination, bullying, marginalisation and stigmatisation of LGB&T people.

Muscle dysmorphia – Having a persistent belief that one's muscles may be small and insufficient, despite having enough muscularity.

Personal agency – The subjective awareness that one is initiating, executing, and controlling one's own will and actions.

Queer – A term used by some people to define their sexual orientation or gender identity. Queer tends to be defined by what it is not – i.e. not having a prescribed view of gender identity and sexual orientation. Queer is also sometimes used to indicate a commitment to 'non-normative' gender and sexual fluidity (rather than to fixed categories of person).

Questioning – A term used by some, mostly young, people in regard to their sexual orientation or gender identity. They may use it because they are experiencing lesbian, gay, bisexual, and/or Trans* feelings or urges, but have not yet identified their gender identity or sexual orientation.

Self-harm – Self-initiated, potentially injurious behaviour without intent to die.

Suicide attempt – Self-initiated, potentially injurious behaviour with intent to die which has a non-fatal outcome.

Trans* – An umbrella term for people whose gender identity and/or gender expression diverges in some way from the sex they were assigned at birth, including those who identify as transsexual, non-binary gendered or cross-dressers, amongst others (see also 'Trans').

Trans (without the asterisk) – Is best applied to trans men and trans women, while the asterisk makes special note in an effort to include all non-cisgender gender identities, including transgender, transsexual, transvestite, genderqueer, genderfluid, non-binary, genderless, agender, non-gendered, third gender, two-spirit, bigender, and trans man and trans woman. Sometimes referred to as 'T'.

Transphobia – A reaction of fear, loathing, and discriminatory treatment of people whose identity or gender presentation (or perceived gender or gender identity) does not 'match', in the societally accepted way, the sex they were assigned at birth; the response of other members of society that results in trans people experiencing hatred, discrimination or inequality.

Trans Man/FTM – A person who was assigned female at birth but has a male gender identity and therefore proposes to transition, is transitioning or has transitioned to live as a man, often with the assistance of hormone treatment and perhaps various surgical procedures.

Trans Woman/MTF – A person who was assigned male at birth but has a female gender identity and therefore proposes to transition, is transitioning or has transitioned to live as a woman, often with the assistance of hormone treatment and perhaps various surgical procedures.

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Appendices

Appendix 1: P1Q Interview guide

Q1 Please tell me a little about yourself [prompt: whatever you would like to tell me].

Q2 Please tell me about your [suicide attempt as a young person] / experience of [nature of health issue].

Q3 What do you think may have played a part in causing [this problem] or making it worse?

Q4 How do you think being [LGBT or Q] may have affected [this problem]?

Q5 Could you tell me about anywhere or anyone that you approached for help? [Prompt that this can be from informal sources, such as friends and family, as well as professional sources].

Q6 What do you think influenced your decisions about seeking help or not seeking help?

Q7 What did you find helpful? [Relevant too are their own coping strategies or incidental events, such as getting into a 'good' relationship].

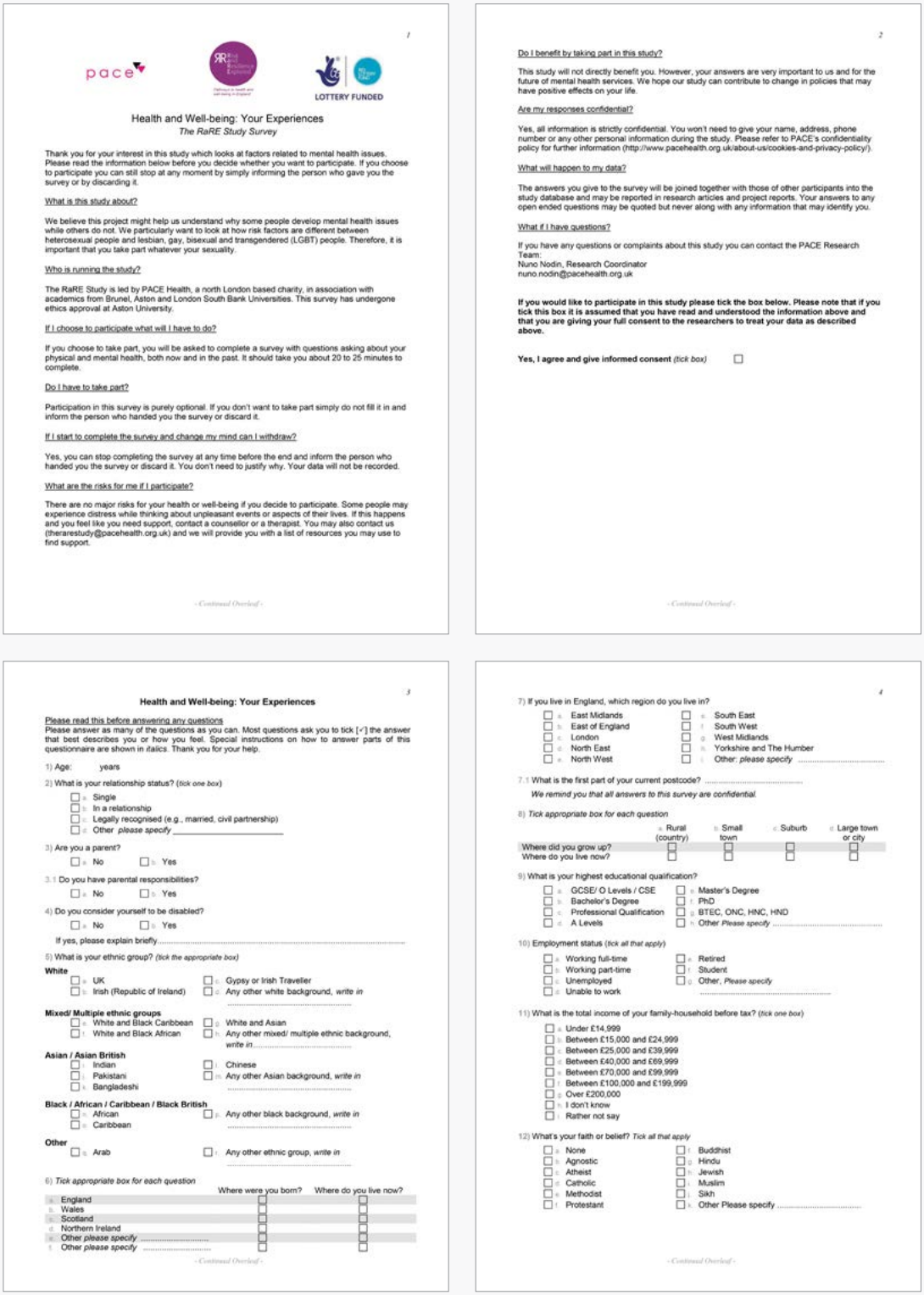
Q8 What did you find unhelpful?

Q9 Can you think of anything that might have helped prevent [this problem]?

Q10 What might have made you better able to cope with [this problem]?

Q11 Is there anything else you'd like to tell us?

Appendix 2: The RaRE Survey (Paper version)



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Health and Well-being: Your Experiences

The RaRE Study Survey

Thank you for your interest in this study which looks at factors related to mental health issues. Please read the information below before you decide whether you want to participate. If you choose to participate you can still stop at any moment by simply informing the person who gave you the survey or by discarding it.

What is this study about?

We believe this project might help us understand why some people develop mental health issues while others do not. We particularly want to look at how risk factors are different between heterosexual people and lesbian, gay, bisexual and transgendered (LGBT) people. Therefore, it is important that you take part whatever your sexuality.

Who is running the study?

The RaRE Study is led by PACE Health, a north London based charity, in association with academics from Brunel, Aston and London South Bank Universities. This survey has undergone ethics approval at Aston University.

If I choose to participate what will I have to do?

If you choose to take part, you will be asked to complete a survey with questions asking about your physical and mental health, both now and in the past. It should take you about 20 to 25 minutes to complete.

Do I have to take part?

Participation in this survey is purely optional. If you don't want to take part simply do not fill it in and inform the person who handed you the survey or discard it.

If I start to complete the survey and change my mind can I withdraw?

Yes, you can stop completing the survey at any time before the end and inform the person who handed you the survey or discard it. You don't need to justify why. Your data will not be recorded.

What are the risks for me if I participate?

There are no major risks for your health or well-being if you decide to participate. Some people may experience distress while thinking about unpleasant events or aspects of their lives. If this happens and you feel like you need support, contact a counsellor or a therapist. You may also contact us (therarestudy@pacehealth.org.uk) and we will provide you with a list of resources you may use to find support.

- Continued Overleaf -

2

Do I benefit by taking part in this study?

This study will not directly benefit you. However, your answers are very important to us and for the future of mental health services. We hope our study can contribute to change in policies that may have positive effects on your life.

Are my responses confidential?

Yes, all information is strictly confidential. You won't need to give your name, address, phone number or any other personal information during the study. Please refer to PACE's confidentiality policy for further information (http://www.pacehealth.org.uk/about-us/cookies-and-privacy-policy/).

What will happen to my data?

The answers you give to the survey will be joined together with those of other participants into the study database and may be reported in research articles and project reports. Your answers to any open ended questions may be quoted but never along with any information that may identify you.

What if I have questions?

If you have any questions or complaints about this study you can contact the PACE Research Team:
Nuno Nodin, Research Coordinator
nuno.nodin@pacehealth.org.uk

If you would like to participate in this study please tick the box below. Please note that if you tick this box it is assumed that you have read and understood the information above and that you are giving your full consent to the researchers to treat your data as described above.

Yes, I agree and give informed consent *(tick box)* ☐

- Continued Overleaf -

3

Health and Well-being: Your Experiences

Please read this before answering any questions
Please answer as many of the questions as you can. Most questions ask you to tick [✓] the answer that best describes you or how you feel. Special instructions on how to answer parts of this questionnaire are shown in *italics*. Thank you for your help.

1) Age: years

2) What is your relationship status? *(tick one box)*
- ☐ a. Single
- ☐ b. In a relationship
- ☐ c. Legally recognised (e.g., married, civil partnership)
- ☐ d. Other *please specify* _____

3) Are you a parent?
☐ a. No ☐ b. Yes

3.1 Do you have parental responsibilities?
☐ a. No ☐ b. Yes

4) Do you consider yourself to be disabled?
☐ a. No ☐ b. Yes

If yes, please explain briefly.....

5) What is your ethnic group? *(tick the appropriate box)*

White
- ☐ a. UK
- ☐ b. Irish (Republic of Ireland)
- ☐ c. Gypsy or Irish Traveller
- ☐ d. Any other white background, *write in* .....

Mixed/ Multiple ethnic groups
- ☐ e. White and Black Caribbean
- ☐ f. White and Black African
- ☐ g. White and Asian
- ☐ h. Any other mixed/ multiple ethnic background, *write in* .....

Asian / Asian British
- ☐ i. Indian
- ☐ j. Pakistani
- ☐ k. Bangladeshi
- ☐ l. Chinese
- ☐ m. Any other Asian background, *write in* .....

Black / African / Caribbean / Black British
- ☐ n. African
- ☐ o. Caribbean
- ☐ p. Any other black background, *write in* .....

Other
- ☐ q. Arab
- ☐ r. Any other ethnic group, *write in* .....

6) *Tick appropriate box for each question*

	Where were you born?	Where do you live now?
a. England	☐	☐
b. Wales	☐	☐
c. Scotland	☐	☐
d. Northern Ireland	☐	☐
e. Other *please specify*	☐	☐
f. Other *please specify*	☐	☐

- Continued Overleaf -

4

7) If you live in England, which region do you live in?
- ☐ a. East Midlands
- ☐ b. East of England
- ☐ c. London
- ☐ d. North East
- ☐ e. North West
- ☐ f. South East
- ☐ g. South West
- ☐ h. West Midlands
- ☐ i. Yorkshire and The Humber
- ☐ j. Other: *please specify* .....

7.1 What is the first part of your current postcode? .....
We remind you that all answers to this survey are confidential.

8) *Tick appropriate box for each question*

	a. Rural (country)	b. Small town	c. Suburb	d. Large town or city
Where did you grow up?	☐	☐	☐	☐
Where do you live now?	☐	☐	☐	☐

9) What is your highest educational qualification?
- ☐ a. GCSE/ O Levels / CSE
- ☐ b. Bachelor's Degree
- ☐ c. Professional Qualification
- ☐ d. A Levels
- ☐ e. Master's Degree
- ☐ f. PhD
- ☐ g. BTEC, ONC, HNC, HND
- ☐ h. Other *Please specify* .....

10) Employment status *(tick all that apply)*
- ☐ a. Working full-time
- ☐ b. Working part-time
- ☐ c. Unemployed
- ☐ d. Unable to work
- ☐ e. Retired
- ☐ f. Student
- ☐ g. Other, *Please specify* .....

11) What is the total income of your family-household before tax? *(tick one box)*
- ☐ a. Under £14,999
- ☐ b. Between £15,000 and £24,999
- ☐ c. Between £25,000 and £39,999
- ☐ d. Between £40,000 and £69,999
- ☐ e. Between £70,000 and £99,999
- ☐ f. Between £100,000 and £199,999
- ☐ g. Over £200,000
- ☐ h. I don't know
- ☐ i. Rather not say

12) What's your faith or belief? *Tick all that apply*
- ☐ a. None
- ☐ b. Agnostic
- ☐ c. Atheist
- ☐ d. Catholic
- ☐ e. Methodist
- ☐ f. Protestant
- ☐ g. Buddhist
- ☐ h. Hindu
- ☐ i. Jewish
- ☐ j. Muslim
- ☐ k. Sikh
- ☐ l. Other Please specify .....

- Continued Overleaf -

5

	a. Extremely important	b. Very important	c. Somewhat important	d. Not very important	e. Not at all important
13) How important is your faith or belief to you now? *(tick one box)*	☐	☐	☐	☐	☐
14) How important was faith or belief in your home when you were growing up? *(tick one box)*	☐	☐	☐	☐	☐

About your Health

15) General Health Questionnaire GHQ-12

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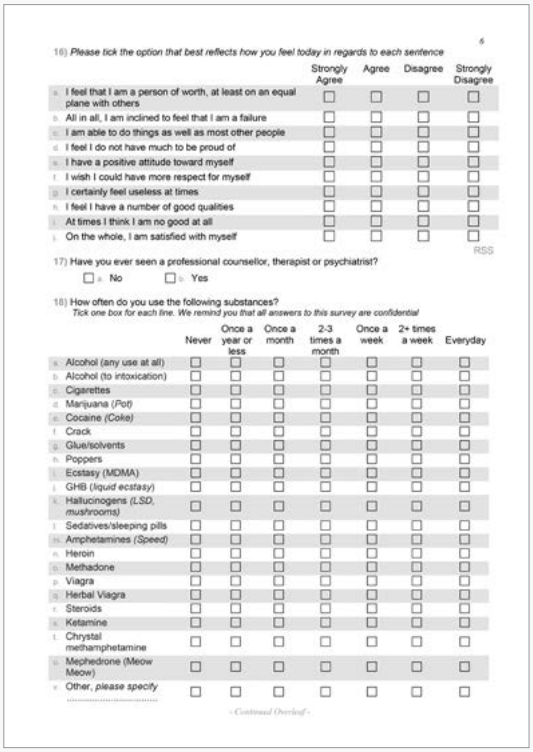

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16) *Please tick the option that best reflects how you feel today in regards to each sentence*

	Strongly Agree	Agree	Disagree	Strongly Disagree
a. I feel that I am a person of worth, at least on an equal plane with others	☐	☐	☐	☐
b. All in all, I am inclined to feel that I am a failure	☐	☐	☐	☐
c. I am able to do things as well as most other people	☐	☐	☐	☐
d. I feel I do not have much to be proud of	☐	☐	☐	☐
e. I have a positive attitude toward myself	☐	☐	☐	☐
f. I wish I could have more respect for myself	☐	☐	☐	☐
g. I certainly feel useless at times	☐	☐	☐	☐
h. I feel I have a number of good qualities	☐	☐	☐	☐
i. At times I think I am no good at all	☐	☐	☐	☐
j. On the whole, I am satisfied with myself	☐	☐	☐	☐

RSS

17) Have you ever seen a professional counsellor, therapist or psychiatrist?

☐ a. No ☐ b. Yes

18) How often do you use the following substances?
Tick one box for each line. We remind you that all answers to this survey are confidential

	Never	Once a year or less	Once a month	2-3 times a month	Once a week	2+ times a week	Everyday
a. Alcohol (any use at all)	☐	☐	☐	☐	☐	☐	☐
b. Alcohol (to intoxication)	☐	☐	☐	☐	☐	☐	☐
c. Cigarettes	☐	☐	☐	☐	☐	☐	☐
d. Marijuana *(Pot)*	☐	☐	☐	☐	☐	☐	☐
e. Cocaine *(Coke)*	☐	☐	☐	☐	☐	☐	☐
f. Crack	☐	☐	☐	☐	☐	☐	☐
g. Glue/solvents	☐	☐	☐	☐	☐	☐	☐
h. Poppers	☐	☐	☐	☐	☐	☐	☐
i. Ecstasy (MDMA)	☐	☐	☐	☐	☐	☐	☐
j. GHB *(liquid ecstasy)*	☐	☐	☐	☐	☐	☐	☐
k. Hallucinogens *(LSD, mushrooms)*	☐	☐	☐	☐	☐	☐	☐
l. Sedatives/sleeping pills	☐	☐	☐	☐	☐	☐	☐
m. Amphetamines *(Speed)*	☐	☐	☐	☐	☐	☐	☐
n. Heroin	☐	☐	☐	☐	☐	☐	☐
o. Methadone	☐	☐	☐	☐	☐	☐	☐
p. Viagra	☐	☐	☐	☐	☐	☐	☐
q. Herbal Viagra	☐	☐	☐	☐	☐	☐	☐
r. Steroids	☐	☐	☐	☐	☐	☐	☐
s. Ketamine	☐	☐	☐	☐	☐	☐	☐
t. Chrystal methamphetamine	☐	☐	☐	☐	☐	☐	☐
u. Mephedrone (Meow Meow)	☐	☐	☐	☐	☐	☐	☐
v. Other, *please specify*	☐	☐	☐	☐	☐	☐	☐

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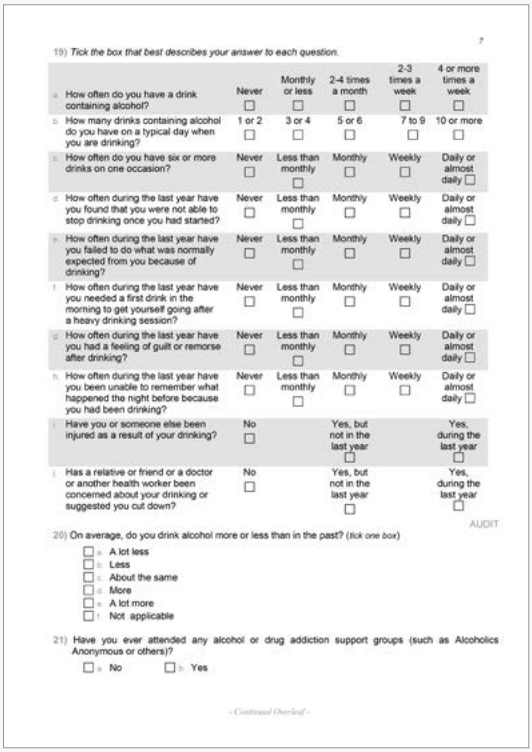

7

19) *Tick the box that best describes your answer to each question.*

a. How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2-4 times a month ☐	2-3 times a week ☐	4 or more times a week ☐
b. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2 ☐	3 or 4 ☐	5 or 6 ☐	7 to 9 ☐	10 or more ☐
c. How often do you have six or more drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
d. How often during the last year have you found that you were not able to stop drinking once you had started?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
e. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
f. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
g. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
h. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
i. Have you or someone else been injured as a result of your drinking?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐
j. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐

AUDIT

20) On average, do you drink alcohol more or less than in the past? *(tick one box)*

☐ a. A lot less
☐ b. Less
☐ c. About the same
☐ d. More
☐ e. A lot more
☐ f. Not applicable

21) Have you ever attended any alcohol or drug addiction support groups (such as Alcoholics Anonymous or others)?

☐ a. No ☐ b. Yes

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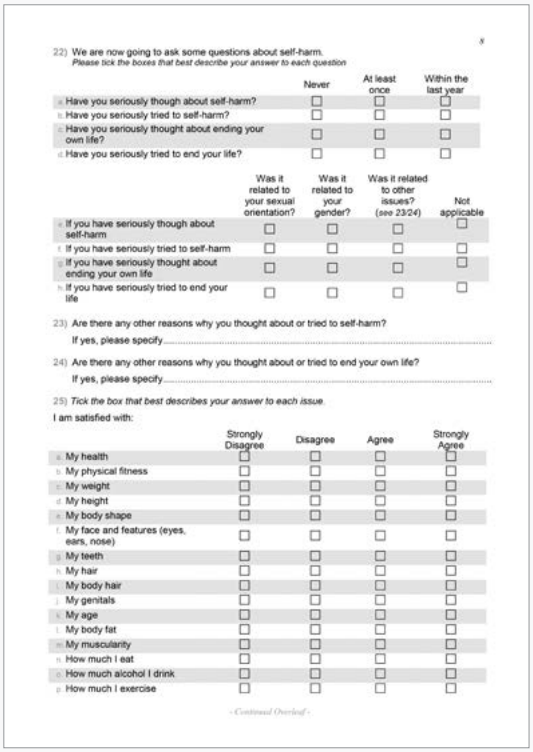

8

22) We are now going to ask some questions about self-harm.
Please tick the boxes that best describe your answer to each question

	Never	At least once	Within the last year
a. Have you seriously though about self-harm?	☐	☐	☐
b. Have you seriously tried to self-harm?	☐	☐	☐
c. Have you seriously thought about ending your own life?	☐	☐	☐
d. Have you seriously tried to end your life?	☐	☐	☐

	Was it related to your sexual orientation?	Was it related to your gender?	Was it related to other issues? *(see 23/24)*	Not applicable
e. If you have seriously though about self-harm	☐	☐	☐	☐
f. If you have seriously tried to self-harm	☐	☐	☐	☐
g. If you have seriously thought about ending your own life	☐	☐	☐	☐
h. If you have seriously tried to end your life	☐	☐	☐	☐

23) Are there any other reasons why you thought about or tried to self-harm?

If yes, please specify.....

24) Are there any other reasons why you thought about or tried to end your own life?

If yes, please specify.....

25) *Tick the box that best describes your answer to each issue.*

I am satisfied with:

	Strongly Disagree	Disagree	Agree	Strongly Agree
a. My health	☐	☐	☐	☐
b. My physical fitness	☐	☐	☐	☐
c. My weight	☐	☐	☐	☐
d. My height	☐	☐	☐	☐
e. My body shape	☐	☐	☐	☐
f. My face and features (eyes, ears, nose)	☐	☐	☐	☐
g. My teeth	☐	☐	☐	☐
h. My hair	☐	☐	☐	☐
i. My body hair	☐	☐	☐	☐
j. My genitals	☐	☐	☐	☐
k. My age	☐	☐	☐	☐
l. My body fat	☐	☐	☐	☐
m. My muscularity	☐	☐	☐	☐
n. How much I eat	☐	☐	☐	☐
o. How much alcohol I drink	☐	☐	☐	☐
p. How much I exercise	☐	☐	☐	☐

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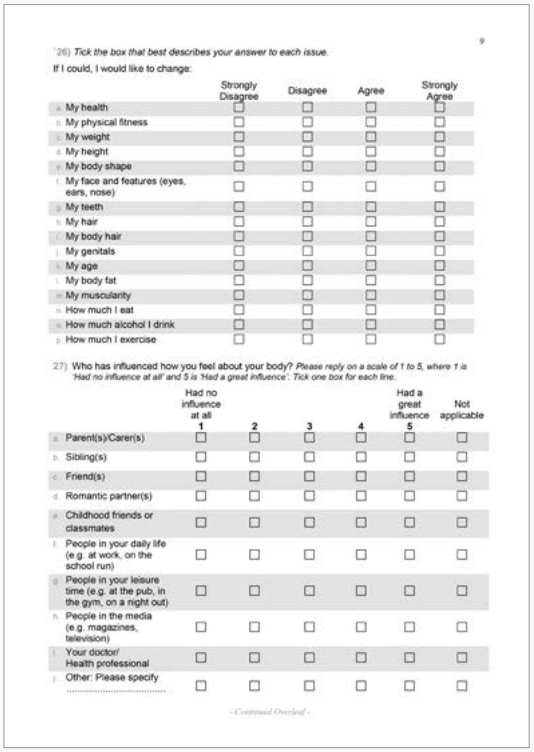

9

26) *Tick the box that best describes your answer to each issue.*

If I could, I would like to change:

	Strongly Disagree	Disagree	Agree	Strongly Agree
a. My health	☐	☐	☐	☐
b. My physical fitness	☐	☐	☐	☐
c. My weight	☐	☐	☐	☐
d. My height	☐	☐	☐	☐
e. My body shape	☐	☐	☐	☐
f. My face and features (eyes, ears, nose)	☐	☐	☐	☐
g. My teeth	☐	☐	☐	☐
h. My hair	☐	☐	☐	☐
i. My body hair	☐	☐	☐	☐
j. My genitals	☐	☐	☐	☐
k. My age	☐	☐	☐	☐
l. My body fat	☐	☐	☐	☐
m. My muscularity	☐	☐	☐	☐
n. How much I eat	☐	☐	☐	☐
o. How much alcohol I drink	☐	☐	☐	☐
p. How much I exercise	☐	☐	☐	☐

27) Who has influenced how you feel about your body? *Please reply on a scale of 1 to 5, where 1 is 'Had no influence at all' and 5 is 'Had a great influence'. Tick one box for each line.*

	Had no influence at all 1	2	3	4	Had a great influence 5	Not applicable
a. Parent(s)/Carer(s)	☐	☐	☐	☐	☐	☐
b. Sibling(s)	☐	☐	☐	☐	☐	☐
c. Friend(s)	☐	☐	☐	☐	☐	☐
d. Romantic partner(s)	☐	☐	☐	☐	☐	☐
e. Childhood friends or classmates	☐	☐	☐	☐	☐	☐
f. People in your daily life (e.g. at work, on the school run)	☐	☐	☐	☐	☐	☐
g. People in your leisure time (e.g. at the pub, in the gym, on a night out)	☐	☐	☐	☐	☐	☐
h. People in the media (e.g. magazines, television)	☐	☐	☐	☐	☐	☐
i. Your doctor/ Health professional	☐	☐	☐	☐	☐	☐
j. Other: Please specify	☐	☐	☐	☐	☐	☐

- Continued Overleaf -

10

Life events and relationships

28) If you have experienced any of the following major life events in the last 12 months, please indicate how it has affected you. *Tick one box for each line.*

	Not at all	A little	Some what	Quite a bit	Very much	Not applicable
a. Bereavement (death of family member or close friend)	☐	☐	☐	☐	☐	☐
b. Violent crime (including physical and sexual assault)	☐	☐	☐	☐	☐	☐
c. Negative change in relationship	☐	☐	☐	☐	☐	☐
d. Positive change in relationship	☐	☐	☐	☐	☐	☐
e. Positive change in working/education conditions	☐	☐	☐	☐	☐	☐
f. Negative change in working/education conditions	☐	☐	☐	☐	☐	☐
g. Negative change in your health	☐	☐	☐	☐	☐	☐
h. Positive change in your health	☐	☐	☐	☐	☐	☐
i. One or more holidays with family or friends	☐	☐	☐	☐	☐	☐
j. Achieved personal goal	☐	☐	☐	☐	☐	☐
k. Failed to achieve personal goal	☐	☐	☐	☐	☐	☐
l. Welcomed a new member to the family (e.g. baby)	☐	☐	☐	☐	☐	☐

29) Please state how much you agree or disagree with each of the following statements *Tick one box for each line.*

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
a. There is a special person(s) who is around when I am in need	☐	☐	☐	☐	☐
b. There is a special person(s) with whom I can share my joys and sorrows	☐	☐	☐	☐	☐
c. My family really tries to help me	☐	☐	☐	☐	☐
d. I get emotional help and support from my family	☐	☐	☐	☐	☐
e. I have a special person(s) who is a real source of comfort to me	☐	☐	☐	☐	☐
f. My friends really try to help me	☐	☐	☐	☐	☐
g. I can count on my friends when things go wrong	☐	☐	☐	☐	☐
h. I can talk about my problems with my family	☐	☐	☐	☐	☐
i. I have friends with whom I can share my joys and sorrows	☐	☐	☐	☐	☐
j. There is a special person(s) in my life who cares about my feelings	☐	☐	☐	☐	☐
k. My family is willing to help me make decisions	☐	☐	☐	☐	☐
l. I can talk about my problems with my friends	☐	☐	☐	☐	☐

MDSPSS

29.1 Who is the special person(s) in your life? (*please specify; don't use any names, simply write what relationship you have with this person, e.g. partner; mother; friend; teacher; etc.*)

.....

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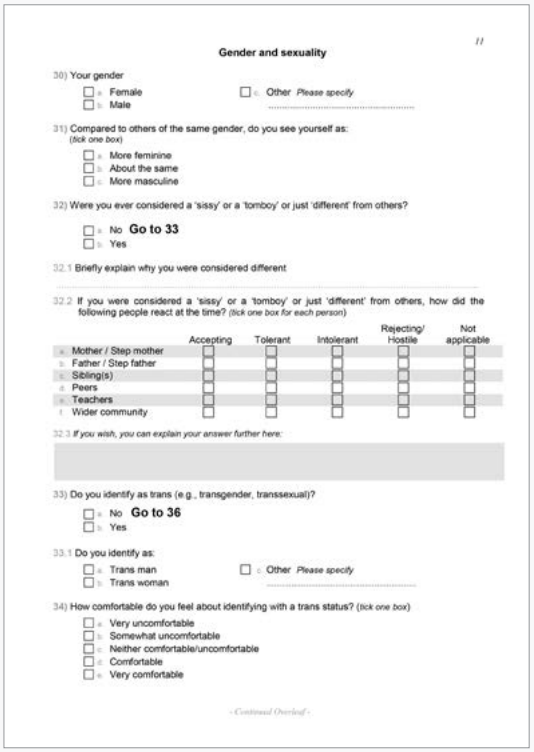

11

Gender and sexuality

30) Your gender

☐ a. Female ☐ c. Other *Please specify* .....
☐ b. Male

31) Compared to others of the same gender, do you see yourself as: (*tick one box*)

☐ a. More feminine
☐ b. About the same
☐ c. More masculine

32) Were you ever considered a 'sissy' or a 'tomboy' or just 'different' from others?

☐ a. No **Go to 33**
☐ b. Yes

32.1 Briefly explain why you were considered different

.....

32.2 If you were considered a 'sissy' or a 'tomboy' or just 'different' from others, how did the following people react at the time? (*tick one box for each person*)

	Accepting	Tolerant	Intolerant	Rejecting/ Hostile	Not applicable
a. Mother / Step mother	☐	☐	☐	☐	☐
b. Father / Step father	☐	☐	☐	☐	☐
c. Sibling(s)	☐	☐	☐	☐	☐
d. Peers	☐	☐	☐	☐	☐
e. Teachers	☐	☐	☐	☐	☐
f. Wider community	☐	☐	☐	☐	☐

32.3 *If you wish, you can explain your answer further here:*

33) Do you identify as trans (e.g., transgender, transsexual)?

☐ a. No **Go to 36**
☐ b. Yes

33.1 Do you identify as:

☐ a. Trans man ☐ c. Other *Please specify* .....
☐ b. Trans woman

34) How comfortable do you feel about identifying with a trans status? (*tick one box*)

☐ a. Very uncomfortable
☐ b. Somewhat uncomfortable
☐ c. Neither comfortable/uncomfortable
☐ d. Comfortable
☐ e. Very comfortable

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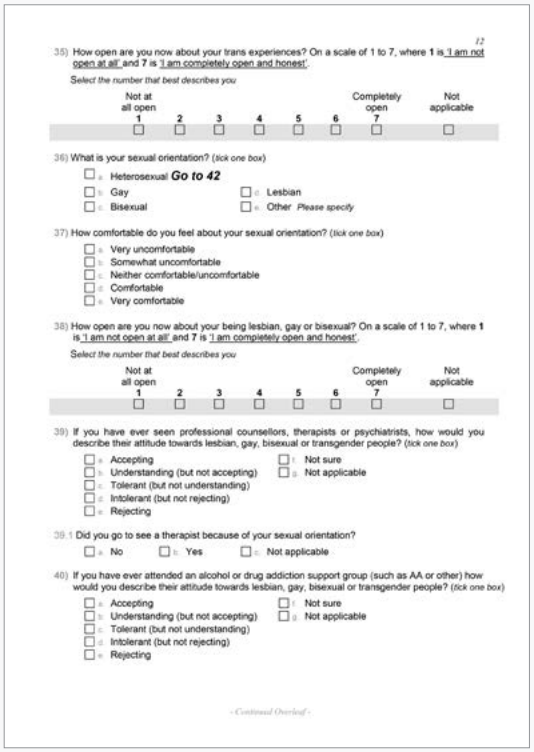

12

35) How open are you now about your trans experiences? On a scale of 1 to 7, where **1** is 'I am not open at all' and **7** is 'I am completely open and honest'.

Select the number that best describes you

Not at all open 1	2	3	4	5	6	Completely open 7	Not applicable
☐	☐	☐	☐	☐	☐	☐	☐

36) What is your sexual orientation? (*tick one box*)

☐ a. Heterosexual **Go to 42**
☐ b. Gay ☐ c. Lesbian
☐ d. Bisexual ☐ e. Other *Please specify*

37) How comfortable do you feel about your sexual orientation? (*tick one box*)

☐ a. Very uncomfortable
☐ b. Somewhat uncomfortable
☐ c. Neither comfortable/uncomfortable
☐ d. Comfortable
☐ e. Very comfortable

38) How open are you now about your being lesbian, gay or bisexual? On a scale of 1 to 7, where **1** is 'I am not open at all' and **7** is 'I am completely open and honest'.

Select the number that best describes you

Not at all open 1	2	3	4	5	6	Completely open 7	Not applicable
☐	☐	☐	☐	☐	☐	☐	☐

39) If you have ever seen professional counsellors, therapists or psychiatrists, how would you describe their attitude towards lesbian, gay, bisexual or transgender people? (*tick one box*)

☐ a. Accepting
☐ b. Understanding (but not accepting)
☐ c. Tolerant (but not understanding)
☐ d. Intolerant (but not rejecting)
☐ e. Rejecting
☐ f. Not sure
☐ g. Not applicable

39.1 Did you go to see a therapist because of your sexual orientation?

☐ a. No ☐ b. Yes ☐ c. Not applicable

40) If you have ever attended an alcohol or drug addiction support group (such as AA or other) how would you describe their attitude towards lesbian, gay, bisexual or transgender people? (*tick one box*)

☐ a. Accepting
☐ b. Understanding (but not accepting)
☐ c. Tolerant (but not understanding)
☐ d. Intolerant (but not rejecting)
☐ e. Rejecting
☐ f. Not sure
☐ g. Not applicable

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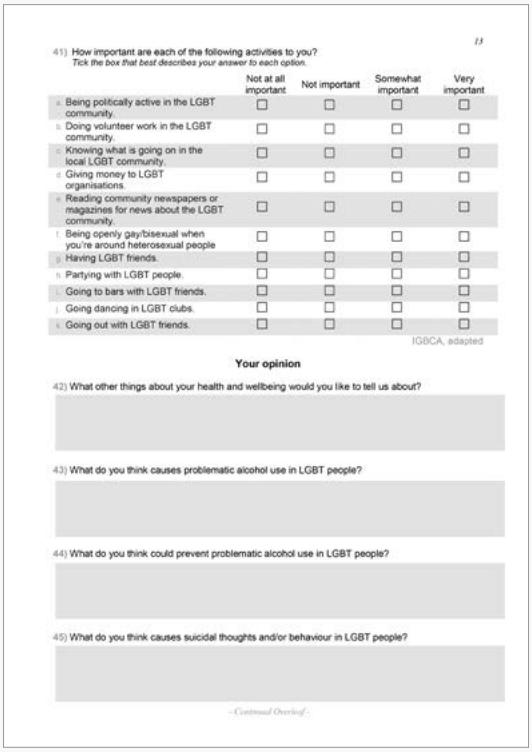


13

41) How important are each of the following activities to you?
Tick the box that best describes your answer to each option.

	Not at all important	Not important	Somewhat important	Very important
a. Being politically active in the LGBT community.	☐	☐	☐	☐
b. Doing volunteer work in the LGBT community.	☐	☐	☐	☐
c. Knowing what is going on in the local LGBT community.	☐	☐	☐	☐
d. Giving money to LGBT organisations.	☐	☐	☐	☐
e. Reading community newspapers or magazines for news about the LGBT community.	☐	☐	☐	☐
f. Being openly gay/bisexual when you're around heterosexual people	☐	☐	☐	☐
g. Having LGBT friends.	☐	☐	☐	☐
h. Partying with LGBT people.	☐	☐	☐	☐
i. Going to bars with LGBT friends.	☐	☐	☐	☐
j. Going dancing in LGBT clubs.	☐	☐	☐	☐
k. Going out with LGBT friends.	☐	☐	☐	☐

IGBCA, adapted

Your opinion

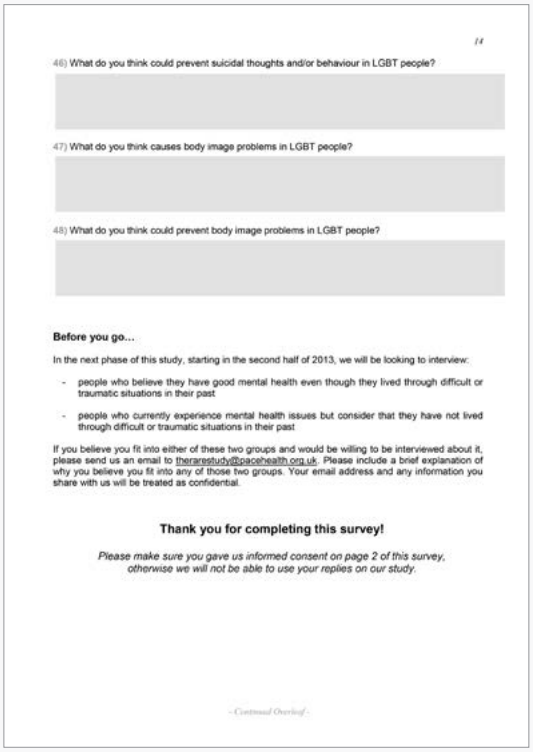
42) What other things about your health and wellbeing would you like to tell us about?

43) What do you think causes problematic alcohol use in LGBT people?

44) What do you think could prevent problematic alcohol use in LGBT people?

45) What do you think causes suicidal thoughts and/or behaviour in LGBT people?

- Continued Overleaf -



14

46) What do you think could prevent suicidal thoughts and/or behaviour in LGBT people?

47) What do you think causes body image problems in LGBT people?

48) What do you think could prevent body image problems in LGBT people?

Before you go...

In the next phase of this study, starting in the second half of 2013, we will be looking to interview:

- people who believe they have good mental health even though they lived through difficult or traumatic situations in their past
- people who currently experience mental health issues but consider that they have not lived through difficult or traumatic situations in their past

If you believe you fit into either of these two groups and would be willing to be interviewed about it, please send us an email to therarestudy@pacehealth.org.uk. Please include a brief explanation of why you believe you fit into any of those two groups. Your email address and any information you share with us will be treated as confidential.

Thank you for completing this survey!

Please make sure you gave us informed consent on page 2 of this survey, otherwise we will not be able to use your replies on our study.

- Continued Overleaf -

Appendix 3: P2Q Interview guide

#	Question	Probe
1	Can you tell me a bit about why were you interested in this phase of the study?	-
2i	We want to hear from people who believe they have good mental health even though they lived through difficult or traumatic situations in their past.	2.1. How do you think you fit into this profile? [or 'In what ways...'] 2.2. Can you tell me a bit more about it? 2.3. What do you think contributed to that? 2.4. What do you think could have made it any different?
2ii	We want to hear from people who experienced mental health issues but consider that they have not lived through difficult or traumatic situations in their past.	2.1. How do you think you fit into this profile? 2.2. Can you tell me a bit more about it? 2.3. What do you think contributed to that? 2.4. What do you think could have made it any different?
3a	What are your experiences with alcohol?	3.1. How do you think that compares to other LGBT people? 3.2. How do you think that compares to the general population, or specifically to non-LGBT people?
3b	What are your experiences with body image issues?	3.1. How do you think that compares to other LGBT people? 3.2. How do you think that compares to the general population, or specifically to non-LGBT people?
3c	What are your experiences with suicidal thoughts/behaviours?	3.1. How do you think that compares to other LGBT people? 3.2. How do you think that compares to the general population, or specifically to non-LGBT people?
4a	What would you say can cause problematic alcohol use in LGBT people?	4.1. What informed your opinion? 4.2. What else? 4.3. Is there anything more you can think of? 4.4. How does that compare to your own experience?
5a	What would you say could prevent problematic alcohol use in LGBT people?	5.1. What informed your opinion? 5.2. What else? 5.3. Is t here anything more you can think of? 5.4. How does that compare to your own experience?

#	Question	Probe
4b	What would you say can cause suicidal thoughts and/or behaviour in LGBT people?	4.3. Is there anything more you can think of? 4.4. How does that compare to your own experience?
5b	What would you say could prevent suicidal thoughts and/or behaviour in LGBT people?	5.1. What informed your opinion? 5.2. What else? 5.3. Is there anything more you can think of? 5.4. How does that compare to your own experience?
4c	What would you say can cause body image problems in LGBT people?	4.1. What informed your opinion? 4.2. What else? 4.3. Is there anything more you can think of? 4.4. How does that compare to your own experience?
5c	What would you say could prevent body image problems in LGBT people?	5.1. What informed your opinion? 5.2. What else? 5.3. Is there anything more you can think of? 5.4. How does that compare to your own experience?
6a	Initial findings from our survey indicate that 42% of LB women on our sample drink to intoxication at least once a month as opposed to 35% of the hetero-sexual women.	6.1. How does your experience fit with that?
6b	Initial findings from our survey indicate that 16% of the gay and bisexual men on our sample were strongly dissatisfied with their body image as opposed to 7% of the heterosexual male partici-pants	6.1. How does your experience fit with that?
6c	Initial findings from our survey indicate that 27% of LGB participants have seriously attempted to take their lives as opposed to 16% of heterosexual participants. They also show that 40% of Trans* participants have seriously attempted to take their lives as opposed to 22% of non-trans participants.	6.1. How does your experience fit with that?
7	Is there anything else about what we just discussed that you would like to add?	-

Appendix 4: Survey demographics

By sexual orientation

Age

	Hetero (n=700)	GL (n=949)	Bisexuals (n=302)
Mean	37.24	39.31	36.04
SD	13.47	12.17	12.21
Range	18-76	18-83	18-77

Your gender

	Hetero (n=700)	GL (n=949)	Bisexuals (n=302)
Female	75.7% (530)	36.9% (350)	60.6% (183)
Male	23.4% (164)	61.4% (583)	34.4% (104)
Other	0.9% (6)	1.7% (16)	5.0% (15)

Relationship status

	Hetero (n=700)	GL (n=949)	Bisexuals (n=302)
Single	34.1% (239)	46.8% (444)	41.4% (125)
Relationship	34.4% (241)	34.8% (330)	39.4% (119)
Legally recognised	28.7% (201)	15.6% (148)	13.6% (41)
Other	2.7% (19)	2.8% (27)	5.6% (17)

Do you have parental responsibilities?

	Hetero (n=700)	GL (n=948)	Bisexuals (n=302)
Yes	34.0% (238)	8.0% (76)	20.2% (61)
No	66.0% (462)	91.9% (872)	79.8% (241)

Do you consider yourself to be disabled?

	Hetero (n=700)	GL (n=949)	Bisexuals (n=302)
Yes	10.0% (70)	16.1% (153)	23.8% (72)
No	90.0% (630)	83.9% (796)	76.2% (230)

Ethnic group

	Hetero (n=700)	GL (n=949)	Bisexuals (n=302)
White	85.0% (595)	87.9% (834)	86.1% (260)
Mixed/multiple	3.9% (27)	4.3% (41)	7.6% (23)
Asian/Asian British	5.0% (35)	2.6% (25)	2.0% (6)
Black/African/…	4.7% (33)	3.4% (32)	3.0% (9)
Other	1.4% (10)	1.8% (17)	1.3% (4)

In which region in England do you live in?

	Hetero (n=700)	GL (n=949)	Bisexuals (n=302)
East Midlands	7.9% (55)	7.0% (66)	7.3% (22)
East of England	5.1% (36)	5.2% (49)	5.0% (15)
London	30.3% (212)	52.8% (501)	46.0% (139)
North East	7.4% (52)	2.5% (24)	3.0% (9)
North West	7.0% (49)	7.7% (73)	6.0% (18)
South East	15.4% (108)	13.2% (125)	15.2% (46)
South West	8.7% (61)	3.3% (31)	6.3% (19)
West Midlands	9.0% (63)	4.1% (39)	6.6% (20)
Yorkshire and the Humber	8.6% (60)	4.0% (38)	4.6% (14)
Other	0.6% (4)	0.3% (3)	0.0% (0)

Where did you grow up?

	Hetero (n=700)	GL (n=949)	Bisexuals (n=301)
Rural	14.6% (102)	19.1% (181)	19.5% (59)
Small town	36.6% (256)	29.7% (282)	26.5% (80)
Suburb	17.3% (121)	17.9% (170)	25.2% (76)
Large town / city	31.6% (221)	33.3% (316)	28.5% (86)

Where do you live now?

	Hetero (n=698)	GL (n=948)	Bisexuals (n=302)
Rural	10.3% (72)	5.8% (55)	4.0% (12)
Small town	26.1% (183)	13.7% (130)	15.2% (46)
Suburb	15.7% (110)	11.6% (110)	16.2% (49)
Large town / city	47.6% (333)	68.8% (653)	64.6% (195)

Highest educational qualification

	Hetero (n=700)	GL (n=948)	Bisexuals (n=302)
GCSE / O-Levels / CSE	10.9% (76)	7.9% (75)	5.0% (15)
Bachelor's Degree	30.6% (214)	30.9% (293)	33.1% (100)
Professional qualification	11.3% (79)	11.1% (105)	10.9% (33)
A-Levels	14.6% (102)	11.7% (111)	11.9% (36)
Master's Degree	18.0% (126)	23.2% (220)	21.5% (65)
PHD	3.0% (21)	3.2% (30)	4.6% (14)
BTEC, ONC, HNC, HND	6.7% (47)	6.6% (63)	7.6% (23)
Other	5.0% (35)	5.4% (51)	5.3% (16)

By gender identity

Age

	Trans* (n=120)	Cis (n=1958)
Mean	38.4	37.7
SD	13.3	12.7
Range	18 - 68	18 - 83

Your gender

	Trans* (n=120)	Cis (n=1958)
Female	30.0% (36)	55.7% (1090)
Male	25.0% (30)	43.4% (850)
Other	45.0% (54)	0.9% (18)

Do you identify as:

Trans man	27 (22.7%)
Trans woman	46 (38.7%)
Other	46 (38.7%)

Relationship status

	Trans* (n=120)	Cis (n=1958)
Single	54.2% (65)	41.3% (808)
Relationship	23.3% (28)	35.4% (694)
Legally recognised	14.2% (17)	19.7% (385)
Other	8.3% (10)	3.6% (71)

Do you have parental responsibilities?

	Trans* (n=120)	Cis (n=1957)
Yes	15.8% (19)	19.0% (371)
No	84.2% (101)	81.0% (1586)

Do you consider yourself to be disabled?

	Trans* (n=120)	Cis (n=1958)
Yes	33.3% (40)	14.8% (1669)
No	66.7% (80)	85.2% (289)

Ethnic group

	Trans* (n=120)	Cis (n=1958)
White	89.2% (107)	86.0% (1684)
Mixed/multiple	7.5% (9)	4.9% (95)
Asian/Asian British	1.7% (2)	3.6% (71)
Black/African/…	1.7% (2)	3.8% (74)
Other	0.0% (0)	1.7% (34)

In which region in England do you live in?

	Trans* (n=120)	Cis (n=1958)
East Midlands	13.3% (16)	6.7% (132)
East of England	4.2% (5)	5.2% (101)
London	34.2% (41)	44.5% (872)
North East	5.8% (7)	4.2% (82)
North West	7.5% (9)	7.3% (142)
South East	17.5% (21)	13.9% (272)
South West	3.3% (4)	6.0% (117)
West Midlands	6.7% (8)	6.1% (119)
Yorkshire and the Humber	7.5% (9)	5.8% (114)
Other	0.0% (0)	0.4% (7)

Where did you grow up?

	Trans* (n=120)	Cis (n=1958)
Rural	13.3% (16)	17.7% (347)
Small town	32.5% (39)	31.0% (607)
Suburb	24.2% (29)	19.2% (375)
Large town / city	30.0% (36)	32.1% (628)

Where do you live now?

	Trans* (n=120)	Cis (n=1958)
Rural	7.5% (9)	6.9% (136)
Small town	17.5% (21)	18.0% (353)
Suburb	18.3% (22)	13.5% (264)
Large town / city	56.7% (68)	61.4% (1202)

Highest educational qualification

	Trans* (n=120)	Cis (n=1957)
GCSE / O-Levels / CSE	11.7% (14)	8.2% (160)
Bachelor's Degree	27.5% (33)	31.3% (612)
Professional qualification	8.3% (10)	10.7% (210)
A-Levels	16.7% (20)	12.9% (252)
Master's Degree	12.5% (15)	22.0% (430)
PHD	6.7% (8)	3.3% (65)
BTEC, ONC, HNC, HND	10.8% (13)	6.5% (128)
Other	5.8% (7)	5.1% (100)

ISBN: 978-0-9932385-0-5

Published by PACE - Project for Advocacy Counselling and Education

PACE is a trading name for Project for Advocacy Counselling and Education
and is registered in England and Wales, Company Limited by Guarantee.
(Registered charity number: 801271)

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PACE is the LGBT+ mental health charity.

We offer face to face and online services across England, including counselling, group work and advocacy.

We also carry out research and work with mainstream services to improve their LGBT+ clients' experiences.

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