GAY AND BISEXUAL MEN'S MENTAL HEALTH-RELATED HELP-SEEKING: AFFECT AND NORMS ONLINE

WILLEM J. STANDER

A thesis submitted in partial fulfilment of the requirements of the University of Brighton for the degree of Doctor of Philosophy

April 2020

Abstract

Amidst limited information about gay and bisexual men's mental health help-seeking, this thesis concentrates on their experiences seeking help online. International evidence suggests that gay and bisexual men have disproportionately high rates of mental health problems and poorer healthcare experiences. As early adopters and pervasive users of digital and social media technologies, online interventions have particular potential to address the mental health challenges faced by this group. However, few studies have specifically examined their help-seeking experiences with much of the extant research limited by a narrow, rational choice conceptualisation of help-seeking which emphasises service engagement patterns. This thesis contributes to the literature by providing a dynamic understanding of gay and bisexual men's online help-seeking relations that is considerate of help-seeking as a relational, subjective and ongoing process.

Utilising a multi-method qualitative approach combining both conventional and online research methods, this Brighton/UK-based study draws on the experiences and perspectives of 18 participants (aged 23 – 58; mean age 37). Participants included 9 gay and bisexual men with lived experiences of mental health difficulties and online help-seeking, and 9 community-based LGBTQ digital outreach and support workers. A thematic analysis using drawing on interdisciplinary theory and paying specific attention to the normative and emotional dimensions of help-seeking was used to identify key themes.

The findings indicate that emotions, norms, and relational dilemmas are key to understanding gay and bisexual men's preferences for online help-seeking. I argue that gay and bisexual men's help-seeking involves emotions such as shame and feelings of failure which arise from the navigation of multiple sociocultural norms. Struggling against all of these norms means there is the possibility of failure and social disapproval on

many levels and this restricts the type of help-seeking possible, with online supports being one of the few available options. Online help-seeking, I argue, provides gay and bisexual men with some relief from these difficulties through a variety of help-seeking strategies which generate a sense of social and emotional connectedness. Finally, I address the possibilities and challenges of digital and social media to help generate and support outreach work with gay and bisexual men in the context of peer-led mental health services.

Altogether, these insights demonstrate the importance of relationally oriented and peer focused online interventions for gay and bisexual men in a mental health capacity. Recommendations for practice, policy, and corporate social media platforms actively targeting this group are provided.

Keywords

Mental health, help-seeking, gay and bisexual men, online, emotion, norms

Table of Contents

LIST OF FIGURES ..... **VIII**

LIST OF TABLES ..... **IX**

LIST OF ABBREVIATIONS AND ACRONYMS ..... **X**

ACKNOWLEDGEMENTS ..... **XI**

CANDIDATE'S DECLARATION ..... **XIII**

1. INTRODUCTORY OVERVIEW **1**

1.1 WHY STUDY GAY AND BISEXUAL MEN'S ONLINE MENTAL HEALTH HELP-SEEKING EXPERIENCES? 4

1.2 SITUATING THE RESEARCH PROJECT: INTRODUCING MY COMMUNITY PARTNER AND 'SORTED' LGBTQ BRIGHTON 8

1.2.1 Collaboration with an LGBTQ mental health service 8

1.2.2 Brighton as a national exception? 11

1.3 A NOTE ON TERMINOLOGY 14

1.4 THESIS STRUCTURE 16

2. REFRAMING GAY AND BISEXUAL MEN'S MENTAL HEALTH HELP-SEEKING **19**

2.1 MENTAL HEALTH HELP-SEEKING AS A CONCEPT 19

2.2 MOVING BEYOND THE RATIONAL CHOICE MODEL: DOMINANT APPROACHES TO GAY AND BISEXUAL MEN'S MENTAL HEALTH HELP-SEEKING 22

2.2.1 Mental health help-seeking disparities and minority stress explanatory frameworks 25

2.2.2 Barriers and facilitators model of help-seeking 32

2.2.3 Masculinity norms in the context of (non-)help-seeking and maladaptive coping styles 37

2.3 DEVELOPING AN ALTERNATIVE PERSPECTIVE: TOWARDS A DYNAMIC CONCEPTUALISATION OF GAY AND BISEXUAL MEN'S MENTAL HEALTH HELP-SEEKING 41

2.3.1 The cycle of avoidance model of (non-)help-seeking 43

2.3.2 The normative and emotional dimensions of help-seeking relations 46

2.4 Online mental health service provision for gay and bisexual men: Mapping the terrain 50

3. METHODOLOGY AND METHODS 56

3.1 Troubling norms of recognition: Neoliberalism, Heteronormativity and Homonormativity 57

3.2 Troubling emotion: Reconceptualising emotional distress and employing shame as a critical concept for mental health help-seeking 60

3.3 What is an organic, contextualist thematic analysis? 63

3.4 Research design overview 66

3.5 Participants 68

3.6 Data generation 70

3.6.1 Focus group 70

3.6.2 Online and face-to-face semi-structured interviews 72

3.6.3 Participant-generated web-based materials 73

3.7 Data analysis 75

3.8 Ethical procedures: Considering principles and negotiating tensions 77

3.8.1 Informed consent 78

3.8.2 Confidentiality and anonymity 80

3.8.3 Debriefing and minimising harm 81

4. FAILURE 85

4.1 Punishing failure 85

4.2 Avoiding failure 95

4.3 Articulating failure 103

5. RELIEF 112

5.1 Safer wit(h)nessing 112

5.2 Critical relationality 120

5.3 Sociosexual respite 128

6. SUPPORT 139

6.1 Delivering a peer-led digital mental health intervention 140

6.2 Social media (out)reach with gay and bisexual men 149

6.3 Challenges to online outreach and facilitating peer support 156

6.3.1 Facilitating emotional reflexivity 156

6.3.2 Managing expectations and new cultures of engagement.....159
6.3.3 Avoiding context collisions and norm violations.....162

7. CONCLUSIONS, IMPLICATIONS AND CRITICAL REFLECTIONS 165

7.1 AN EXPANDED FRAMING OF GAY AND BISEXUAL MEN'S MENTAL HEALTH HELP-SEEKING: AFFECT, NORMS, AND ONLINE HELP-SEEKING 168
7.2 DIGITAL COMMUNITY OUTREACH WORK WITH GAY AND BISEXUAL MEN IN A MENTAL HEALTH CONTEXT.....171
7.3 PROMOTING GAY AND BISEXUAL MEN'S ONLINE MENTAL HEALTH HELP-SEEKING 173
7.3.1 Implications for LGBTQ community-based organisations.....173
7.3.2 Implications for policymaking and funding bodies.....174
7.3.3 Implications for corporate social media platforms targeting gay and bisexual men 175
7.4 CRITICAL REFLECTIONS AND FUTURE RESEARCH OPPORTUNITIES.....177
7.4.1 Moving beyond the 'usual suspects'.....178
7.4.2 Moving towards a diversity of help-seeking pathways and research methods.....180
7.4.3 Reflecting on analytical choices: Approaching the study differently 182
7.4.4 Becoming (in)visible: Researcher reflexivity and the help-seeking process.....188

REFERENCES..... 192

APPENDICES 223

APPENDIX 1: SCOPING EXERCISE OF LGBTQ MENTAL HEALTH-RELATED SERVICES.....223
APPENDIX 2: LETTER TO PARTICIPATE (PACE).....225
APPENDIX 3: LETTER TO PARTICIPATE (MINDOUT).....227
APPENDIX 4: EDUBLOG (SCREENSHOT OF RECRUITMENT WEBSITE/BLOG).....229
APPENDIX 5: FOCUS GROUP TOPIC POINTS.....230
APPENDIX 6: INTERVIEW SCHEDULE (SERVICE PROVIDERS) 231
APPENDIX 7: INTERVIEW SCHEDULE (SERVICE USERS).....236
APPENDIX 8: THEMATIC MAP (FAILURE) 238
APPENDIX 9: THEMATIC MAP (RELIEF).....239
APPENDIX 10: THEMATIC MAP (SUPPORT) 240
APPENDIX 11: CONSENT FORM (SERVICE PROVIDERS).....241

APPENDIX 12: CONSENT FORM (SERVICE USERS).....243
APPENDIX 13: PARTICIPANT INFORMATION SHEET (SERVICE PROVIDERS) 245
APPENDIX 14: PARTICIPANT INFORMATION SHEET (SERVICE USERS).....249
APPENDIX 15: LIST OF LGBTQ-SPECIFIC MENTAL HEALTH SUPPORT SERVICES
.....253
APPENDIX 16: LETTER OF SUPPORT (MINDOUT).....254
APPENDIX 17: PHOTO/IMAGE REPRODUCTION FORM.....256

List of Figures

Figure 1. Minority stress conceptualisation of gay and bisexual men's mental health help-seeking……..…28

Figure 2. (Dis)connection…….…….....84

Figure 3. After a long day of pretending to be straight……..……....89

Figure 4. The sad truth is, if you don't look like either of these, you're worthless to a majority of the white gay 'community'…….93

Figure 5. You're making a scene ……..…..…….....99

Figure 6. Validation from people I don't even know on the Internet…..120

Figure 7. When you are mid hook-up and realise the intimacy you are experiencing is only temporary…….…….....132

Figure 8. Pop-up banner of MindOut's online support service……..142

Figure 9. MindOut broadcast adverts on Scruff and Grindr..…….....152

Figure 10. G4E MindOut broadcast advertisement…….....177

List of Tables

Table 1. Research Design……67

List of Abbreviations and Acronyms

A&E	Accident and Emergency
Apps	Mobile software applications
BAME	Black and Asian Minority Ethnic
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
cCBT	Computerised Cognitive Behavioural Therapy
CMC	Computer-Mediated Communication
COA	Cycle of Avoidance
G4E	Grindr for Equality
GEO	Government Equalities Office
GP	General Practitioner
GSN	Geosocial Networking
IAPT	Increasing Access to Psychological Therapies
ICTs	Information and Communication Technologies
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
MP	Member of Parliament
MSM	Men who have Sex with Men
NHS	National Health Service
ONS	Office for National Statistics
OSCI	Oxford Consultants for Social Inclusion
PTSD	Posttraumatic Stress Disorder
SNSs	Social Networking Sites
TA	Thematic Analysis
THT	Terrence Higgins Trust
UK	United Kingdom
US	United States

Acknowledgements

First and foremost, I would like to express my deepest gratitude to the eighteen participants who shared and discussed their experiences seeking, giving and receiving help with me. I am indebted to Helen Jones and the entire MindOut team for their kind support throughout the research process. Their generous assistance not only enabled connections with participants willing to take part but also provided interview facilities and a support network for everyone involved in this project.

I am incredibly grateful to those who have been part of my supervisory team at varying stages of this project for their expertise: Olu Jenzen, Katherine Johnson and Kath Browne. Olu, your enduring patience, support and encouragement has meant the world to me. Thank you for not letting me give up. I would also like to thank the Transforming Sexuality and Gender Research Cluster at the University of Brighton for awarding me with a studentship, without which I would not have been able to pursue my doctorate. Also, a special thanks to Fiona Sutton at the doctoral college for a shoulder to lean on and for saying the right thing, at the right time.

A special thanks to my PhD colleagues, Helen Williamson, Kimberley Belle, Abby Barras, Claire Warrington, and Lucie Fremlova for their advice and friendship. I would also like to thank my friends for providing me with much-needed respite throughout the arduous task of writing: Marsha Fournier and Rebecca Kennedy.

An extra special thanks to my partner, Max James, and his wonderful family for their support during what has been a particularly challenging period. Max, words can’t describe how much your love and support means to me. Thank you for being my rock and keeping me going.

Lastly, I would like to thank my family – Johan, Jenny, and Michelle Stander – for their emotional and financial support during my time in Brighton. Thank you for encouraging me to pursue my postgraduate studies and an opportunity to go on a grand adventure. I am forever grateful.

Candidate's Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed Willem J. Stander

Date 17th April 2020

1. Introductory Overview

A substantial body of international research demonstrates that lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) people experience elevated rates of mental health concerns. Survey evidence has repeatedly linked sexual and gender minorities with a higher risk of depression, anxiety, suicidality (i.e., ideation and/or attempts), self-harm, and substance misuse or dependency compared to their heterosexual and cisgender[1] counterparts (e.g., Borgogna, McDermott, Aita, & Kridel, 2018; Cochran, Sullivan, & Mays, 2003; Gonzales, Pzedworski, & Henning-Smith, 2016; Grella, Cochran, Greenwell, & Mays, 2011; Haas et al., 2011; King et al., 2008; Plöderl & Tremblay, 2015). While there has been less research in the United Kingdom (UK), large-scale studies similarly suggest poorer mental health outcomes among individuals reporting a non-heterosexual orientation (Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Elliot et al., 2015; King et al., 2003; Semlyen, King, Varney, & Hagger-Johnson, 2016; Warner, McKeown, Griffin, Johnson & Ramsay, 2004). In interpreting these findings, these researchers often draw on the concept of minority stress (Meyer, 1995, 2003) and explain that these disparities stem from excess exposure to social stress and diminished coping resources as a result of sexual and gender minorities' social disadvantage and stigmatised statuses. Although there have been significant advances in the legislative process and social acceptance of LGBTQ people, experiences of discrimination and victimisation are relatively common for some LGBTQ people across parts of the UK (Bachmann & Gooch, 2017; Government Equalities Office [GEO], 2018b).

Despite the disproportionate burden of mental health problems and psychological distress, sexual orientation and gender diversity remain marginalised as a focus of enquiry within mainstream help-seeking studies (McDermott, Hughes, & Rawlings, 2017a). The few studies that have been carried out suggest that LGBTQ people are significantly more likely than heterosexuals to utilise mental health services[2]

[1] People whose assigned sex at birth is consistent with their gender identity.
[2] These include contact with primary and community care services such as a general practitioner (GP), psychiatrist, psychologist, psychiatric or community nurse, a social worker, self-help or mutual support groups, and mental health outreach workers.

(Chakraborty et al., 2011; King et al., 2003; King, Semleyn, Killaspy, Nazareth, & Osborn, 2007; Platt, Wolf, & Scheitle, 2018), and also report greater dissatisfaction with standard mental health services (Elliot et al., 2015; McNair, Szalacha, & Hughes, 2011). Identified barriers to service use or treatment include fears of mistreatment or pathologisation, heterosexist language and assumptions, and a lack of LGBTQ-affirming or specialist services (Ash & Mackereth, 2013; MacKay, Robinson, Pinder, & Ross, 2017; Smalley, Warren, & Barefoot, 2015). A recent survey by the UK charity Stonewall indicates a lack of cultural competence among health and social care workers in their ability to understand and meet the specific needs of LGBTQ people with practitioners citing a lack of training opportunities or specialist resources (Somerville, 2015). It is not surprising, then, that sexual and gender minority individuals report feeling devalued, dismissed, invisible and accustomed to receiving inadequate support from generic helping professionals (Ash & Mackereth, 2013).

Although the nascent literature on LGBTQ people's mental health help-seeking offers important insights into service engagement patterns and barriers to accessing care, critical gaps remain. First, the majority of previous research has focused on comparisons between LGBTQ populations and non-LGBTQ populations to establish group-based disparities. For the most part, this has involved collapsing LGBTQ people into one group and comparing them with their heterosexual and cisgender peers. This 'catch-all' approach is problematic because LGBTQ subgroups are diverse, and their help-seeking behaviours are not necessarily comparable (MacKay et al., 2017; McNair & Bush, 2016). Recent literature recommends the development of interventions tailored to specific LGBTQ subgroups and efforts to encourage help-seeking (Haas et al., 2011; Smalley, Warren, & Barefoot, 2016). Yet, this is not possible until the unique experiences of different subgroups are understood more fully. Second, previous studies have predominantly focused on mainstream service utilisation. Consequently, less is known about how LGBTQ people engage with a diversity of supports. The role of online information and communication technologies (ICTs) in promoting help-seeking has been highlighted (Shepherd, Sanders, Doyle, & Shaw, 2015); however, little research has been conducted to explore how LGBTQ people or specialist outreach services use online settings to assist with mental health-related challenges. Further, much of the extant work is limited by a narrow conceptualisation of the core concept of help-seeking as an either/or decision (i.e., an isolated, single decision point

leading towards or away from services). As dominant quantitative approaches prioritise efforts to predict or explain help-seeking patterns, there is a limited understanding of how LGBTQ people experience help-seeking as a subjective and relational or interactive process of decision-making. This expanded view is key to providing a nuanced consideration of help-seeking and developing the knowledge needed to enable relevant and appropriate supports.

To address these gaps, this thesis pays attention to gay and bisexual men's online mental health help-seeking relations. Specifically, the objectives of this thesis are to answer the following research questions:

i. How is gay and bisexual men's mental health help-seeking constructed?
ii. How do gay and bisexual men experience their use of online ICTs in seeking help for mental health-related concerns?
iii. How do LGBTQ specialist mental health services utilise online ICTs to support gay and bisexual men experiencing mental health-related challenges?

By exploring gay and bisexual men's online help-seeking, this study will provide further insights and considerations for practice and policy, particularly regarding digital and social media initiatives targeting gay and bisexual men within a mental health context. An additional ambition is for this study to support both policy and practice in developing effective online interventions and support modalities.

In this chapter, I first provide an argument for the specific focus on gay and bisexual men's mental health help-seeking and the potential of online outreach work with this group in a mental health domain. I then attend to specific contexts that shaped this project and its outcomes by introducing my community partner and the Brighton and Hove landscape where this research was carried out. The penultimate section clarifies key terminology employed throughout and, lastly, I present a chapter-by-chapter outline for the remainder of this thesis.

1.1 Why study gay and bisexual men's online mental health help-seeking experiences?

Although seeking help for mental health problems or distress is problematic at a wider population level, the state of men's help-seeking continues to cause concern. It has been well-documented within the literature that men seek out professional help less frequently than women (Liddon, Kingerlee, & Barry, 2018; Twomey, Baldwin, Hopfne, & Cieza, 2015), regardless of age, nationality, or racial and ethnic background (Addis & Mahalik, 2003). Whether this observed 'gender gap' extends to sexual minorities has been less clear, however, given a paucity of international evidence[3] and other methodological issues such as small sample sizes, a lack of comparison groups, and nonprobability sampling methods (Platt et al., 2018). While some studies suggests that sexual minority men and women utilise mental health care at approximately similar rates (and at higher rates than heterosexuals) (e.g., Cochran & Mays, 2000b; Grella et al., 2011; Platt et al., 2018), other research mirrors the aforementioned gap demonstrating that sexual minority men are less likely to utilise mental health professionals relative to sexual minority women (e.g., Cochran et al., 2003; Dickinson & Adams, 2014; Grella, Greenwell, Mays, & Cochran, 2009). Previous research exploring help-seeking among LGBTQ subgroups has primarily focused on sexual minority women perhaps due to their combined experience of minority sexuality and gender-based discrimination (e.g., Bradford, Ryan, & Rothblum, 1994; Koh & Ross, 2013; McNair & Bush, 2016; McNair et al., 2011; Sorensen & Roberts, 1997; Steele et al., 2017; Zaki, Gross, & Pachankis, 2017), and LGBTQ youth and young people under the age of 25 who are at an increased risk of various mental health problems compared to older LGBTQ adults (e.g., Byron et al., 2016; Hatchel et al., 2019; Lytle, Silenzio, Homan, Schneider, & Caine, 2018; McDermott, 2015; McDermott, Hughes, & Rawlings, 2016; McDermott et al., 2017a; McDermott & Roen, 2016). By comparison, research specifically focused on gay and bisexual men's help-seeking experiences remains rather limited and neglected topic area within the mental health literature (for similar arguments, see Parent & Bradstreet, 2017; Platt et al., 2018).

[3] Available data predominantly stem from a North American context, the United States (US) in particular.

The dearth of gay and bisexual men's help-seeking studies is disconcerting as research suggests a high incidence and prevalence of poorer mental health outcomes among this group when compared to sexual minority women. For example, a systematic review of 199 studies documenting the mental health of sexual minority groups reports elevated risks of depression, anxiety, suicidality and drug-related mental health difficulties among male-identified subgroups (Plöderl & Tremblay, 2015). Similarly, a survey of 2,702 LGBTQ people by Smalley, Warren and Barefoot (2016) found elevated rates of depression and psychological distress among gay men compared to lesbians. Even though sexual and gender minorities share collective experiences of stigma and prejudice, these experiences may be relatively different depending on the specific subgroup. Researchers have found that heterosexual people, heterosexual men in particular, have more favourable attitudes toward sexual minority women than sexual minority men (Bettinsoli, Suppes, & Napier, 2019; Copp & Koehler, 2017; Dodge et al., 2016; Herek, 2000), and less favourable attitudes towards bisexual and transgender or gender diverse individuals than cisgender lesbians or gay men (Anderson, 2018; Copp & Koehler, 2017; Norton & Herek, 2013). It is, therefore, unsurprising that male-identified sexual minorities report higher rates of discrimination, victimisation and identity concealment than their female counterparts (Bariola, Lyons, & Leonard, 2016), and feel demonstrably neglected by mental healthcare systems (Guasp, 2013). Furthermore, mental health crisis presentations to accident and emergency (A&E) services are known to peak after-hours (Mental Health Taskforce, 2016). Given that gay and bisexual men are more likely to access these services due to mental distress (Sánchez, Hailpern, Lowe, & Calderon, 2007), they are further disadvantaged because of a lack of professional education and training specific to them among emergency care providers (Blackwell, 2015). Moreover, gay and bisexual men are also known to face a relatively unique confluence of other health threats, including disproportionate exposure to childhood sexual abuse, sexual compulsivity[4], and HIV risk (Balsam, Rothblum, & Beauchaine, 2005; Pachankis, 2014; Woodhead et al., 2016). All together, these factors can create a synergistic conglomerate of mental health burdens and unmet needs. By no means do I mean to discount or minimise the unique mental health challenges faced by lesbian, bisexual

[4] Experiences of sexual fantasies, urges, and behaviours that are perceived as difficult to control (Jerome et al., 2016).

and/or trans women; however, the available evidence does demonstrate a pressing need for research and interventions specific to gay and bisexual men.

With the rapid proliferation of internet-supported mental health interventions, online help-seeking has become an additional area to study which can't be assumed to mirror offline behaviour. Prior research has highlighted the potential of digital outreach services among sexual and gender minority populations. Key benefits include increased accessibility, cost-effectiveness, and varying degrees of anonymity which may offer safer and less confronting modes through which to access support (Lyons, Rozbroj, Mitchell, & Christensen, 2015). Also, online services can offer tailored support around issues specific to LGBTQ people, such as 'coming out', dealing with discrimination, and same-sex relationship issues (Rozbroj, Lyons, Pitts, Mitchell, & Christensen, 2015). As early adopters and heavy users of online technologies (Goedel & Duncan, 2015; Grov, Breslow, Newcomb, Rosenberger, & Bauermeister, 2014), gay and bisexual men might greatly benefit from digital and social media outreach activities. Several studies indicate a strong willingness among this group to engage with mental health-related services online (Hooper, Rosser, Horvath, Oakes, & Danilenko, 2008; Pachankis, Lelutiu-Weinberger, Golub, & Parsons, 2013). Also, Pachankis and Goldfried (2010) found that an online expressive writing intervention targeting minority stress significantly improved the psychosocial functioning of gay men, particularly those with fewer levels of social support. Further, there is growing evidence of the effectiveness of online sexual health outreach initiatives across social media platforms, both mainstream and niche, with gay and bisexual men (e.g., Lelutiu-Weinberger et al., 2015; Sun, Stowers, Miller, Bachmann, & Rhodes, 2015). In light of this evidence, it can be argued that an online presence is an essential dimension for outreach services targeting gay and bisexual men experiencing mental health difficulties.

Yet, there is little evidence that research, practice, policymakers and funding commissioners have engaged with the online help-seeking experiences of gay and bisexual men within a mental health domain. Although UK policy discourses increasingly mobilise 'techno-optimism' and proffer digital self-help/monitoring solutions in response to the burden on mental health services (Fullagar, Rich, & Francombe-Webb, 2017b; Powell, 2016), the government's LGBT Action Plan policy

paper is largely silent on the potential of digital and social media with regards to mental health service provision (GEO, 2018a). To date, research attention has largely focused on the applicability of self-guided/help digital interventions, or e-therapies, among sexual minority adults (see Lyons et al., 2015; Rozbroj et al., 2015). For example, a review of web- and mobile phone-based e-therapies found that these seldom considered the perspectives or experiences of sexual minority individuals in their design and delivery (Rozbroj, Lyons, Pitts, Mitchell, & Christensen, 2014). The authors conclude that most of these interventions actively excluded lesbians and gay men by assuming or suggesting user heterosexuality, and few included explicit content on LGBTQ related issues (Rozbroj et al., 2014). The continued focus on, and prioritisation of, individually targeted online interventions and self-help strategies is questionable given the important influence of peer support on gay and bisexual men's mental wellbeing (Dickinson & Adams, 2014; Lyons, Pitts, & Grierson, 2013, 2014), and help-seeking pathways (MacKay et al., 2017; Wang, Häusermann, & Weiss, 2014). As explored in this project, community and voluntary sector LGBTQ organisations are taking a different approach focusing on social and emotional connectivity rather than self-guided help. There is a scarcity of research on these working practices which have significant value in understanding and facilitating gay and bisexual men's mental health help-seeking behaviour. Elucidating online outreach experiences may help to identify and develop future guidelines to enhance online outreach with this group.

This thesis will provide empirical research specifically investigating gay and bisexual men's online help-seeking for mental health-related challenges. While there is some literature on the online help-seeking practices of LGBTQ youth (McDermott, 2015; McDermott et al., 2016; McDermott & Roen, 2016), and sexual minority women (McNair & Bush, 2016), research attention on gay and bisexual men's experiences remains largely absent. Furthermore, limited data has been reported on digitally-enabled community-based mental health services (Elison et al., 2017), LGBTQ specialist services in particular. Utilising a multi-method qualitative approach, combining both conventional and online research methods, this UK-based study provides an understanding of gay and bisexual men's (aged 23 to 58) experiences seeking help online. In contrast to dominant scientific psychological approaches, this thesis draws on interdisciplinary theory and highlights the normative and emotional dimensions of gay and bisexual men's mental health help-seeking. This research also

engages with digital outreach workers from a specialist LGBTQ mental health service and addresses the challenges and possibilities of a range of digital and social media as used within their practice to help generate and support outreach work with gay and bisexual men.

1.2 Situating the research project: Introducing my community partner and 'sorted' LGBTQ Brighton

Although outcomes from this thesis may undoubtedly resonate with gay and bisexual men's experiences in Western societies, the research findings should be considered within their territorial and temporal context. This is an example of what Bruckman (2002) calls 'situated research', reminding us that both internet-based phenomena and research practice occur and are embedded within specific socio-cultural contexts or locations. This section contextualises this research project and unpacks key elements that helped shaped its direction and research outcomes. This includes an introduction to my community partner (MindOut) and the city of Brighton and Hove (a seaside city in South East England) in order to help frame discussions around participants online help-seeking experiences and the organisation's digital and social media outreach work later on in this thesis.

1.2.1 Collaboration with an LGBTQ mental health service

Desiring an alternative mode of enquiry compared to dominant approaches which mainly focus on mainstream mental health service utilisation (see Chapter Two), I conducted a scoping exercise at the outset of the study to identify potential community partners and LGBTQ-specific mental health services. The aim of this exercise was to work collaboratively with them to ensure that the knowledge produced would be meaningful and relevant to them, to gain an idea of the type of support available online and also to locate organisations within easy travelling distance for data collection purposes. Unsurprisingly, and as found elsewhere (Martos, Wilson, & Meyer, 2017), identified services were concentrated in urban hubs and areas with a high density of sexual and gender minority people. Although six organisations in the Brighton and Hove and greater London area were initially shortlisted (see Appendix 1), only two

were approached in the end given their expansive digital and social media outreach programmes: PACE (London-based) and MindOut (in Brighton and Hove).

In August 2015, I approached PACE, a LGBTQ mental health charity, with an invitation to participate in the research (see Appendix 2). At the time, PACE provided counselling and support programmes delivered by qualified LGBTQ counsellors. It was only a year earlier that the organisation launched their own virtual support service which comprised of a combination of web-based self-assessment and self-monitoring wellbeing tools, message boards, and one-to-one as well as group chat facilities (PinkNews, 2013). In addition to these digital services, PACE also utilised mainstream social media platforms such as Facebook and Twitter as part of their outreach activities and research endeavours of which the Risk and Resilience Explored (or 'RaRE') project is a notable achievement (see Nodin, Peel, Tyler, & Rivers, 2015). Thus, a collaboration with PACE presented a unique opportunity to explore a wide range of internet-supported support modalities, as well as knowledgeable partner vis-à-vis online recruitment.

After back and forth email correspondence discussing the research in greater detail with the charity's research manager, I was informed towards the end of 2015 that PACE would be unable to collaborate as a community partner citing a lack of funding and associated staff and organisational costs. As a consolidation, the organisation offered to disseminate research outcomes with their wider networks both internally and online. News soon broke however about the organisation's closure in January 2016 as a result of austerity measures (Levine, 2016). The closure of PACE after three decades work is a devastating blow to the London LGBTQ community and leaves a big gap in specialist mental health service provision in the city, further reminding of us of the vulnerability of small charities and community groups dependent on short-term funding and grants. This blow is further cemented by a recent study demonstrating the decline of LGBTQ community-oriented and commercially driven spaces or venues in London over the last decade, and highlighting the negative and emotional effects of such closures on survey respondents' sense of identity, community and belonging (Campkin & Marshall, 2017).

In addition to PACE, I also contacted MindOut with a proposal to collaborate (see Appendix 3). Run by and for LGBTQ people with experiences of mental health issues, MindOut and is referred to as an exemplar by the British Psychological Society (BPS) (2016), and prioritises a person-centred, recovery oriented and non-judgemental approach to service delivery (MindOut, 2017). Operational for two decades, MindOut delivers a range of services including information and advice, advocacy, peer support groups and mentoring programmes, workshops, suicide intervention, and, more recently, an in-house counselling service[5]. In 2013, MindOut launched a digital chat support service. The one-to-one synchronous intervention hosted on the organisation's website is run and led by trained LGBTQ-identified volunteers who provide emotional and informational support and is available after hours. The charity also utilises a range of social media platforms, both mainstream and niche, as part of their outreach work. Their presence on same-sex social networking sites (SNSs) is particularly innovative within a mental health context given that these spaces have largely been harnessed by sexual health initiatives. Because of this, the organisation and its service users/providers could offer important insight into a significantly under-researched area within the literature.

Fortunately, my ambitions to collaborate with a community partner proved more fruitful with MindOut. After establishing contact in August 2015, a meeting was soon arranged with its director, Helen Jones, where we discussed and mutually agreed on the research topic, as well as the remits of our working relationship. Given the charity's longstanding relationship with the University of Brighton and ongoing engagement with academic research (e.g., Johnson, 2011; Johnson, Faulkner, Jones, & Welsh, 2007), we were able to draw upon previous debriefing procedures within the context of this study to ensure that participants would be sufficiently supported in instances of emotional or mental distress (see Chapter Three). Additionally, MindOut also assisted with the recruitment of research participants and kindly offered private meeting rooms for research interviews. It was agreed that outcomes from the study would be shared in a research report or presentation and used by the organisation to inform future digital and social outreach practice with gay and bisexual men. Given the nature of

[5] While the majority of MindOut's services are free at the point of delivery, the counselling service is operated at a cost and only available offline and in-person.

PhD research, I opted for this agreement rather than using a more involved participatory action research approach. Should the opportunity arise for a postdoctoral project building on the present research, further exploration into the topic area from this approach would be a potentially productive next step.

1.2.2 Brighton as a national exception?

This section outlines key characteristics and imaginings of Brighton[6] as an extra-ordinary/alternative city (Browne & Bakshi, 2013), and the gay/LGBTQ capital of the UK (Holtz, 2017): a city that is largely seen or presumed as 'sorted' in relation to its treatment of LGBTQ identities, offering protections and possibilities that may be unavailable elsewhere nationally outside of the Brighton 'bubble'. While digital and social media certainly expands MindOut's reach nationally and internationally, the local LGBTQ community of the city of Brighton and Hove remains a core focus for outreach activities and services by the organisation. It should, therefore, come as no surprise that participants recruited for this study stemmed from the local area (see Chapter Three). As such, the city plays an active role in participants narratives of their help-seeking behaviour and therefore requires some consideration.

Located in the affluent South-East coastal region of the UK, Brighton is a small city with an approximate population of 273,000 residents, most of which are White British (80.5%) according to last census figures (Office for National Statistics [ONS], 2011). The local community is described as socially liberal with bohemian sensibilities, celebrating a middle-class diversity and notable for its vibrancy and commitment to tolerance and diversity (Brighton & Hove City Council, 2014; Burchill & Raven, 2007; Holtz, 2017). Moreover, Brighton is seen as a place of radical and progressive politics as is evident from the 2019 general election where the city re-elected left-leaning Members of Parliament (MPs), including the country's only Green MP. This is in stark contrast to the wider South-East region which overwhelmingly returned Conservative representatives.

[6] Although Brighton and Hove is a political, unitary authority with clear geographic boundaries, the city is commonly known or simply referred to as 'Brighton'.

Brighton has a long non-heterosexual history which some claim 'is as old as the [city] itself' (Collis, 2010, p. 133). Local records of its lesbian, gay and bisexual history collected by Brighton Ourstory project[7] demonstrate an extended history of same-sex sexual 'transgressions', arrests, cruising grounds dating back to the early 1800s. Despite harsh legal penalties at the time[8], the project suggests that a floating population of holidaymakers and soldiers[9], and the expansion of regular transport links to London and further afield, saw Brighton become a clandestine destination for escape, hedonism, and alternative experiences. By the 1930s, pubs with a lesbian and gay clientele were flourishing and word filtered along the grapevine about guesthouses where proprietors would turn a blind eye to illegal 'goings-on'. With the establishment of The Sussex Gay Liberation Front in 1971, Brighton saw its first gay demonstration the year in October 1972 and held its first Pride march in July 1973[10]. The Brighton Lavender Line, a helpline known today as the Brighton and Hove LGBTQ Switchboard, followed soon thereafter in 1975 and was instrumental in disseminating early information about the HIV/AIDS epidemic among sexual minority men, producing one of the country's first information leaflets explaining the then known facts about the epidemic. By the late 90's, the Brighton and Hove City Council began to acknowledge and support the endeavours of LGBTQ voluntary and community sector groups through short-term funding, raising both the profile of these groups and the local LGBTQ community.

Today, Brighton ranks among the top ten most LGBTQ inclusive cities in the world (Nestpick, 2017), with tourism guides selling the 'whole' city as LGBTQ-friendly[11]. A recent report suggests that Brighton has one of the largest LGB populations in Britain alongside London and Manchester with estimates placing the number of sexual minority residents somewhere between 11% and 15% of the city's total population (Oxford Consultants for Social Inclusion [OSCI], 2017). The city also boasts the highest number of civil partnerships for a local authority in England (ONS, 2019), and has a thriving commercial LGBTQ scene with an array of clubs, bars, pubs, shops,

[7] See www.brightonourstory.co.uk. Note, trans people's histories are not included in the charity project's archive.
[8] Hanging to life imprisonment for the crime of buggery (i.e., anal intercourse).
[9] During the Napoleonic Wars, and the First and Second World War.
[10] With only a tiny minority ready to take to the streets at the time, Brighton did not see another Pride event until 1991.
[11] See www.visitbrighton.com/lgbt

theatre venues, saunas, and related services and events. Closely aligned with the commercial scene is the city's large annual Pride event which happens on the first weekend of August with approximately 300,000 people attending Brighton Pride in 2019 (Busby, 2019). Brighton offers a wide range of vital LGBTQ support services and community groups, such as the aforementioned MindOut, Allsorts Youth Project, the Brighton and Hove LGBT Switchboard, and the Clare Project (trans support group), to name but a few. Thus, while LGBTQ-specific services, spaces and venues may be relatively rare or in decline elsewhere (London, for example; see Campkin & Marshall, 2017), Brighton appears to be bustling with LGBTQ-related activities and resources. As a result, it is not difficult to understand imaginings of Brighton as a 'safe' city for LGBTQ people.

Yet, while inclusion, acceptance and ordinariness characterise *some* LGBTQ people's experiences in Brighton, findings from the Count Me in Too research project led by Professor Kath Browne contest imaginings of the city as a tolerant and inclusive haven for all. According to the large-scale survey, LGBTQ people with mental health difficulties experience multiple layers of prejudice and discrimination, as well as isolation (Browne & Lim, 2008). Over a quarter of those found it difficult to live in Brighton as someone experiencing mental health problems. As Browne and Bakshi (2013) explain:

> We found that many of the 'old' problems of exclusion, marginalisation, and abuse [continue] to exist [in Brighton], manifesting in poverty, [poor] housing and welfare issues and homophobia… some LGBT people found themselves pushed out on the basis of not fitting norms (including on the basis of class, gender and race). This resulted in forms of multiple marginalisations, where they were not in place in either LGBT or heteronormative spaces (p. 185).

Similarly, Johnson et al.'s (2007) research with MindOut service users note a 'double stigma' where participants experienced alienation from within the local LGBTQ community because of ongoing mental health issues and isolation, sometimes pathologisation, from mainstream service providers because of their sexual orientation

or gender identity. These research findings not only underscore the importance of examining a broad range of social, economic and cultural factors which may influence gay and bisexual men's mental health help-seeking (a neglected topic area within the literature, see Chapter Two), but also contest imaginings of Brighton as a 'sorted' in relation to its support of vulnerable, isolated and distressed LGBTQ people. As a result, the city provides a unique context from which to investigate gay and bisexual men's mental health help-seeking, particularly as it relates to elements which have not been well explored within the research and literature. First, it allows for a consideration of help-seeking vis-à-vis an (online) LGBTQ mental health support service. Second, it provides an opportunity to consider the extent to which contemporary LGBTQ community norms, practices, and cultures may be implicated in some of the difficulties experienced by some gay and bisexual men, particularly in reproducing forms of isolation and exclusion (Cover, 2012).

1.3 A note on terminology

For the purpose of clarity, this section defines some key terms deployed throughout this thesis in addition to sketching the remit of the project. One deliberate limitation of this study, as indicated earlier, is that it concerns itself with the mental health help-seeking experiences of gay and bisexual men, that is, individuals who identify as male and gay or bisexual. This definition includes transgender (or 'trans') men who identify as gay or bisexual; individuals whose affirmed gender differs from their assigned gender/sex at birth. Interpretations from this thesis in relation to trans people should be made with caution, however. Given the dearth of available literature and my research participant sample (see Chapter Two and Three respectively), this thesis is limited in its understanding of trans men's unique mental health help-seeking experiences. For this reason, I have chosen to mostly use the term 'gay and bisexual men', rather than 'gay, bisexual, and transgender men'. Nevertheless, I try and incorporate existing literature and the views of trans participants wherever possible. I also use the umbrella term 'LGBTQ' (and variations thereof) to refer to a diverse range of sexual and gender minority individuals and to reflect the term's use within the literature and by specific organisations or community groups discussed herein, as well as to reflect research participants' self-identifications.

While I sometimes oscillate between the terms ‘digital’ and ‘online’ both are used in this thesis to denote internet-supported processes or activities as opposed to, for example, the delivery of mental health support via stand-alone computers or video seminars. Digital community outreach work (herein known as 'digital outreach’) refers to a proactive form of activity or contact facilitated by organisations, such as voluntary and government bodies, where mental health information, resources, and support services are delivered online in order to reach or connect with underserved and hard-to-reach target populations (Brownlie, 2018; Mowlabocus, Haslop, & Dasgupta, 2016). When discussing social media, I often refer to SNSs, seminally defined by Ellison and boyd (2013) as:

> A social network site is a *networked communication platform* in which participants (1) have *uniquely identifiable profiles* that consists of user-supplied content, content provided by other users, and/or system/level data; (2) can *publicly articulate connections* that can be viewed and traversed by others; and, (3) can consume, produce and/or interact with *streams of user-generated content* provided by their connections on the site (p. 157, authors’ emphasis).

I distinguish between mainstream SNSs, designed for general population use such as Facebook and Twitter, and commercial niche SNSs that specifically target and cater to gay and bisexual men. For the purposes of this thesis, the latter also includes socio-sexual geosocial networking (GSN) sites or smartphone applications (‘apps’) (e.g., Grindr, Scruff, and Wapo etc.). Some scholars have questioned whether GSN dating or ‘hook-up’ apps fall under popular SNSs definitions such as the one outlined above (e.g., Dhoest & Szulc, 2016; Wu & Ward, 2017). The point of contention here is that SNSs generally enable platform users to publicly display their connections and facilitate one-to-many communication, whereas GSN apps foreground a location-based model for interaction (i.e., ‘who’s nearby?’) and rely on private, one-to-one messaging between platform users. While I acknowledge these differences, I include niche GSN apps within this thesis and under the umbrella of SNSs given their prominence in facilitating social and sexual connections among gay and bisexual men

(Gudelunas, 2012), and considerations of these platforms as SNSs by service users and providers (Grindr, 2017; Rodriguez, Huemmer, & Blummel, 2016).

Lastly, the terms 'emotion' and 'affect' are often used interchangeably across perspectives and disciplines despite definitional distinctions which signify separate spheres of consciousness and intentionality. For instance, Greco and Stenner's (2013) argues that 'emotion' is generally understood as a more conscious level of cognitive and behavioural response (i.e., personal and intentional), whereas 'affect' refers to the poststructuralist transition towards a more unconscious analysis of processes and embodiment in the 'affective turn' (i.e., pre-personal and non-intentional). However, the authors caution that firm distinctions may be counterproductive as one would be associated with the *traditional* and the other with the *sophisticated,* and risks reducing emotion to a solely cognitive function. Thus, while the cognitive and affective are not necessarily identical, they are also not independent from each other (Michaelsen, 2017). Therefore, I employ the both terms interchangeably in order to avoid these analytical pitfalls.

1.4 Thesis structure

This thesis consists of eight chapters, including this introductory overview. The next chapter, Chapter Two, critically reviews the theoretical and empirical literature on gay and bisexual men's mental health help-seeking. Following a brief introduction to the concept of help-seeking, two broad orientations to conceptualising help-seeking are identified: the dominant rational choice approach and the dynamic approach. The argument is made that research on gay and bisexual men's help-seeking has remained largely consistent with a rational choice approach which threatens to oversimplify our understanding of how gay and bisexual men experience and respond to mental health problems. Specifically, rational choice approaches direct research attention to a narrow conceptualisation of help-seeking as single decision point leading towards or away from services (emphasis on prediction) and limits our understanding of how gay and bisexual men experience help-seeking as a subjective, relational and ongoing process (emphasis on understanding). In arguing for a shift in how their help-seeking is framed, attention is then given to how a dynamic approach considerate of

the normative and emotional dimensions of gay and bisexual men's help-seeking can complement current work. In addition to this, the chapter also maps the field of online mental health service provision with this group, noting two types of Internet-supported interventions (i.e., individually targeted and relationally oriented interventions).

Chapter Three presents a detailed account of the methodology and methods used. The first half outlines the interpretative and thematic analytic framework used to investigate gay and bisexual men's online mental health help-seeking. Drawing on interdisciplinary theory, it sets out the study's approach which highlights the impact of norms and emotions on gay and bisexual men's help-seeking. The second half discusses research methods and includes a description of the research design, the participants, and the process of data generation through to analysis. The chapter ends with a reflection on key ethical challenges encountered throughout the research process, and my attempts to negotiate these at various junctures of the project.

Chapter Four, Five and Six form the analytical bedrock of this thesis. Chapter Four foregrounds the conditions under which gay and bisexual men come to seek help online for their distress. In this chapter, I first consider gay and bisexual men's help-seeking more generally and their engagement with offline support mechanisms and services. It explores how feelings of failure and shame connected to prevailing sociocultural norms can restrict the type of help-seeking possible. Chapter Five explores gay and bisexual men's experiences seeking help online and demonstrates how online help-seeking provides some relief from these punishing norms, as well as a sense of social and emotional connectedness which they use to get through difficult times. Chapter Six examines how a LGBTQ mental health support service utilises digital and social media to help generate and support outreach with vulnerable, isolated or distressed gay and bisexual men. This includes an examination of my community partner's bespoke online support service and outreach vis-à-vis already existing social media platforms, including mainstream and niche SNSs.

The final and concluding chapter, Chapter Seven, summarises the thesis in terms of its rationale and main analytical contributions to the topic area. The chapter then considers the resultant implications for practice and policy. Finally, the chapter

concludes with a discussion of the study’s strengths and limitations and also highlights several directions for future research.

2. Reframing Gay and Bisexual Men's Mental Health Help-seeking

This chapter offers a critical review of current theoretical and empirical work on gay and bisexual men's mental health help-seeking. Following a brief discussion around what is meant by the term 'mental health help-seeking' within the literature, two broad orientations to conceptualising help-seeking are identified, namely, the dominant rational choice approach and the dynamic approach, with emphasis given to how the latter can complement current understandings of gay and bisexual men's help-seeking. Specifically, as dominant perspectives prioritise efforts to predict or explain professional help-seeking patterns, less is known about gay and bisexual men's subjective experience of this process and how they engage a diversity of supports. In arguing for a shift in how gay and bisexual men's help-seeking is framed, attention is given to how a dynamic approach attentive to the emotional and normative dimensions of help-seeking can offer a more nuanced understanding of the help-seeking process. In addition to this, the chapter also maps the field of online mental health service provision with this group, noting two types of Internet-supported interventions (i.e., individually targeted and relationally oriented interventions) and their potential for facilitating help-seeking.

2.1 Mental health help-seeking as a concept

Although widely used within the literature, there is no commonly applied or agreed on definition of mental health help-seeking (Dearing & Twaragowski, 2010). A systematic review of 316 mainstream (or general population) help-seeking studies reported that almost half of these provided no clear definition of what the researchers meant by the term 'help-seeking' with many offering vague and minimal definitions, such as 'utilisation of care' and 'seek advice and assistance' (Rickwood & Thomas, 2012). Likewise, research specifically investigating the mental health help-seeking behaviour of LGBTQ people often treat the term as self-evident or used interchangeably with 'mental health service utilisation' and 'treatment uptake' (e.g., Chakraborty et al., 2011; Meyer, Teylan, & Schwartz, 2015; Platt et al., 2018). Help-seeking, however, is a

complex construct and there is wide variation in its operationalisation within the field. It is for this reason perhaps, suggests Rickwood and Thomas (2012), that a consensus definition remains lacking:

> the focus of the [help-seeking] process varies from hypothetical attitudes to specific past behaviour; the types of problems or symptoms are wide-ranging and can include very specific mental health problems/diagnoses or generic terms for psychological or emotional distress; and there are many potential external sources of help (p. 180).

As a result, those who study mental health help-seeking may choose to limit their coverage differently according to specific parts of the behavioural process (e.g., general attitudinal orientation towards obtaining assistance, future behavioural intent, or observable behaviour); timeframe (i.e., retrospective or prospective); source of assistance (e.g., professional/formal, informal, self-help, as well medium of the source e.g., online); type of assistance (e.g., instrumental, informational, affiliative, emotional or treatment); and, the type of mental health concern for which help is sought (e.g., general concern/distress or a specific type of mental health problem such as depression) (Dearing & Twaragowski, 2010; Rickwood & Thomas, 2012). Notably, the research focus on three parts of the behavioural processes (i.e., attitudes, intentions, and behaviour) is consistent with the theory of planned behaviour (Azjen, 1991), which hypothesises that actual behaviour (i.e., seeking support) is a rational decision made according to intentions to perform a particular behaviour, and that intentions are in turn determined by attitudes. However, the strength of relationships between the three are relatively weak according to evidence from meta-analytic and systemic reviews, the relationship between help-seeking intentions and observed behaviour in particular (Armitage & Connor, 2001; Hardeman, Johnston, Bonetti, Wareham, & Kinmoth, 2002).

Despite diversity in how help-seeking has been investigated, a common component evident in many definitions or implicit in their application within the literature is that help-seeking refers to an *active* and *adaptive* process where external resources are utilised to cope with a mental health concern (Rickwood & Thomas, 2012). According

to Rickwood and Thomas (2012), this conceptualisation originates from early medical sociological models examining illness behaviour, that is, the study of human health behaviour which examines how individuals adapt or respond to illness symptoms and utilise health care systems (Alonzo, 1984; Mechanic, 1962), where one of the earliest definitions was put forward by David Mechanic (1982) who saw help-seeking as an adaptive form of coping. Adaptive help-seeking is understood to facilitative short-term, situation-specific stress reduction, as well as enable the long-term development of intra- and interpersonal resources to help manage and address future challenges (Newman, 2008). The process is recognised as active in that the issue or problem is actively acknowledged and addressed by the individual (Rickwood, Deane, Wilson, & Ciarrochi, 2005). With this conceptualisation in mind, it is not surprising then that traditional help-seeking studies have come to focus on engagement with, and experiences of, mental health services as formal resources are widely recognised to provide protection against a variety of mental health risk factors (Rickwood et al., 2005; Rickwood & Thomas, 2012). Sexual and gender minority individuals, in particular, are likely to benefit from such investigations, given that they experience unique forms of psychosocial stress, often lack social support from nonprofessional sources (e.g., family), and report greater dissatisfaction with standard mental health services (Spengler & Ægisdóttir, 2015).

There is a growing recognition, however, that practice and policy may be better served by research focusing on the more protracted and relational process of help-seeking (Biddle, Donovan, Sharp, & Gunnel, 2007; Cauce et al., 2002), broadening the scope of research to begin with a time when a problem is first noticed and 'acknowledging the process as influenced by perceptions, interactions, skills, and strategies and varying in methods and outcomes' (Wenger, 2011, p. 496). Within this expanded framing, research attention shifts from, what Cauce and colleagues (2002) terms, *'help getting'* (e.g., service engagement patterns, service user satisfaction) to *help-seeking* with greater emphasis on the role of culture and context at multiple levels across the help-seeking pathway (e.g.., individual, familial, societal, systemic). These two differing orientations to conceptualising mental health help-seeking have usefully been identified within sociological literature as the 'dominant positivistic' or 'rational choice' approach exploring *who* seeks help (emphasis on prediction), and the 'dynamic' approach exploring *when* and *how* individuals seek assistance (emphasis on

understanding) (Pescosolido, 1991; Pescosolido & Boyer, 1999). It is within the first orientation that I believe much of the extant work on gay and bisexual men's mental health help-seeking has been located and that such approaches have theoretical and methodological limitations to understanding help-seeking more fully.

2.2 Moving beyond the rational choice model: Dominant approaches to gay and bisexual men's mental health help-seeking

Despite a high level of research, practice and policy interest in mental health help-seeking more generally (Rickwood & Thomas, 2012), relatively little scholarship has explored help-seeking among sexual and gender minorities (for similar arguments, see Chakraborty et al., 2011; McDermott et al., 2017a; Semp & Read, 2015). The scant evidence we do have about gay and bisexual men's help-seeking predominantly stem from psychological and psychiatric rationalist perspectives reliant on quantitative or positivist methodological approaches. As Pescosolido and Boyer (1999) detail, rational choice approaches conceptualise help-seeking as an individual, voluntary, and rational decision point leading towards or away from mental health services (i.e., an either/or decision), and assumed to be made by informed individuals in the form of a cost-benefit analysis. As research focuses on providing a profile of mental health service users, tallying service outcomes, and predicting help-seeking patterns by measuring broad psychological, structural, or demographic factors influencing service use (Biddle et al., 2007; Wenger, 2011), the study of help-seeking becomes a question of whether assistance is sought and by which population (sub)groups.

Within this broader orientation, I identify three frameworks researchers draw on to predict and explain gay and bisexual men's help-seeking. The first and most common of these is a disparities and minority stress explanatory framework. This is where high rates of service utilisation among sexual and gender minorities is understood to reflect the greater prevalence of mental health problems and collective experiences of stigma and discrimination, thus prompting their help-seeking behaviour. The other observed framework is the barriers and facilitators model where researchers identify factors that hinder or enable help-seeking. Lastly, there is the gender role socialisation paradigm

where research prioritises the influence of masculinity norms as determinants of (non-)help-seeking and maladaptive coping strategies.

Although this model of help-seeking offers valuable insights into service engagement patterns, broad cues/barriers to care, and potential targets for policy intervention, positivist research threatens to (over)simplify theoretical and empirical understandings of how gay and bisexual men experience and respond to mental health-related challenges. Specifically, dominant quantitative approaches have a tendency to conceal gay and bisexual men's subjective experiences and perspectives (King et al., 2007) which, in my view, are crucial to facilitating early help-seeking and mental wellbeing, as well as enabling culturally relevant (digital) support. Drawing on McDermott and Roen (2016), and Pescosolido (1992, 2000), two overarching critiques of the prominent models used to frame gay and bisexual men's help-seeking studies emerge: first, that the help-seeking process is narrowly conceptualised and individualised as an either/or decision; and, second, that this conceptualisation excludes a range of complex and interconnecting social, cultural and economic factors which may influence gay and bisexual men's mental health and help-seeking.

Mainstream LGBTQ mental health research largely view help-seeking in dichotomous and restricted terms, or what Pescosolido (2000) refers to as the 'tyranny of use/no use' survey responses. That is, help-seeking is viewed as an isolated, individualistic decision-making process occurring in the presence of psychiatric morbidity where (mainstream) mental health treatment and service utilisation are an assumed logical outcome or end-goal. Implicit in this conceptualisation is a presumption a unitary, rational, and autonomous subject in a neoliberal vein who is responsible for their own mental wellbeing and for self-directing their help-seeking (Brijnath & Antoniades, 2016; Rose, 1989). This linear cause-and-effect explanation assumes that every help-seeking decision is commonplace and predictable and limits consideration of how gay and bisexual men are making sense of a diversity of needs and supports. The field's narrow focus on individual psychopathology limits an integration of deeper understandings of help-seeking meanings, processes, and practices (Pescosolido, 2000; Wenger, 2011). Specifically, extant work overlooks a plethora of complex interconnecting social, economic, and cultural factors which may influence gay and bisexual men's mental health difficulties and help-seeking. Consequently, there is

room for more attention to be paid to the sociocultural relations that shape mental wellbeing, emotional distress and help-seeking behaviour (Fullagar, 2005).

There is a longstanding critique of liberal, individualised psychology and psychotherapy as it relates to members of the LGBTQ community (for a more detailed account of the early and more recent history of LGBT psychology and psychotherapy, see Clarke & Peel, 2007; Hegarty, 2018). Critical psychologists, such as Celia Kitzinger (1987; 1993) and Richardson and Hart (1981), argue that mainstream psychological theories and practices are far from neutral endeavours conducted in a socio-political vacuum: they are value-laden and reinforce an unjust status quo. Kitzinger was critical of early lesbian affirmative psychology, which assumed that 'patriarchy (not capitalism or sex roles or socialization or individual sexist men) is the root of all forms of oppression; that all men benefit from it and maintain it and are, therefore, our political enemies' (Kitzinger, 1987, p. 67). Central to Kitzinger's critique was the charge that lesbian and gay-affirmative psychology was complicit with an ideology of liberal humanism and individual self-determination, thereby distracting from more substantive structural changes (Hegarty, 2018). She argued, for example, that the concept of homophobia 'depoliticises lesbian and gay oppression by suggesting that it comes from the personal inadequacy of particular individuals suffering from a diagnosable phobia' (Kitzinger, 1997, p. 211). She was equally critical of the concept of internalised homophobia, arguing that it shifts the focus of concern from the oppressor back onto the victims of oppression. Instead, Kitzinger called for a radical, feminist, critical, social constructionist perspectives on homosexuality, taking to task the ways in which mainstream psychological practices and norms has contributed to the marginalisation of women and homosexuality (Clarke & Peel, 2007). These more discipline-specific debates exist in relation to a wider affective turn in social and cultural studies which draws attention to the loaded socio-political conditions in which the subject is constituted, and from which the subject emerges, rather than solely dissecting the internal psychic structure of the subject (for example, see Ahmed, 2015; Bersani & Phillips, 2008; Halperin & Traub, 2009; Munt, 2007; Probyn, 2005).

Emerging understandings of mental health help-seeking focus on the ways in which individuals embody, negotiate and manage difficult emotions, as well as the discursive

and material contexts which makes such emotions and their management possible (McDermott, 2015; McDermott et al., 2017a; McDermott & Roen, 2016). Rather than figure emotional distress as solely residing in the individual (i.e., as psychological or psychobiological), these approaches reconceptualise emotional distress as relational and implicated in the production and maintenance of sociocultural norms. Yet, current work largely ignores the affective nature of gay and bisexual men's mental health help-seeking relations.

Taken together, these critiques set the stage for an alternative approach to researching and understanding of gay and bisexual men's mental health help-seeking that moves beyond a narrow focus on individual psychopathology and positivistic understandings about the nature of the subject at hand. I now outline and critique each framework in turn.

2.2.1 Mental health help-seeking disparities and minority stress explanatory frameworks

Research on the health of sexual and gender minority individuals has predominantly been framed within the context of disparities and social stress models. Mental health disparities have consistently been documented between heterosexual and non-heterosexual populations with a now substantial body of evidence reporting elevated rates of psychological distress and mental health problems such as depression, anxiety, suicidality, self-harm, and other health-risk behaviours (e.g., substance misuse/dependency, sexual compulsivity, risky sexual behaviour) among LGBTQ persons compared to heterosexual people (e.g., Borgogna et al., 2018; Chakraborty et al., 2011; Elliot et al., 2015; Gonzales et al., 2016; Haas et al., 2011; King et al., 2003, 2008; Plöderl & Tremblay, 2015; Semlyen et al., 2016; Warner et al., 2004; Woodhead et al., 2016). In addition to this, sexual minorities are also more likely to report universal mental health risk factors such as hopelessness, rumination and social isolation, even from an early age (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008; Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). Although two salient explanatory approaches can be distinguished in explaining these disparities, namely Meyer's (1995, 2003) Minority Stress Theory (emphasis on group-specific

processes present in non-heterosexuals) and Hatzenbeuhler's (2009) Psychological Mediation Framework (emphasis on general psychological processes implicated in the development of psychologies of both non-heterosexuals and heterosexuals) (for a review of both, see Pitoňák, 2017), I mostly focus on minority stress theory given its predominance within gay and bisexual men's mental health help-seeking literature.

Drawing on the minority stress hypothesis, these studies, reviews, and meta-analyses explain observed disparities as a result of the direct and cumulative effects of excess social – or minority – stress experienced throughout the lifespan, and diminished coping resources as a result of gay and bisexual men's social disadvantage and stigmatised statuses. The minority stress conceptual framework distinguishes between several specific but interconnected psychosocial processes - distal and proximal stressors - that confront gay and bisexual men as a stigmatised group. For example, overt and interpersonal types of stigma such as acute stressful life events caused by prejudice and chronic everyday forms of discrimination based on one's sexual minority identity are considered distal or external stressors, whereas proximal stressors are internalised or intrapersonal types of stigma (e.g., fear of discrimination or rejection, sexual/gender identity concealment, and self-stigmatisation or internalised homophobia) (Meyer, 2003). Minority stress theory therefore considers minority stress as unique and additive to general stressors experienced by all members of society, and necessitates 'an [extra] adaptation effort above that required of similar others who are not stigmatised' (Meyer, 2003, p. 676). Recent efforts have expanded these stressors to include structural stigma in the form of institutionalised heterosexism (e.g., discriminatory social policies) and nonevent stress (i.e., frustrated personal pursuits in the arenas of relationships and work because of structural and interpersonal stigma) (Frost & Leblanc, 2014; Hatzenbuehler, 2014; Meyer, Ouellette, Haile, & McFarlane, 2011). There is now considerable research evidence linking a variety of these minority stressors to a multitude of mental and physical health problems among sexual minorities (see Meyer & Frost, 2013 for a review), with some studies even showing that when exposure to factors indicative of minority stress are analytically controlled, the differences between heterosexual and sexual minority populations in negative health outcome measures are substantially attenuated (Frost & Leblanc, 2014; Mays & Cochran, 2001).

Because of their explanatory potential, disparities and minority stress explanatory frameworks has also been the dominant approach to studying gay and bisexual men's mental health help-seeking. International evidence indicates that sexual minority men and women seek mental healthcare at higher rates compared to their heterosexual counterparts (Cochran & Mays, 2000b; Cochran et al., 2003; Grella et al., 2011, 2009; Platt et al., 2018). While there has been less research in the UK (e.g., King et al., 2003), perhaps the best evidence of mental health service utilisation among sexual minorities in the UK comes from two large scale surveys. Using the 2007 UK Adult Psychiatric Morbidity Survey (a nationally representative sample), the first study found elevated levels of mental health-related GP consultations and community-care service use among the non-heterosexual population in the past 12 months (Chakraborty et al., 2011). The second study, based on the 2009/2010 English General Practice Patient Survey (a nationally administered survey), indicate that, in addition to higher rates of longstanding psychological or emotional problems, sexual minorities were about one and one-half times more likely to report unfavourable primary healthcare experiences than heterosexual people (Elliot et al., 2015).

Within these studies, minority stress is positioned as *the* major contributing factor to elevated rates of service use (Chakraborty et al., 2011; Grella et al., 2011, 2009; King et al., 2003; Mays & Cochran, 2001), where disproportionate exposure to minority stress is theorised to lead to an increased incidence of mental health problems, which in turn prompts greater help-seeking behaviour and service utilisation as shown in Figure 1. Moreover, minority stressors may carry over into services, leading to poor mental healthcare experiences (Elliot et al., 2015). Although some authors point to additional factors such as differential cultural norms within the LGBT community that normalise help-seeking, minority stress is the most common and sometimes sole or preferred explanation for increased psychological help-seeking within the literature. Further to this, some studies cite minority stress as a particularly salient factor in gay and bisexual men's service seeking (Herek & Garnets, 2007). For example, Platt et al. (2018) found similar rates of service utilisation between sexual minority men and women, closing the gender gap observed in comparative heterosexual populations. Explaining these findings, the authors suggest that:

> Sexual minority men have unique cultural experiences as the intersection of gender and sexual orientation is often particularly salient for this group. Traditional gender roles dictate that men show little intimacy, especially toward other men, out of fear of seeming gay or too feminine. There are many implicit cultural norms that enforce the taboo of homosexuality in men (Solobello & Elliot, 2011). Therefore, when a man does have same-sex attraction and identifies as a sexual minority, he may face considerable social backlash, sometimes even violent reactions (D'haese, Dewaele, & Van Houtte, 2016). This minority stress … [and] additional need may increase the utilisation of sexual minority men so that it not only exceeds heterosexual men, but also rises to the level of use by sexual minority women (p. 149).

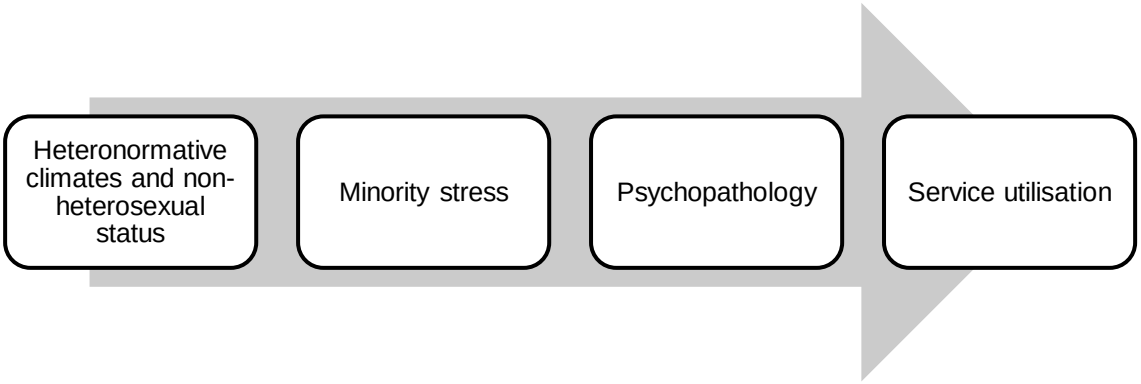


Figure 1. Minority stress conceptualisation of gay and bisexual men's mental health help-seeking.

Although theoretical and empirical work employing the minority stress model to explain mental health disparities between cisgender and gender minority populations is less robust (Frost, 2017), minority stress theory has been drawn on to explain high service rates among trans people with respect to mental health services (Ellis, Bailey, & McNeil, 2015).

In addition to its explanatory potential, approaching the study of sexual and gender minority mental health from a disparities and social stress framework has numerous benefits. Chiefly, the concept of minority stress provides a unifying framework for understanding the social origins of sexual and gender minorities' mental health

disparities and has produced a body of evidence that challenges the long historical psycho-medical pathologisation of non-heterosexuality and assumptions that poor mental health outcomes are inherent to sexual and gender minority identities in and of themselves (Frost, 2017). With regards to help-seeking, this evidence base has been at the forefront of bringing national attention to mental health problems that disproportionately affect sexual and gender minorities and the need for improved access to high quality, culturally appropriate mental healthcare services. This commitment is outlined in recent policy efforts where the 'national'[12] LGBT Action plan aims to work with relevant statutory organisations and professional associations to embed LGBT issues in mental health services, as well as bring forward proposals to end the practice of conversion therapy (GEO, 2018a, 2018b).

Despite its widespread adoption, this approach to gay and bisexual men's mental health help-seeking is by no means unproblematic. First, by comparing the experiences of a disadvantaged minority group with a dominant majority group, a disparities framework risks universalising the experiences of sexual minority men. This risks portrayals of the group as stereotypically 'sicker' or 'damaged', thereby perpetuating the social stigma that underlies the very disadvantage theorised to be the root of such mental health disparities (i.e., suggesting that it is solely a burden to be part of an underrepresented group of people) (Braveman, 2006; McDermott & Roen, 2016). While elevated rates of poorer mental health outcomes and service use are statistically significant, these indices turn up among a minority of sexual minority men where the majority do not have a mental health problem (Plöderl & Tremblay, 2015; Savin-Williams, 2005). An important factor that undoubtedly impacts the available literature is that research funding has hitherto been directed towards studies documenting that sexual and gender minorities people have mental health problems (BPS, 2016), and, as a consequence, there is scant evidence on help-seeking or interventions which target them specific subgroups group, such as gay and bisexual men. Additionally, the preoccupation with service engagement patterns also risks suggesting that gay and bisexual men will readily seek out services in response to mental health problems or psychological distress. However, research suggests delays

[12] While published by the UK Government, the cross-departmental LGBT action plan is mainly applicable to England and Wales, with much less purchase in Scotland and Northern Ireland given existing devolution arrangements.

in service utilisation (MacKay et al., 2017), with one study reporting that a large proportion of gay and bisexual men did not seek help when they considered or attempted suicide (Lytle et al., 2018).

Second, by treating sexual minority men as a homogenous group and focusing predominantly on service utilisation rates, this framework often omits within-group variability, intersectional identities and a diversity of supports. For example, minority stress theory does not explain why some sexual minority men experience poor mental health while others may not, nor why those who occupy multiple marginalised positions may be at greater risk of mental health problems than those occupying just one marginalised subject position (Ellis, Riggs, & Peel, 2019). Additionally, emerging evidence suggests that there are important subgroup differences in mental health such that bisexual and trans people evidence higher rates of mental health problems than their lesbian/gay and cisgender counterparts (Fredriksen-Goldsen et al., 2014; Hickson, Davey, Reid, Weatherburn, & Bourne, 2016; Plöderl & Tremblay, 2015; Sju et al., 2016; Smalley et al., 2016), and may be more likely to avoid formal mental health services, even in times of significant need (Eady, Dobinson, & Ross, 2011; Macapagal, Bhatia, & Greene, 2016). In accordance with findings from mainstream help-seeking studies (see C. Cooper et al., 2013; Gulliver, Griffiths, & Christensen, 2010), studies report a marked reluctance among LGBTQ youth and racial/ethnic minorities to use formal mental health services. For example, Meyer, Teylan and Schwartz (2015) report that black and Latino LGB people experiencing suicidal distress are underrepresented in mental health or medical treatment and overrepresented in religious or spiritual treatment settings compared to their white LGB counterparts. Similarly, white gay and bisexual men were more likely to utilise counselling or psychotherapy than their Black and Asian men (Storholm et al., 2013). Also, data on LGBTQ youth suggest a preference for informal sources (e.g., online, friends, and family) rather than National Health Service (NHS) mental health services for help with suicidal feelings and self-harming behaviour (McDermott et al., 2016).

Third, although the minority stress model flips the etiology of pathology back to the social structure, Meyer (2003) defines minority stress in terms of an individual psychology resulting from ‘experiences of prejudice events, hiding and concealing, internalised homophobia, and ameliorative coping processes’ (p. 674). In this respect,

stigma is conceptualised as a rather taken-for-granted object that is attached to interior psyche of sexual minorities (Liu, 2017). Consequently, minority stress theory is 'largely devoid of an account of the role of social norms in shaping how particular individuals may be rendered legitimate targets of negative regard' (Riggs & Treharne, 2017, p. 595), nor does it acknowledge how a range of social norms might impact the help-seeking of gay and bisexual men. As part of a larger project on the mental health and social well-being of LGB people, King et al. (2003) interviewed 23 LGB people on their experiences of mental health professionals, participants reported that heteronormativity impacted more on services than did direct pathologizing. Furthermore, research often points to connections with queer communities and LGBTQ-specific services as 'saving refuges' in a predominantly heteronormative society; however, there are arguments that the community, much like all minority groups, can remain elusive, exclusive, and inaccessible for some gay and bisexual men, thereby doubling the vulnerability of the already vulnerable (Cover, 2012; Doolin, 2010). For instance, a qualitative study by Johnson, Faulkner, Jones, and Welsh (2007) points to the stigma that comes from having a mental health problem within the LGBTQ community and the difficulties that result in forming and maintaining relationships with other LGBTQ individuals.

Lastly, Meyer's minority stress theory is often presented in the field as the most important factor in understanding LGBTQ mental health and help-seeking to the exclusion of other explanatory frameworks. An application of the Hatzenbeuhler's (2009) psychological mediation framework, for example, may offer additional insights into the help-seeking process. Expanding upon Meyer's model, Hatzenbuehler hypothesises that stigma-related stress can result in higher levels of general (non-LGB-specific) deleterious sequalae such as rumination – compulsively focused attention on the symptoms, possible causes and/or consequences of one's distress as opposed to its solutions (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008) – which, in turn, results in psychopathology. The role of rumination on help-seeking was apparent in the experiences of participants within this study. Chapter 4 (see section 4.1 and 4.2) demonstrates how rumination cam contribute to participants' (increasingly severe) distress, initial non-help-seeking and other avoidant behaviour/coping strategies. The ruminative focus on, and the ongoing anticipation of, negative social consequences (e.g., rejection, social judgements), for example, not only intensifies some participants'

distress but inhibits or delays help-seeking behaviour in face-to-face setting. Although not an issue in my data set, it is also worth considering how the hyperlinking structure of the Internet might fuel ruminative thinking (i.e., ruminative self-focus, a spiral of self-assessing/diagnosis etc.) in relation to online help-seeking. As a result, Hatzenbeuhler's model may offer additional or further insights when it comes the help-seeking process, but, ultimately, remains subject to the same critiques as outlined above. The model is limited in that it individualises psychological distress by attributing it to psychological factors (e.g., poor coping skills, inability to regulate emotions) and fails to address the primary issue of minority stress (Ellis et al., 2019). Consequently, there is a need to consider a wide range of factors that may influence help-seeking behaviour.

These critiques are not to suggest that this body of literature is not valuable; however, more attention needs to be paid to the diversity of lived experience to produce a more nuanced account of factors that both impede and promote mental health help-seeking within this group. This concludes the review of the disparities and minority stress framework. In the next section, attention is given to models that focus on barriers and facilitators model of help-seeking.

2.2.2 Barriers and facilitators model of help-seeking

Another dominant framework operationalised within the literature is the 'barriers and facilitators' model of help-seeking. In addition to high mental health service utilisation rates, LGBTQ people often report negative mental healthcare experiences associated with their sexual orientations and/or gender identity, and feel that healthcare practitioners are unresponsive to their needs as an LGBTQ person (Ash & Mackereth, 2013; Elliot et al., 2015; McCann & Sharek, 2014). A study by Guasp (2013) indicates that one third of gay and bisexual men who accessed healthcare services in the previous 12 months reported a negative experience related to their sexual orientation, and others expressed concerns about breaches in service user-provider confidentiality (e.g., inappropriate discussion of service user details with other members of staff). Even more, Meyer et al. (2015) found no protective effect of receiving mental health or medical treatment in preventing suicide attempts among a diverse group of gay and

bisexual men. The paradox between high service uptake and unmet mental health needs suggest important barriers to effective service provision for gay and bisexual men, and previous research highlights several factors that hinder or enable formal help-seeking among this group.

Even though mental health services are subsided by the NHS for the citizens of the UK (as opposed to Insurance-based care which common elsewhere in the world), the general issue of long waiting lists in accessing mental health services remains a significant barrier to care. Despite the introduction of the Increasing Access to Psychological Therapies (IAPT) programme in England, which was intended to alleviate the pressures on primary mental health services (Clark, 2011), general population surveys continue to indicate long waiting times for mental health assessment. For example, the British Medical Association (2018) reports waiting lists for specialised talking therapies, such as cognitive behavioural therapy (CBT) and dynamic psychotherapy, ranging from six months up to two years, citing a rising demand and national shortage of therapists as reasons for the recorded delays. Similarly, long waiting lists was the most frequent reason given for difficulties accessing mental health services in a national survey of 108,100 LGBT people (GEO, 2018b). Trans people and service providers working with this group also suggest significant delays in accessing NHS gender identity services of up to 3 years (Ellis et al., 2015; McDermott et al., 2016). Other commonly cited general barriers among gay and bisexual men include a preference for self-reliance, discomfort discussing emotions, feeling embarrassed and ashamed about mental health challenges (i.e., mental illness-related stigma), and the high cost of private and voluntary healthcare services (Ferlatte et al., 2019; MacKay et al., 2017; McIntyre, Daley, Rutherford, & Ross, 2011).

Barriers more specific to sexual minorities include fears of pathologisation, discrimination, mistreatment or judgement by mental health professionals (Berg, Mimiaga, & Safren, 2008; Israel, Gorcheva, Burnes, & Walther, 2008; McNair & Bush, 2016; Pennant, Bayliss, & Meads, 2009; Simeonov, Steele, Anderson, & Ross, 2015). The decision access professional support may be complicated for some gay and bisexual men as the fields of psychology and psychiatry have a long history of pathologising same-sex attraction and gender atypicality (see Ellis et al., 2019).

Although every major counselling and psychotherapy bodies, as well as the NHS, now strongly condemns treatments such as conversion therapy or other sexual orientation and gender identity change efforts (see the Memorandum of Understanding, 2017), there are likely those who remember this history and may feel hesitant to seek out services for fear of providers who might respond negatively towards them. Unfortunately, this reluctance may be well founded as research continues to suggest a lack of LGBTQ-specific cultural competence among healthcare providers, and this includes barriers such as a lack of affirming or specialist services, heterosexist language, rural-urban variations[13], and the prioritisation of medication as the first line of treatment (i.e., the biomedical framework) (Blackwell, 2015; Israel et al., 2008; MacKay et al., 2017; McIntyre et al., 2011; Mizock & Lundquist, 2016; Pennant et al., 2009; Robertson, 1998; Willging, Salvador, & Kano, 2006). A primary limitation of the biomedical model is its inherent diminishment of individuality of mental healthcare; that, regardless of unique and diverse contexts that shape mental health problems, comparable symptoms are produced by similar causal factors and, therefore, will respond to homogenous therapeutic or medical approaches (McIntyre et al., 2011). Furthermore, survey evidence suggests that the abhorrent practice of conversion therapy is still used by some practitioners (GEO, 2018b; Somerville, 2015), despite condemnation from the UK government (GEO, 2018a). In light of this evidence, it is not hard to imagine why sexual minority men report feeling invisible, ignored, and accustomed to poor mental healthcare experiences (Ash & Mackereth, 2013), or withhold relevant information from health care providers about their sexual orientation which may be relevant to the process and outcome of support or treatment (Durso & Meyer, 2013; Lee, Oliffe, Kelly, & Ferlatte, 2017).

While few studies have examined the experiences of bisexual and trans individuals, the evidence suggests that bisexual men and trans people face additional barriers to care and are more likely report to unmet needs compared to their cisgender gay counterparts (Macapagal et al., 2016; Smalley et al., 2015; Steele et al., 2017). A common theme within the literature concerns fears that mainstream service providers may assert narrow, binary definitions and understandings of sexual orientation and/or

[13] Accessing to competent mental health services may be particularly problematic for gay and bisexual men in rural areas given issues such as distance and more common experiences of discrimination (Kalra, Ventriglio, & Bhugra, 2015; McCann & Sharek, 2014; Willging et al., 2006).

gender identity or expression by healthcare providers where a cisgender gay identity could be seen as more appropriate or healthy, thereby positioning bisexual and trans people within a framework of pathology where their mental health challenges are seen as a direct result or symptom of them being bisexual and/or trans (Ellis et al., 2015; MacKay et al., 2017). Regarding trans individuals, the outdated Gender Recognition Act 2004 – a law that enables some trans people to have their gender recognised under law – still treats being trans as a mental illness requiring a gender dysphoria diagnosis. A UK survey of trans people's experiences in mental health and gender identity services suggests that practitioners tend to be poorly informed about trans issues (Ellis et al., 2015), which is particularly problematic given their gatekeeping role to gender identity treatment (i.e., hormones, surgery) and other support. Outside of standard mental health services, there are also sentiments that services designed for the LGBTQ community are heavily gay and lesbian oriented, and this may be an additional barrier given discrimination within the LGBTQ community (Wheldon & Kirby, 2013).

Although far less investigated, studies also identify factors facilitate formal help-seeking and access to mental health services among gay and bisexual men. These include the affordability of private and voluntary services, timely access, flexible provider hours, informal LGBTQ referral networks, LGBTQ affirmative or specialist support, privileged identities (e.g., gender, race, language, income), and self-advocacy skills (MacKay et al., 2017; Willging et al., 2006). The latter refers to an individual's capacity to effectively navigate service by communicating one's needs and ensuring that the service received is relevant, even in the face of resistance on the part of service providers (MacKay et al., 2017).

Critics have challenged the concept of 'barriers' as the main explanation for non-help-seeking within the mental health help-seeking literature. For example, Biddle et al. (2007) argues that:

> 'Barriers' [offer] superficial representations of much more dynamic issues. The concept provides a convenient means of approaching help-seeking by exchanging complexity for crude 'measurable' categories but is reductive and does not engage with individuals'

> experiences of negotiating [the meanings of mental health symptoms and help-seeking choices] (p. 1000).

Due its limited explanatory potential, this model reduces complex belief systems and actions that shape gay and bisexual men's help-seeking behaviour to descriptive categories and thereby creating the image of 'willing' help-seekers constrained by structural obstacles. These approaches fail to acknowledge the purposeful action of individuals, meaning-making and interaction in understanding help-seeking (Biddle et al., 2007; McDermott et al., 2017a). As a result, the ways in which gay and bisexual men understand or define their mental health and the social meanings attached to help-seeking are usually absent from dominant explanations of help-seeking.

Additionally, while some argue for restricted focus on adaptive help-seeking (Rickwood & Thomas, 2012), others highlight the value of adopting a framework of non-adaptive helps-seeking (Biddle et al., 2007; Wenger, 2011). As Biddle et al. (2007) noted, research can benefit from explicitly examining the perception and interpretations, or what they term 'drivers of action', that move individuals away from supports rather than viewing these as barriers to the process. Non-adaptive help-seeking practices refer to coping strategies that may contribute to long-term vulnerabilities yet succeed in the short-term by reducing immediate distress (Newman, 2008). An example of this is avoidant help-seeking where an individual does not seek assistance when necessary an either passively does nothing, actively avoids help, or continues to use another coping strategy such as helplessness, escape, and/or rigid perseveration (i.e., rumination, intrusive thoughts) (Newman, 2008). By adopting a framework of non-adaptive help-seeking, there is an opportunity to consider how such practices can limit gay and bisexual men's ability to address their concerns in the short-term. This broader conceptualisation of help-seeking may lead to new opportunities where intervention or prevention is concerned.

Lastly, McDermott et al. (2017a) argues that the barriers and facilitators models rarely address questions of why these factors hinder or enable mental health help-seeking. To use an example from the previously cited literature, commonly reported barriers in Ferlatte et al.'s (2019) survey include preferences for self-reliance, discomfort discussing emotions, and feeling embarrassed and ashamed about mental health

challenges, and the authors offer minimal explanations, such as ‘to prevent encountering prejudice and negative attitudes about their gender or sexual orientation by health care providers’ and ‘the persistence of mental illness stigma’ in wider society’. Thus, we might probe further and ask why is some gay and bisexual men’s mental (ill-) health stigmatised or pathologised; why do some of these men experience difficulty articulating their feelings, emotions, or thoughts; and, why do they believe they must rely on and cope by themselves rather than seek (in)formal support. By asking these *deeper* questions, McDermott et al. (2017a) contends, we may be in a better position to generate evidence that can guide effective mental health interventions and support modalities. The next section considers the final framework within the rational choice orientation and examines the relationship between masculinity norms and (non-)help-seeking.

2.2.3 Masculinity norms in the context of (non-)help-seeking and maladaptive coping styles

Because gay and bisexual men’s experiences reflect both identifying as gay or bisexual and male, another interpretation of (non-)help-seeking among this group surround the influence of masculinity norms. The most common interpretation for men’s low rates of service utilisation at a general population level surround masculine gender role socialisation theories which posits that social environments teach men distinct behaviours and attitudes that influence how they see themselves in relation to their gender and how the perceive expectations for their gender (Brown, Sagar-Ouriaghli, & Sullivan, 2019). It is now well-documented that traditional or hegemonic masculine norms such as stoicism, self-reliance and restrictive emotionality (i.e., disinclination to express emotions), which stem from dominant models of male socialisation in the West (Pleck, 1995), may inhibit men’s help-seeking behaviour and reinforce maladaptive or non-adaptive coping styles (e.g., Addis & Mahalik, 2003; Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016; Wirback, Forsell, Larsson, Engström, & Edhborg, 2018; Yousaf, Popat, & Hunter, 2015). Asking for help – which often involves relying on others, admitting to and recognising that there may be a problem, and addressing emotional difficulties - contradicts these ideals and can be perceived by men themselves and others as ‘unmanly’, ‘effeminate’, and a sign of weakness

(Affleck, Carmichael, & Whitley, 2018; Brown et al., 2019). Rather than seek help because of heightened self and societal stigma, some men may adopt 'masculine' coping strategies in line with avoidant- or escape-oriented tactics to assert and preserve their masculinity, such as social withdrawal, alcohol and substance abuse, and risky sexual behaviour (Mahalik, Burns, & Syzdek, 2007; Mahalik, Lagan, & Morrison, 2006; Seidler et al., 2016). Additionally, men are also significantly more likely than women to use sex or pornography as a way to cope or distract from stress (Liddon et al., 2018). Of notable concern, is the construction of suicide in some men's accounts as a brave, masculine attempt to regain control of overwhelming feelings (Emslie, Ridge, Ziebland, & Hunt, 2006; Oliffe, Ogrodniczuk, Bottorf, Johnson, & Hoyak, 2012). Consequently, some men experiencing mental health problems may avoid or delay service utilisation, only accessing these when in crisis and once their internal resources are depleted (Seidler, Rice, Oliffe, Fogarty, & Dhillon, 2018).

Despite a large literature base on men's mental health help-seeking (Addis & Mahalik, 2003), few studies have incorporated the concept of masculinity in regard to gay and bisexual men's mental health help-seeking (Parent & Bradstreet, 2017). Within quantitative inquiry, research has drawn on the gender role conflict paradigm to explain some gay and bisexual men's non-help-seeking. Put forth by O'Neil (O'Neil, 1981a, 1981b, 1982) , the paradigm posits that individuals experience conflict because of adherence to traditional gender roles. Using the Gender Role Conflict Scale (O'Neil, Helms, Gable, David, & Wrightsman, 1986), an early study by Simonson, Blazina, and Watkins (2000) reported a negative correlation between greater masculine gender role conflict and positive help-seeking attitudes among gay men with regards to psychological help-seeking. Similarly, a more recent study by Sánchez, Bocklandt and Vilain (2013), which examined the relationship between help-seeking attitudes and masculinity norms among heterosexual and gay monozygotic male-twins, found that a greater endorsement of traditional masculine norms (such as success and restrictive emotionality) significantly predicted negative professional help-seeking attitudes among gay men within their sample. Alternatively, researchers have also drawn on the gender role conformity paradigm, which posits that individuals receive messages about how they should behave by virtue of their sex or gender (Parent & Bradstreet, 2017), as a possible explanation for higher rates of service utilisation among sexual minority men. Platt et al. (2018), for instance, suggest that, because their sexual

orientation already violates the norms of masculinity, sexual minority men may not experience the same cultural pressure and gender norms against professional help-seeking that heterosexual men do. As such, the additional stigma to seeking mental health services may be less relevant among gay and bisexual men. The authors caution, however, that 'this explanation assumes that there should be equal utilization between heterosexual men and women and that the [well-known gender] gap is a matter of heterosexual men suppressing their utilisation for gender role conformity' (Platt et al., 2018, p. 149).

In addition to inhibiting professional help-seeking, masculinity norms may also reinforce maladaptive coping styles among gay and bisexual men as a way to endure distress. Research evidence suggest that an adherence to traditional constructions significantly predicted and reinforced risky or unsafe sexual practices (Halkitis & Parsons, 2003; Hamilton & Mahalik, 2009), and substance abuse problems among sexual and gender minority men (de Visser & Smith, 2007; Hamilton & Mahalik, 2009; Reisner, Gamarel, Dunham, Hopwood, & Hwahng, 2013). Regarding sexual risk behaviours, sexual compulsivity among gay, bisexual and other men who have sex with men (MSM) in the face of clinically significant distress and depression has also been noted within the literature (Jerome, Woods, Moskowitz, & Carrico, 2016; Parsons, Grov, & Gloub, 2012; Storholm, Satre, Kapadia, & Halkitis, 2016). According to their findings, Jerome et al. (2016) suggest that some men utilise sexual thoughts, urges or experiences as a way to facilitate escape or avoidance from stressful circumstances or negative affect by shifting one's attention to immediate sensations or proximal goals. This form of avoidant-oriented coping is further positively reinforced because the likelihood of sexual experiences serves as a source of physical pleasure or contact and/or emotional validation (e.g., feeling validated by another person, or enhancing one's self-esteem by feeling desired by another person); however, sexual compulsive acts may also lead to more stress, anxiety or depressed mood (Jerome et al., 2016). Although casual sex is becoming more common in society (Mark, Garcia, & FIsher, 2015), sexual minority men typically have more partners and engage in more types of sexual activities than their heterosexual partners[14] (Bailey, Gaulin, Agyei, &

[14] For some this would suggest to confirm the perception that gay and bisexual men are hypersexual; however, such a generalisation neglects two facts, as Sánchez (2016) points out: one, that men in general (regardless of their sexual orientation) are more interested in casual sex than women; and, two,

Gladue, 1994; Schmidtt, 2006) and, as such, sexual compulsivity or casual sexual activity as a coping strategy may be more available and accessible within urban gay and bisexual communities. With regards to masculinity and its association with sexual prowess, (casual) sexual activity and multiple sexual partners may be a way to adhere to or fulfil masculine norms related to power, success, and competitiveness (Sánchez, 2016; Sánchez, Bocklandt, & Vilain, 2009).

Although useful for explaining some variation in gay and bisexual men's professional help-seeking and coping styles, a common trope within this literature more generally is a reductionist and reproachful emphasis on masculinity as a pathology or deficit in the context of mental health. For example, Affleck, Carmichael and Whitley (2018) argues that the common interpretation of men's non-help-seeking as due to their stubbornness or self-reliance can be construed as '"victim blaming", and [ignores] the role played by social determinants and the cultural climate as well as any possible problems in the existing mental health system' (p. 585). With regards to compulsive casual sexual activity specifically, Bolton (2019) cautions against restrictive, negative and heteronormative views within the psychotherapeutic community which regards the impact of casual sex on gay men's mental health as associated with promiscuity, pathology or due to emotional pain and woundedness. Within in his findings, casual sexual activity and open or consensual non-monogamous relationships is reported to have a significant positive influence on gay men's psychological wellbeing. Furthermore, quantitative research prioritising conflict scales accepts gender as a relatively stable, individual-level trait and such approaches have been criticised for treating gender as passively acquired, and as insufficiently attuned to issues of power and context (Wenger, 2011). By contrast, qualitative approaches examining the influence on gay and bisexual men's mental health help-seeking has received little attention. All taken together, the criticisms of these three frameworks within the broader orientation of dominant rational choice model sets the stage for an alternative approach to researching and understanding gay and bisexual men's mental health help-seeking which will be explored in the next section.

---

the object of their sexual desire (i.e., heterosexual men are pursuing woman who are generally not as interested in casual sex, whereas gay/bisexual men are pursuing other men who are typically more interested in casual sex.

2.3 Developing an alternative perspective: Towards a dynamic conceptualisation of gay and bisexual men's mental health help-seeking

In the previous section, I provided an argument for why we need to reframe the parameters of the field of study and consider an alternative approach to researching and understanding gay and bisexual men's mental health help-seeking. Specifically, as dominant scientific psychological approaches focus on *predicting* and *explaining* mental health service engagement patterns, we know less about how gay and bisexual men *experience* help-seeking as a subjective, relational and protracted process or how they engage with a diversity of supports. This gap in the literature leads to missed opportunities where knowledge, training, and intervention is concerned. In this section, I first provide an overview and critique of current dynamic conceptualisations. Thereafter, I note two emerging perspectives within this broader orientation, namely the Biddle et al.'s (2007) 'cycle of avoidance' (COA) model and research attentive to the normative and emotional dimensions of help-seeking.

Critiques of dominant help-seeking approaches have given rise to more dynamic conceptualisations (Pescosolido, 1992). Instead of viewing mental health help-seeking in dichotomous and restricted terms, or what Pescosolido (2000) refers to as the 'tyranny of [service] use/no use' (p. 177), dynamic approaches focus on the more subjective, interactive and ongoing process of help-seeking (Pescosolido, 1992). By examining help-seeking as a trajectory or pathway, the scope of research is broadened to begin with the time when a problem is first noticed (Cauce et al., 2002), and is considerate of how individuals engage with multiple others or communities to recognise and define their needs, decide to seek help (or not), evaluate a diversity of supports, and acknowledging the process as varying in strategies, methods and outcomes (Wenger, 2011). This orientation emphasises the use of qualitative methodologies in accessing subjective and social meanings attached to mental health help-seeking in order to provide a nuanced understanding of how men perceive, interpret and respond to mental health-related challenges (Wenger, 2011). Dynamic approaches therefore enable researchers to engage more fully with the role of context and culture (Cauce et al., 2002), and examine the complexity of how individuals might 'muddle' through mental health-related challenges and help-seeking (Pescosolido, Gardner, & Lubell, 1998). Moreover, while rational choice models implicitly view

service or treatment entry as a matter of individual choice, dynamic approaches include other pathways seldom considered within the literature such as non-adaptive processes, coercion and supported choice. Coercion refers to service or treatment entry heavily influenced or controlled by someone other than the individual in need of support (Gardner et al., 1993), and can further be distinguished between legal coercion (i.e., formal measures to compel service use and compliance, for e.g., involuntary hospitalisation in cases of suicidality) or extra-legal coercion (i.e., pressures or arrangements by family, friends and employers) (Pescosolido et al., 1998). This is district from supported choice pathways where individuals decisions to seek care are assisted by their social networks (e.g., an offer by a friend to help find appropriate services) (Dearing & Twaragowski, 2010). In this expanded framing, the study of help-seeking becomes a question of 'when' and 'how' (emphasis on understanding), rather than 'if' and by 'who'' (an emphasis on prediction) (Biddle et al., 2007).

Empirical development of the dynamic approach in relation to gay and bisexual men's help-seeking is scarce. One such study focuses specifically on the experiences of bisexual individuals, including trans and non-binary gendered people who identify as bisexual, and offers a nonlinear model of both formal *and* informal help-seeking characterised by four interrelated stages, namely, the consideration of services, the process of finding services, barriers and facilitators to accessing services, and experiences of service utilisation (MacKay et al., 2017). MacKay et al.'s (2017) findings highlight the importance of social networks in supporting bisexual people's mental health help-seeking behaviour. The authors report that social supports (i.e., partners, family, friends, online communities) are the 'first stop' for bisexual men experiencing mental distress and these significantly impacted later mental health service use. Participants whose social networks supported formal help-seeking were more likely to access services or treatment; however, this did not translate into timely or immediate access. Further, the study also points out that bisexual men's social networks and supports mostly consisted of individuals with non-monosexual sexuality[15] and/or non-binary gender expression, as well as heterosexual allies, rather than lesbian and gay communities. This highlights that bisexual men and trans individuals are additionally

[15] Non-exclusive sexual orientations

burdened by negative attitudes from within the gay/lesbian community, a factor not often considered within dominant models. The importance of social support in the research on gay and bisexual men's mental health and help-seeking has also been noted elsewhere. Survey data suggest that sexual minorities are among those who most need and benefit from supportive social relations and interventions with respect to their mental health (Hsieh, 2014). Furthermore, studies suggest that gay and bisexual men are more likely to be rejected from their family of origin than lesbian and bisexual women, and therefore may be more reliant on 'families of choice' (i.e., LGBT networks) for everyday social and major support (Frost, Meyer, & Schwartz, 2016).

Although the ground has been laid for a more in-depth understanding of gay and bisexual men's mental health help-seeking, development of the dynamic approach has been limited. Most attempts at developing dynamic models of help-seeking more generally have been criticised for being rigid, linear, behaviourist, and giving primacy to psycho-medical perspectives (Biddle et al., 2007; McDermott & Roen, 2016). While MacKay et al.'s (2017) work provides an important contribution to the field in that their study critically expands existing knowledge by examining the broader help-seeking pathway as a social process beyond a restrictive focus on formal support services and is one of the very few investigations into bisexual and trans people's help-seeking experiences, critical gaps remain. Although the study examines both informal and formal help-seeking, it predominantly tracks pathways to services as an inevitable end point. Furthermore, their model continues to give primacy to a minority stress explanatory framework in understanding how bisexual men navigate help-seeking, and non-help-seeking remains couched in terms of 'barriers' to care. To engage more fully with the complexity of gay and bisexual men's mental health help-seeking, this thesis draws upon interdisciplinary theory and emerging perspectives, the work of Biddle et al. (2007) and McDermott and colleagues (2015; 2016) in particular. By adopting these insights, we may have a greater chance of generating a more nuanced understanding of online help-seeking. I now examine each of these in turn.

2.3.1 The cycle of avoidance model of (non-)help-seeking

Perhaps the most important predictors of *actual* help-seeking behaviour are the level of mental distress or problem severity, and a perceived need for help (Pescosolido & Boyer, 1999). To put it simply, people are more likely to seek or ask for help when experiencing high levels of psychological distress or when they are at a crisis point (e.g., suicidal distress, nervous breakdown etc.) (Cleary, 2012; Dearing & Twaragowski, 2010; Storholm et al., 2013). Even where a perceived need for help is present, there are often significant delays between acknowledging a need for help and initiating active help-seeking behaviour (Dearing & Twaragowski, 2010; MacKay et al., 2017). A common reason for not seeking help is a preference for self-reliance and feeling that they can deal with problems on their own (Ferlatte et al., 2019; Lawrence et al., 2006; Rickwood, Deane, & Wilson, 2007; Savage et al., 2016). It is therefore not uncommon for help-seeking and contact with mental health services to be described as 'a last resort'. This is reflected in the literature focused on men more generally (Lynch, Long, & Moorhead, 2018; Wirback et al., 2018), as well as findings with gay and bisexual men which suggest that access to services may be associated with crisis (Storholm et al., 2013). Past research attuned to sociological discussions of illness behaviour and mental health help-seeking may offer valuable insights into these delays, particularly as to how it explains the denial or delay of help-seeking in relation to social disapproval, normalisation and coping.

Biddle and colleagues (2007) point to interpretive complexity in help-seeking. Their COA model conceptualises help-seeking as a cyclical process of 'lay diagnosis' involving repeated attempts to cope and normalise increasingly severe distress. In addition to this, they offer 'a model of "non-help-seeking" in which lay conceptions of mental distress, the social meanings attached to "help-seeking" and treatment, and the purposeful action of individuals, assume central importance' (Biddle et al., 2007, p. 983). They found that their young participants (aged 16 to 24) use a range of normalisation and coping strategies – some harmful – to avoid help-seeking, because of anticipated negative social consequences of presenting with mental distress or asking for help with a mental health concern. As a result, help-seeking trajectories often involve long periods of non-help-seeking and varying pathways (e.g., chance, individual/supported choice, and/or coercion).

Delving further into the COA, the following key factors emerge. Within their study, participants polarised mental distress into two distinct categories, that is, 'normal' or 'universal' distress; and, 'real' or 'extreme' distress. Normal distress is described as a passing phase or minor transient stress encompassing common life events and stresses, whereas real distress is characterised as abnormal, rare, and long-lasting, and seen to include severe mental health problems or crisis events (i.e., schizophrenia, psychosis, exceptional forms of depression such manic depression). Within this understanding, the need for help or treatment was located with an inability to cope and real distress only, while normal distress was identified by coping. Most importantly, participants' conceptualisations of normal distress included clinically significant or severe episodes, encompassing minor transient stress to severe depression. Concerns about stigma permeates this interpretative process where the negative social meanings and outcomes attached to mental distress (both normal and real) and 'being helped' drive the cycle of avoidance (i.e., non-help-seeking), often to the point of crisis[16]. Thus, participants repeatedly accommodated, normalised, and temporalised increasingly severe distress in order to avoid help-seeking, which was regarded an act that would transform distress by 'making' it 'real', 'worse', and 'long-term'. To summarise, normalisation and stigma has two important outcomes for help-seeking: first, that symptoms are often responded to with a range of coping strategies (e.g., avoidance, inactivity, delay); and, second, that the threshold for actual or active help-seeking is progressively moved to higher levels of severity and even towards or beyond the point of crisis.

Biddle et al.'s (2007) COA model may provide a useful conceptual starting point for a dynamic approach to gay and bisexual men's (online) help-seeking. One of the main benefits of their approach is that it aims to understand help-seeking choices, including reasons for non-help-seeking. By exploring stigma as a normative belief system that is 'felt' or anticipated by reflexive social actors, the COA model considers various social actions (Biddle et al., 2007, p. 1000). It therefore differs from most existing approaches (both dominant and dynamic), which tend to track pathways to formal services as an inevitable endpoint. By drawing on this approach, research on gay and

[16] It is important to clarify that not all episodes of distress within this study involved a trajectory towards crisis.

bisexual men's mental health help-seeking can benefit from explicitly examining the 'drivers of action', that is, the perceptions and interpretations, that move them away from support mechanisms and services rather than viewing these as barriers to the help-seeking process. However, one limitation is that by restricting its focus to the stigma associated with mental health problems and help-seeking among young people, there is a need to consider the applicability of the model in relation to other age groups and stigmatised identities. Emerging qualitative research indicate that LGBTQ young people may process their mental health help-seeking in similar ways. The evidence demonstrates that that they may avoid or delay seeking help due to shame and stigma connected to social disapproval, and instead attempt to deal with emotional distress through minimising its importance and trying to cope alone often up to point of crisis (McDermott, 2015; McDermott et al., 2017a; McDermott & Roen, 2016; McDermott, Roen, & Scourfield, 2008). However, whereas the COA focuses is restricted to mental health stigma, these studies critically expand the research terrain to include norms and normalising processes in relation to sexuality, gender, and their mental health help-seeking, and demonstrates the importance of understanding help-seeking as an affective process. This knowledge base opens up potentially fruitful avenues for investigation hitherto unexplored in gay and bisexual men's mental health help-seeking. This body of literature will be explored in the next section.

2.3.2 The normative and emotional dimensions of help-seeking relations

Another emerging area of inquiry which is rarely acknowledged in the help-seeking literature is what Simone Fullagar (2005) describes as the emotional or affective nature of help-seeking, that is, the difficult emotions involved in asking for help with a mental health concern. This focus on affect echoes a more general shift within academia known as 'the affective turn', and can be defined as an interdisciplinary approach to theory and method which is used to 'grasp the changes that constitute the social and to explore them as spaces in ourselves, circulating through our bodies, our subjectivities, yet irreducible to the individual, the personal, or the psychological' (Clough, 2007, p. 3). In other words, instead of dissecting the internal psychic structure of the subject, an affective approach directs research attention to the socio-political conditions in which the subject is constituted and from which it emerges (Liu, 2017).

Here, affect ‘is conceived of as an embodied understanding, or a sense or feeling that provides an interpretation of the social conditions within which we reside’ (Johnson, 2015a, p. 122). Drawing on interdisciplinary theory (feminism, queer theory, critical psychology, and sociology, for example), these studies work with the idea of emotion (and emotional distress) as relational to sociocultural norms and implicated in their production and maintenance.

There is now an emerging body of work furnished through qualitative studies which highlights the normative and emotional dimensions of young people’s mental health help-seeking relations (Fullagar, 2005; McDermott, 2015; McDermott et al., 2017a; McDermott & Roen, 2016). Fullagar’s (2005) work connects shame to cultural norms which discourage the expression of emotional distress, where young participants within her study described help-seeking as intensifying their feelings of shame, failure or negative affect because it involved admitting to a lack of autonomy and adult status associated with rational management of emotional life within neoliberalism. Similarly, research on LGBT youth suicide and self-harm suggest that they are reluctant to seek help due to shame related to transgressing neoliberal heterosexual norms and attempt to deal with their distress alone through minimising its importance (McDermott et al., 2008). The work of Elizabeth McDermott and Katrina Roen (2015; 2016) is particularly relevant to this thesis given its focus on online help-seeking and thus provides a foundation from which to explore. Their findings suggest that emotion, norms and their management are central to young LGBTQ people’s preferences for online help-seeking. Specifically, shame and sociocultural norms connected to adolescence, heterosexuality (i.e., sexuality and gender-variance), and rational neoliberal adulthood contributed to their difficulties asking for help from adults and formal services. By contrast, online queer settings allowed for agentic help-seeking by troubling these hegemonic norms and provides spaces for the recognition of sexual and gender diversity, emotional distress, and youthful subjectivities. Another key finding of theirs relates to the regulation of sexuality and gender online and how help-seeking options can seem restricted both in face-to-face and online settings. The spaces in which queer youth turn to for support and advice online are specific queer spaces and not generic websites.

How can theoretical and empirical work on gay and bisexual men's mental health help-seeking be enhanced by a consideration and understanding of help-seeking as an affective approach? First, as previously stated, much of the research on gay and bisexual men's help-seeking for mental health problems either ignores or pathologises emotion. Much of the literature on gay and bisexual men's experiences is dominated by the application of Goffman's (1963) theory of stigma, where stigma is attributed to an individual or collective as their innate social identity or interior psyche during social interaction. This fixation on stigma does not deal with the source of shame but treats it as a sexual or gender minority problem. As Liu (2017) explains:

> In Goffman's theory of stigma, the gaze comes from the top down—the ''normals'' determine the absolute difference of the stigmatized. The stigma is something that one possesses, and this fact is further solidified in the encounter. For Goffman, the stigmatized almost have no other choice but to internalize the stigma into shame: ''Shame becomes a central possibility arising from the individual's perception of one of his own attributes as being a defiling thing to possess, and one he can readily see himself as not possessing'' (1963, p. 7). In Goffman's view, people are split into the stigmatized and the normal in every social interaction. The stigmatized are further split into those who feel ashamed and those who can sometimes pass as ''normal.'' But both of these conditions are motivated by the internalization of shame (p. 53).

Here, shame becomes the affect that only the stigmatised embody. By contrast, critical approaches to shame – drawing on the notable work of psychologist Silvan Tomkins (1962, 1963) and queer theorist Eve Sedgwick (2003; 1995) – points to an alternative framework that resists the dogmatic, ritual positivism of cause and effect explanations. Tomkin's work on shame as a circulating affect that connects the lookers and the looked at insists on the relationality of interest (as opposed to rejection) and the capacity to re-socialise (rather than internalise). In other words, 'shame is no longer an affect produced by the self in relation to the object of interest; instead, it becomes an external object that turns to regulate the self' (Liu, 2017, p. 55). If we understand shame as a particularly effective enforcer of social norms, then we might come to

provide a more nuanced consideration of the deeper meanings, processes and practices that influence gay and bisexual men's mental health help-seeking.

Second, the overwhelming focus of existing scholarship on rational choice approaches to help-seeking (e.g., minority stress explanatory frameworks, barriers, masculinity norms) means that less attention has been paid to understanding a rage of sociocultural norms and normalising processes that influence gay and bisexual men's mental health help-seeking. Some studies point to the influence of cultural norms within the LGBT community that promote and normalise help-seeking, and psychotherapy in particular, among gay and bisexual men (e.g., Bradford et al., 1994; Goldblum, Pflum, Skinta, Evans, & Balsam, 2017). According to Goldblum et al. (2017),

> These norms likely developed from the needs of [sexual minority] men who faced the increased psychological burden of coping with the HIV epidemic (Cochran & Mays, 2000a; Pobuda, Crothers, Goldblum, Dilley, & Koopman, 2008) and to the self-reflective, introspective nature of coming to terms with a sexual [and gender] minority identity and developing strategies to come out to others (Meyer, 2003) (p. 331).

This view suggests that the extensive existence of HIV-related counselling services targeting gay, bisexual and other MSM may help facility entry into mental health services (Cochran & Mays, 2000b). Additionally, in recognising their own sexual orientation and/or gender identity as part of the coming out process, most sexual and gender minority men go through an important self-defining period when introspection is likely (Meyer, 2003). This could also potentially lead to greater ease in seeking out supports and disclosing mental health difficulties. Altogether, these factors may increase the social norms and expectations that mental health services are appropriate places for coping with the stresses associated with being a sexual and/or gender minority and getting them through their hardships (Grella et al., 2009; King et al., 2003).

Another issue with the extant literature on gay and bisexual men's mental health help-seeking is that heteronorms are most often associated with experiences of victimisation or discrimination on the basis of sexual orientation or gender diversity. The far more subtle ways in which neoliberal heteronormativity or homonormativity regulates subjectivation are not countenanced. Some gay and bisexual men may have trouble fitting in with heteronormativity, but they may also have trouble conforming to homonormative expectations, and these issues have received little attention within the field of study. This interpretative frame will be explored in greater detail within the next chapter (see Chapter Three).

2.4 Online mental health service provision for gay and bisexual men: Mapping the terrain

Very little scholarship has investigated the use of digital and social media platforms by gay and bisexual men for mental health or outreach purposes despite these men ranking mental health as one of their top concerns, as well as demonstrating a strong willingness to receiving mental health services online (Grov, Ventuneac, Rendina, Jimenez, & Parsons, 2013; Hooper et al., 2008). Within this final section, I briefly sketch this terrain in terms of online service provision noting two types of Internet-supported mental health interventions.

Scholars continue to underscore the central role of digital and social media in the lives of LGBTQ persons across the globe. Gay and bisexual men in particular are historically early adopters of online technologies (Grov et al., 2014), and remain significant users of digital and social media compared to other social groups (Mowlabocus, 2010; Mustanski, Lyons, & Garcia, 2011). The popularity of online technologies among gay and bisexual men echoes a much longer history of media use by this community such as printed media from the first half of the 20th century (Cocks, 2002), and gay switchboards or telephone helplines (as well as commercial chatlines) in London and elsewhere from the 1970s (Healey, 2000; Weeks, 2016). For a long time, the gay press, in particular, was *the* medium for disseminating information within and among the LGBTQ community, whether it be companionship or 'lonely hearts' adverts, bar/club listings, soft porn, lifestyle features, sexual health information,

or ‘gay news’ (Miles, 2018; Mowlabocus, 2010). The rapid incorporation of digital platforms into gay and bisexual men’s lives as a key resource becomes intelligible when we recognise factors such as a history invisibility, prejudice, violence and shame in navigating a heterosexist society.

Numerous studies have examined the roles of the Internet in regard to facilitating sexual and/or gender identity development, exploration, and expression. This includes health information seeking and education; emotional support; and LGBTQ community building (for e.g., Baams, Jonas, Utz, Bos, & van der Vuurst, 2011; Grov et al., 2014; Gudelunas, 2012; Harper, Serrano, Bruce, & Bauermeister, 2016; Kryzan & Walsh, 1998; Kubicek, Carpineto, McDavitt, Weiss, & Kipke, 2011; Magee, Bigelow, DeHaan, & Mustanski, 2012; McKenna & Bargh, 1998; Miller, 2015; Mustanski et al., 2011; Pingel, Bauermeister, Johns, Eisenberg, & Leslie-Santana, 2013; Szulc & Dhoest, 2013). Additionally, corporate or commercial social media platforms, such as GSN apps, targeting gay, bisexual and other MSM have found huge success. Industry behemoth Grindr, founded in 2009, is the world’s largest social networking app for gay, bi, trans and queer people with over 3 million daily active users worldwide (Grindr, 2017). These SNSs proliferate the market and tap into a wide range of niche interests and subcultures that specialise in body type, geographical area, or fetish, such as GROWLr for those who identify as ‘bears[17]’ and Recon for the fetish/leather community. It is within this broader context that health professionals and academics have begun to show an interest in utilising mainstream and niche social media platforms with gay and bisexual men as part of their sexual health promotion intervention work. Following this, an increasing number of studies have investigated to the acceptability, feasibility, and efficacy of delivering peer-led online outreach services via such spaces (e.g., Fantus, Souleymanov, Lachowsky, & Brennan, 2017; Lelutiu-Weinberger et al., 2015; Mowlabocus et al., 2016; Sun et al., 2015).

This interest has also extended to fields of electronic and mobile mental health initiatives, or e-mental health and m-health respectively, where researchers have highlighted the role of online resources as a possible means for reducing stigma and

[17] Although there is some debate as to the definition, the bear subculture usually refers to some mature gay/bisexual men who resist mainstream gay culture by embracing the masculinity and natural characteristics that men have (i.e.., heavyset, facial and body hair, baldness) (Gough & Flanders, 2009).

promoting help-seeking among gay and bisexual men (Lyons et al., 2015; Rozbroj et al., 2014, 2015). Broadly, these strategies involve the harnessing of digital and online tools to support and improve mental health conditions and mental health care. Such initiatives include 'interactive digital interventions to treat or prevent mental health problems, online information and education, applications and tools to monitor symptoms and provide feedback, and communities that provide peer support for a range of mental health conditions' (Powell, 2016, p. 1). Because of their relative anonymity and ease of access, online resources are positioned as offering increased access to 'safe(r)' spaces that help address the stigma of mental health concerns, thereby overcoming a range of 'barriers' associated with accessing traditional mental healthcare services (Barak & Grohol, 2011). As a result, gay and bisexual men may feel less inhibited to seek help.

Several researchers have attempted to provide a unifying terminology to label, define, and categorise different types of Internet-supported mental health interventions (e.g., Barak & Grohol, 2011; Lal & Adair, 2014); however, no widely agreed upon nomenclature exists. For the purposes of this thesis, I distinguish between two forms of Internet-supported mental health interventions with gay and bisexual men, namely, individually targeted or focused interventions and more relationally oriented and peer focused interventions. Individually targeted interventions here refer to highly individualised online psychological treatments such as interaction with a mental health professional online (e.g., online counselling and psychotherapy) or interactive, self-guided/help intervention programs – or e-therapies – based on a recognised therapeutic modality such as CBT. By contrast, relationally oriented and peer focused digital interventions facilitate supportive relational connections and includes online mutual self-help support groups, as well as more formalised peer outreach initiatives. Mutual self-help support groups rely on individuals helping one another by offering emotional and informational social support online (e.g., discussing worries, decision-making advice etc.), generally without a mental health professional's intervention or guidance (Barak & Grohol, 2011), whereas digital outreach efforts signify a proactive form of support facilitated by community and voluntary sector organisations and peer workers (Brownlie, 2018). These workers are LGBTQ individuals with lived experiences of mental health difficulties who are employed or volunteer to explicitly use those experiences to support others.

With claims that the growth in demand for mental healthcare is exceeding provision in the NHS (Hollis et al., 2016), the drive towards efficiency and cost reduction sets in motion the value of e-therapies as personalised solution to a broader crisis (Fullagar, Rich, & Francombe-Webb, 2017a). The NHS has supported e-therapies by incorporating them into their healthcare strategy and subsiding their use (Rozbroj et al., 2014). Researchers have highlighted the potential of CBT with sexual and gender minorities (Austin, Craig, & Alessi, 2017; Balsam, Martell, & Safren, 2006; Goldblum et al., 2017; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015), and there are a number of reasons to view computerised CBT (cCBT) as particularly helpful for gay and bisexual men. First, the evidence indicates that men more generally have a preference for short-term, goal-oriented, and action-focused interventions based on problem-solving strategies, emphasising the practical utility of CBT over other forms of 'just talking' therapies (Emslie, Ridge, Ziebland, & Hunt, 2007; Kingerlee, Precious, Sullivan, & Barry, 2014; Liddon et al., 2018; Seidler et al., 2016). Second, outcome research suggests that CBT approaches are effective treatments for a range of mental health problems with a high prevalence among gay and bisexual men, including depression, anxiety, substance abuse, suicidality and posttraumatic stress disorder (PTSD) (Cary & McMillen, 2012; Hedman et al., 2014; Morley, Sitharthan, Haber, Tucker, & Sitharthan, 2014; Twomey, O'Reilly, & Byrne, 2014). Lastly, a particular advantage of cCBT as a delivery mode is their capacity to deliver tailored, targeted content specific to gay and bisexual men (e.g., 'coming out' to friends and family, managing experiences of discrimination and other forms of stigma, the 'coming out' process, same-sex relationships etc.) (Rozbroj et al., 2014, 2015).

Yet, LGB consumer consultation in the development of mental health interventions, policies, or guidelines are very rare (McNair & Hegarty, 2010). It is not surprising, then, a review of 24 web- and mobile-based e-therapies indicate that these seldom catered to the unique mental health needs of sexual minorities (Rozbroj et al., 2014). Of those e-therapies surveyed, Rozbroj and colleagues (2014) argue that most were designed for the population in general:

> The majority did not address many of the key additional factors for depression and anxiety experienced by lesbians and gay men. They

> largely did not acknowledge lesbians and gay men, or address core issues like coming out, dealing with discrimination and prejudice, or same-sex relationships. Many of the therapies that used scenarios to deliver content, which tended to be the more prominent type of e-therapy in terms of numbers and evidence of effectiveness, also contained instances of language and content that assumed user heterosexuality (p. 8).

The authors conclude that by excluding sexual minorities, these e-therapies may inadvertently contribute to minority stress or disconnection with a treatment. Byron (2019) similarly questions the use of digital self-help treatments with gay and bisexual men, arguing that ‘‘if social isolation, stigma, and inadequate mental health services are significant barrier [to sexual minorities] mental health help-seeking, [then] an app can do little to improve this’ (p. 11). Furthermore, Lupton (2013) argues that self-monitoring and self-care digital technologies reflect a neoliberal political orientation to mental healthcare which emphasises personal responsibility for their mental health outcomes. The prioritisation of such approaches fails to recognise mutual dependencies, and the fact that individuals are often feeling highly vulnerable when the seek help or need mental healthcare. These may further intensify feelings of failing to cope and manage oneself. Moreover, because the success of mental health apps rely on consumer uptake, must be actively sought which may be unlikely.

What is missing from the literature, however, is more focused attention on the relational aspects of online support that is available. As has been demonstrated, all too often the support that is the main focus both within research and policy are those that is intensely individualised in their focus. Research evidence that formalised peer support groups improve mental health outcomes for sexual minorities (Eliason, 2015). From a community coping perspective, LGBTQ peer workers may be best able to help gay and bisexual men cope with social stress that arises from stigmatisation and discrimination given that they share similar identities and lived experiences (Frost et al., 2016). As a result, peer workers may provide specific support that a heterosexual helping professional may not be capable of providing given their lack of a personal connection to gay and bisexual men’s experiences. In terms of service delivery, peer workers are thought to facilitate by help-seeking vis-à-vis a non-clinical and non-

judgemental approach which can act as a bridge between the mental health system and the individual seeking care (Holley, Gillard, & Gibson, 2015). Benefits for peer workers include skill development, personal discovery, and better emotional regulation skills that may transfer to future situations (Doré, Morris, Burr, Picard, & Ochsner, 2017; Holley et al., 2015). To fill this gap, this study will examine the ways in which digital and social media are currently by peer-led mental health promotion initiatives.

Conclusion

This chapter offered a critical review of current theoretical and empirical work on gay and bisexual men's (online) mental health help-seeking. Following a brief discussion to the term 'mental health help-seeking' within the literature, two broad orientations to conceptualising help-seeking are identified, namely, the dominant rational choice approach and the dynamic approach, with emphasis given to how the latter can complement current understandings of gay and bisexual men's help-seeking. In the main, as dominant perspectives prioritise efforts to predict or explain professional help-seeking patterns, less is known about gay and bisexual men's subjective experience of this process and how they engage a diversity of supports. In arguing for a shift in how gay and bisexual men's help-seeking is framed, attention was given to how a dynamic approach attentive to the emotional and normative dimensions of help-seeking can lead to a more nuanced understanding of the help-seeking process. In addition to this, the chapter also mapped the field of online mental health service provision with this group, noting two types of Internet-supported interventions (i.e., individually targeted and relationally oriented interventions) and their potential for facilitating help-seeking. The following chapter looks at the methodology and methods used to conduct this qualitative investigation.

3. Methodology and Methods

This chapter outlines the methodology and methods used to provide an alternative understanding of gay and bisexual men's mental health help-seeking, specifically focusing on their online help-seeking. The first half of the chapter sets out the interpretative frame which draws on the work of McDermott and Roen (2015; 2016) who highlight the complex entanglement of emotions, norms, and subjectivity involved in mental health help-seeking. Central to their approach is the idea that, despite improvements in LGBTQ equality, some LGBTQ individuals experience difficult emotions connected to sociocultural norms and this significantly impacts upon their help-seeking behaviour. To unpack this framework and its potential for deepening our understanding of gay and bisexual men's online help-seeking, I begin by focusing on the discursive and material conditions under which subjectivation take place. This includes a discussion of specific norms which may impact upon gay and bisexual men's mental wellbeing and help-seeking possibilities: neoliberal norms, heteronorms, and homonorms. I then present this study's conceptualisation of emotional distress and discussing shame in particular which I argue plays a significant role in some gay and bisexual men's help-seeking trajectories. Thereafter, I consider the suitability of a contextualist thematic analysis in bringing the outlined interpretative frame to bear on the data.

The second half of the chapter offers a detailed account of the research methods. This includes an outline of the research design as well as a description of the research participants and their recruitment. I then present my multi-method qualitative approach to data generation, which included a focus group, on- and offline semi-structured interviews, and an adaptation of photo-elicitation techniques to a digital terrain. Following this a discussion of the thematic data analysis process as driven by my interpretative analytic lens. The chapter concludes with a consideration of research ethics, identifying key tensions that arose during the course of the research project and the ways in which these were negotiated.

3.1 Troubling norms of recognition: Neoliberalism, Heteronormativity and Homonormativity

In Chapter Two I critique the body of research which furnish current understandings of gay and bisexual men's mental health help-seeking. Specifically, I argue that dominant approaches rigidly adhere to an at-risk, psychopathological, and unidimensional frame of explanation which not only limits our understanding of help-seeking but also leads to missed opportunities where intervention is concerned. Such approaches overlook a plethora of complex and interconnecting social, economic, and cultural factors which influence gay and bisexual men's mental health help-seeking. In order to reframe the parameters of the field of study, I draw on theorising by Elizabeth McDermott and Katrina Roen (2015; 2016) who take a critical epistemological approach using interdisciplinary theory - feminism, queer theory, critical psychology, and sociology - make sense of the relationship between mental (ill) health, sexuality, gender, and help-seeking. A critical feature of their theoretical framework involves an analysis of the sociocultural norms that influence emotional distress and help-seeking behaviour.

Following Foucault and Foucault-inspired scholars, McDermott and Roen highlight the psychic anxieties – feelings of exclusion, inadequacy and failure – embedded in normative subject-making for young queer people. At the heart their approach is a notion of neoliberal subject-making, where the affective life of human subjects must undergo various forms of self-discipline and self-governance to become the rational subject: a process which comes at an emotional cost, particularly in so far it involves the transgression of prevailing sociocultural norms. Specifically, the authors work with an understanding of subjectivation[18] as discursive, material, normative, and ongoing process, and consider how (queer) subjects become more or less viable, more or less intelligible (Butler, 1993), within a nexus of norms about how subject should be. Like other critics (Fraser, 1999; Hennessy, 2000; Jackson & Scott, 2010; Seidman, 1996), they emphasise the propensity within queer theory and research to concentrate on the discursive conditions under which subjectivation takes place thereby suggesting that

[18] That is, 'the process by which we become a person who is subject to social norms and rules of intelligibility' (Ellis et al., 2019, p. 295).

meaning is solely dictated by cultural norms. To tackle these critiques, the authors give specific emphasis to the material, economic, and structural circumstances of intelligibility (e.g., socioeconomic or socio-structural factors such as poverty, class, and work inequalities).

In order to foreground the material and discursive workings of normativity, McDermott and Roen's approach works with an understanding of heteronormativity as embedded in the wider neoliberal capitalist mode of subjectivation. That is, neoliberal capitalism requires a certain type of heteronormative subject: one who is autonomous, self-governing, and responsible for their own wellbeing and self-directing their help-seeking (Foucault, 1977; Rose, 1989). There is now a burgeoning literature documenting how neoliberal discourses shape individual experience and mitigate what type of resources are available (Peacock, Bissell, & Owen, 2014a, 2014b; Weiner, 2011). Neoliberal principles often assign responsibility for social risks (e.g., mental illness, unemployment, poverty etc.) to individuals as a problem of self-care which, in practice, means a stronger reliance on individual self-sufficiency and pro-market forces which, in turn, is matched by a concomitant drop in government funding for social and care services (Brijnath & Antoniades, 2016). This privileging of individualism within research, policy, and practice is highly problematic because such practices locate mental health problems as an individual problem requiring individual solutions. Furthermore, it also negates the contribution of wider socio-structural factors and also obscures the actions of the state in these areas from analysis. According to Peacock, et al. (2014a) this results in:

> The greatest burdens falling on those most unable to shoulder them. When failure results, this can only understood as a reflection of individual merit or effort – to seek to explain it in any other way if further evidence of one's own moral and practical deficits (p. 179).

Thus, for those who are unable to comply with neoliberal expectations, that failure is constructed as their own fault or as a sign of personal pathology, rather than being due to social and economic inequalities (Halberstam, 2011). By putting the neoliberal subject at the heart of our reframing of gay and bisexual men's mental health help-

seeking, we can come to understand how failing to conform to norms can be felt to be one's own fault.

In addition to neoliberal norms, McDermott and Roen (2016) framework also emphasises norms related to heterosexuality and homosexuality can potentially impact upon the help-seeking process. Heteronormativity, a concept developed in queer theory, refers to the privileging and presumption that heterosexuality and the gender-binary (i.e., male/female) are they only natural or normal sexualities and genders (Clarke, Ellis, Peel, & Riggs, 2010). Despite improved tolerance of sexual and gender diversity in the West, most gay and bisexual men are raised under the presumption of heterosexuality as children, and most attitudes about gay and bisexual men are developed in the context of heteronormativity. While heteronormativity certainly excludes, such exclusion is neither complete nor wholesale: 'it excludes heterosexuality by placing it on a distribution curve, where non-heterosexual desires, behaviours, and identities deviate from a norm or average or commonality, but are valued differently in terms of the distance from the norm' (Cover, 2012, p. 120). This increased tolerance is shaped by 'narrow norms that fit within [the] neoliberal economization of subjectivity' (Cover, 2013, p. 335), and creates homonormative categories of acceptance which are most easily applied to those who are affluent, white, fit, gender-conforming, straight-mirroring, coupled, gay and male (W. Brown, 2006; Cover, 2012). Thus, homonormativity is seen as a facet of heteronormativity because it seeks compliance of LGBTQ individuals demanding inclusion within the framework of heteronorms: '[homonormativity] does not challenge heterosexist institutions and values, but rather upholds, sustains, and seeks inclusion with them' (Duggan, 2003, p. 50). Those who deviate further from these norms are accorded less tolerance within wider neoliberal sociality. As a consequence, some gay and bisexual men may experience difficulties fitting with heteronormativity, but they may also have trouble conforming to homonormative categories of the successful gay person.

Help-seeking can involve the negotiation of norms which can ignore, marginalise, or, alternatively, confer recognition. Butler's (2004) thinking around intelligibility and recognition allows an appreciation of how difficult it can to seek help when an individual feels outside the norms or conditions of cultural intelligibility. As Foucault (1976) illustrated, norms do not just exist; they regulate, coerce, and enforce narrow modes

of sexual and gendered existence. For those who risk not being a coherent or recognisable subject within dominant sociocultural norms ‘is to risk access to subjectivity, social participation and belonging, to risk exclusion from intelligibility and selfhood’ (Cover, 2012, pp. 89–90).The negotiation of these inter-related normative dimensions can significantly impact upon the help-seeking (im)possibilities of gay and bisexual men who are emotional distressed. With this view in mind, we can come more fully understand how these norms are implicated in feelings of difference, exclusion, and failure. The next section sets out this study’s conceptualisation of emotional distress.

3.2 Troubling emotion: Reconceptualising emotional distress and employing shame as a critical concept for mental health help-seeking

In Chapter Two I argue that it is the affective nature of help-seeking has been underacknowledged in the literature on gay and bisexual men’s mental health help-seeking. A second feature of McDermott and colleagues’ (2015; 2016) analytic framework works with an understanding of emotion as relational and implicated in the production and maintenance of sociocultural norms. In this view, emotional distress is located in the psychological *and* the socio-political, rather than solely figured in the individual as exclusively psychological or psychobiological as within dominant rational choice approaches to help-seeking. Regarding emotion as relational, as involved in the production of shared meanings and the policing of norms, we might come to think of gay and bisexual men’s (non-)help-seeking differently.

As part of their reconceptualisation of emotion, the authors draw on the work of Sara Ahmed (2015) who highlights the importance of understanding emotions as investments in social norms. In her critique of both psychological and sociological models of emotion, Ahmed points out that psychology works with an ‘inside out’ model where emotion is centred internally in subjective feelings which then moves outward towards objects and others, whereas sociological conceptualisations of emotion as feelings located in social structures and cultural practices, imposed on the subject (an ‘outside in’ model). Both models therefore assume a distinction between an inside and outside, and the individual and the social (i.e., that emotion solely reside in either the

individual or the social). Ahmed's analysis resists this division between the individual and the social and, instead, claims that emotions take shape as effects of circulation:

> Emotions create the very effect of the surfaces and boundaries that allow us to distinguish and inside and an outside in the first place. So emotions are not simply something 'I' or 'we' have. Rather, it is through emotions, or how we respond to objects and others, that surfaces or boundaries are made: the 'I' and 'we' are shaped by, and even take the shape of, contact with others (p. 9 – 11).

Thus, as emotions circulate, they materialise social and psychic life, (re)creating particular kinds of subjects and objects and shaping the 'surfaces' of individual and collective bodies. Here, 'affect is not an object that moves between subjects… it is, rather, the flow, or repeating patterns of energy, that circulate across the body and mind, the individual and the social, and the private and public, in which bodies and subjects are constituted and reconstituted' (Liu, 2017, p. 45). Regarding emotions as investments in sociocultural norms, Ahmed argues – like other feminist and queer scholars – that social forms (e.g., heteronormativity) are effects of repetition: it is through the repetition of norms that sociocultural worlds materialise, and that boundary, fixity, and surfaces are produced, and an analysis of emotions show us how relations of power shapes bodies and worlds. For Ahmed, 'emotions are bound up with the securing of social hierarchy: emotions become attributes of bodies as a way of transforming what is "lower" or "higher" into bodily traits' (2015, p. 4).

Why focus on shame in relation to help-seeking? Of course, the affective life of gay and bisexual male subjectivity is more than just 'shame'. I concentrate on shame, however, given its pernicious effects on emotional distress and (non-)help-seeking. Following American psychologist Silvan Tomkins (1962, 1963) and her works on affects, several queer theorists have examined the formation of shame as a circulatory and embodied affect and have pointed to the way shame is intricately bound up in affective life of LGBTQ people and historically associated with the marginalisation of diverse sexualities and genders (Munt, 2000, 2007; Probyn, 2000, 2005; Sedgwick, 2003; Sedgwick & Frank, 1995). Sedgwick (2003), for example, argues that 'for certain ("queer") people, shame is the first, and remains a permanent, structuring fact of

identity' (p. 64). If, like Ahmed (2015), we recognise shame as 'the affective cost of not following the scripts of normative existence' (p. 107), then we can come to understand how shame remains 'stuck' to some gay and bisexual men's negotiation of their everyday sociocultural contexts. In the context of mental health, research findings demonstrate an association between minority stressors and psychological distress (i.e., depression and anxiety) among sexual minorities through greater feelings of shame (Mereish & Poteat, 2015). Additionally, the authors also found that shame was associated with distress through its negative association with individual and community relationships (i.e., a close peer and the LGBTQ community). Previous research also highlight the difficult emotions involved in asking for help, such as shame and embarrassment, and suggest that these may partly explain why some individuals are reluctant to seek out in/formal supports but are willing to use the Internet to find support and advice (McDermott, 2015).

As one of the primary 'negative affects' (Tomkins, 1963), shame is an intense and panful sensation which can be defined as:

> a large family of emotions that includes many cognates and variants, most notably embarrassment, humiliation, and related feelings such as shyness that involve reactions to rejection or feeling of failure or inadequacy. What unites all these cognates is that they involve the feeling of a *threat to the social bond* (Scheff, 2000, pp. 96–97, author's emphasis).

Shame, as a relational and judgemental emotion, is particularly effective in maintaining sociocultural norms. It is coercive in that it involves the affective recognition of the inadequate or failed self as measured against the external construction of superiority (McDermott & Roen, 2016). In other words, experiences of shame involve both an awareness of norms and how one is or might be devalued in the eyes of a generalised or idealised other. Thus, shame can function as a deterrent or a way to reintegrate subjects in their failure to live up to hegemonic sociocultural norms: 'in order to avoid shame, subjects must enter the "contract" of the social bond, by seeking to approximate a social ideal' (Ahmed, 2015, p. 106). In this way, shame informs both subjectivity and practice, as well as operates visibly by stigmatising particular groups

and illuminating which populations are included as moral citizens and which are exposed to scrutiny. Further to this, shame is intensified when it is witnessed. As Ahmed (2015) explains, 'to be witnessed in one's failure is to be ashamed: to have one's shame witnessed is even more shaming. The bind of shame is that it is intensified by being seen by others *as* shame' (p. 106 – 107, author's emphasis). Consequently, social disapproval can be a particularly effective enforcer of norms. To summarise, 'shame is about something (social) and it is felt psychologically (intrapsychic) and physically (bodily)' (McDermott & Roen, 2016, p. 49).

Shame can, however, be transformative within the context of relational reciprocity. As Liu (2017) notes in her reading of Tomkin's (1963) approach to shame, which insists on the relationality of interest (as opposed to rejection) and the capacity to resocialise (as opposed to internalise), 'this reciprocity bridges the double movements towards "painful individualisation" and "uncontrollable relationality"' (p. 48). Thus, shame may be open to reframing, refiguration, transfiguration, and deformation (Sedgwick, 2003); however, as Johnson (2015b) cautions, such processes, particularly as they relate to diverse sexualities and genders, may be:

> highly dependent on accessing cultural resources that enable the reconfiguration of the affective state. This process is made harder by the isolating impact that shame has and its potential to direct itself inwards by attacking the self (Lester, 1997) if the intense affective state cannot be released via connection and communication with an/other (p. 141).

This section has this study's understanding of emotion as relational to sociocultural norms and implicated in their production and maintenance. The next section will outline why a thematic analysis (TA) was chosen to bring these insights to bear on the data.

3.3 What is an organic, contextualist thematic analysis?

With my interpretative frame in mind, I required a *flexible* qualitative analytic framework that would enable an exploratory and interrogative analysis of the data. Most common

qualitative psychological approaches, however, are wholesale methodologies specifying guiding theoretical principles, analytic procedures and appropriate research questions. Aware of critiques of Interpretative Phenomenological Analysis as overly psychological rather than critical socio-cultural, and Grounded Theory's overemphasis of sociological structures and processes (Braun & Clarke, 2013), I required a framework that would bridge these 'boundaries' and sit more comfortably with my approach to emotional distress and the help-seeking process as located in the psychological *and* the socio-political. Further, as my research questions oriented the investigation to participants experiences, constructions, and practices around online help-seeking, I required a framework suitable to a variety of orientations to the data. To incorporate all of these factors, I settled on Thematic Analysis (TA) as a guiding framework to bring my interpretative analysis to bear on the data.

Essentially, TA is a flexible foundational method, as opposed to a methodology, for identifying, analysing and interpreting patterns of meaning, or 'themes', within qualitative data. Unbounded by theoretical commitments, TA can be applied across a range of theoretical frameworks, research questions, and methods of data collection which attributes to its popularity within psychological research (Braun & Clarke, 2012). While there is a tendency to treat TA as a homogenous entity, many different versions exist each with their own underlying assumptions and procedures. Braun and Clarke (2016; 2017) identify and contrast two broad approaches to TA: 'coding reliability' TA and 'organic' TA. 'Coding reliability' approaches to TA (e.g., Boyatzis, 1998; Guest, MacQueen, & Namey, 2012; Joffe, 2012), used with positivist frameworks, assume that themes can be 'captured', 'recognised' and 'noticed'. Here, themes conceptually pre-exist analytic and interpretative efforts of the researcher, with coding involving a process of searching for these already existing/identifiable themes. As such, qualitative analysis in coding reliability approaches follow a more or less quantitative logic. By contrast, organic approaches (e.g., Braun & Clarke, 2006) treat coding and theme development as organic, exploratory and an inherently subjective process, involving active and reflexive researcher engagement. The process of analysis is a recursive: the researcher 'tussles' with the data to develop/construct a refined and evolved analysis that best fit their research question(s) (Braun & Clarke, 2016). It's here, within an organic approach to TA, that I locate my analysis.

There are numerous decisions involved in conducting a TA that require explicit consideration yet remain typically under-discussed (or omitted) in research utilising the method. According to Braun and Clarke (2012), TA straddle three main continua along which qualitative research approaches can be located: inductive versus deductive data coding and analysis; an experiential versus critical orientation to the data; and, an essentialist versus a constructionist theoretical perspective. While an inductive TA is often essentialist in its theoretical framework, focused on individual psychologies and assumptions of unidirectional relationships between meaning and experience, a deductive constructionist TA examines the socio-cultural contexts and structural conditions that enable individual accounts provided. The latter approach seems obvious for this study given the queer feminist perspectives my interpretative frame draws from. This form inquiry certainly works to go deeper and beyond positivistic psychological approaches that focus on individual psychopathology that frame dominant approaches to researching gay and bisexual men's mental health help-seeking. Yet, it's within a contextualist TA that I believe my interpretative frame best fits. According to Braun and Clarke (2006), a contextualist TA:

> Sit[s] between the two poles of essentialism and constructionism… acknowledge[ing] the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'. Therefore, … [a contextualist TA] work[s] both to reflect reality, and to unpick or unravel the surface of 'reality' (Braun & Clarke, 2006, p. 9)

Thus, a contextualist orientation enables a combination of inductive and deductive approaches to the data: inductive as I'm able to identify, analyse and report themes strongly linked to the data and participants' experiences, meaning my analytic preconceptions do not completely overshadow participants' perspectives; deductive as I draw from theoretical work and constructs to render visible issues that participants may not explicitly articulate. Therefore, I am able to provide a rich description of more explicit or surface meanings of digital help-seeking and outreach work with gay and bisexual men (e.g., explanations of the practicalities involved in the delivery of specialist mental health support online), and offer a more detailed and interpretative

analysis of the data's latent meanings (e.g., understanding of the socio-cultural meanings attached to help-seeking and why these factors hinder or enable this process). Furthermore, a contextualist position sees knowledge as emerging from contexts, and therefore local, situated, and provisional (Madill, Jordan, & Shirley, 2000), thus situating the Brighton/UK-based context more centrally in the outcomes of this research.

To conclude this section, I address critiques of TA as a method. Researchers often criticise the interpretative power of TA, assuming the method as atheoretical, as a simple descriptive or realist summary to of the dataset, and a form of analysis that works against a reflexive engagement with the data (see Aguinaldo, 2012 for example). Culpable here, however, are coding-reliability approaches to TA and/or published journal articles that omit clear evidence or discussion of their guiding theoretical principles or frameworks. As demonstrated, my analysis involves an organic approach to TA informed by interdisciplinary theory to help generate a more interpretive and complex analysis of gay and bisexual men's digital help-seeking behaviours. As such, my analysis moves beyond Aguinaldo's critiques of TA in relation to gay and bisexual men's mental health research. Furthermore, the flexibility of this qualitative analytic framework has proven generative, bringing out a rich texture and nuances within the data set, working with both a top-down and bottom-up approach.
As Frith and Gleeson (2012) reminds us 'no method should be fixed and inflexible, and most can be adapted, modified and altered to fit the particular needs of any research situation. Indeed, the most successful methodologies are those that allow for development and creativity' (p. 56).

3.4 Research design overview

This study employed a multi-method qualitative research design generating both face-to-face and online data (see Table **1**). Data was collected in two stages between May 2016 and March 2017. The first stage targeted LGBTQ-specialist/identified digital outreach support workers (i.e., MindOut staff and volunteers), while the second focused on the experiences of gay and bisexual men who have used digital and social media to seek help for mental health concern. Individual data collection methods

included on- and offline semi-structured interviews, a focus group, and an adaptation of photo-elicitation interviewing techniques to online domains.

Table 1. Research design.

Recruitment Phase	Data Source	Data Collection Methods
1	9 LGBTQ-specialist/identified digital outreach and support workers (i.e., MindOut staff and volunteers)	• Semi-structured interviews • A focus group
2	9 gay and bisexual male-identified persons who have sought help and support online for a mental health concern	• On- and/or offline semi-structured Interviews • Web-based elicitation methods (participant-generated online visual and textual materials)

The rationale for collecting multiple modes of qualitative data was to allow for a more comprehensive investigation into gay and bisexual men's mental health help-seeking; a complex phenomenon that has received little scholarly attention to date. As noted previously in Chapter Two, dominant quantitative methodological approaches to the study of LGBQ people's help-seeking often conceal subjective experiences. By contrast, qualitative research methods may provide nuanced understandings of gay and bisexual men's lives (Martin & D'Augelli, 2009), and help-seeking behaviours (Wenger, 2011). Researchers have called for research using both online and conventional qualitative methodologies to investigate help-seeking as these allow for a combination of in-depth probing, fluidity, and nuance (McDermott, 2015; McDermott & Roen, 2016). Also, the use of multiple methods also ensured that participants had options and flexibility in how they chose to participate, for example, online methods have been advocated for investigating potentially sensitive topic areas, such as mental distress, which might be difficult to discuss in face-to-face, interview settings. Blank (2008) suggests that multiple sources of data can convey a more detailed and fuller

understanding of phenomena as each type of data has the potential to validate the results obtained from other data and therefore producing findings which are more credible and trustworthy. Thus, this approach allows for the production of different kinds of knowledge which, in turn, can lead to alternative interventions at practice and policy levels (Harper & Thompson, 2012; McDermott, Roen, & Piela, 2013).

3.5 Participants

Sampling and recruitment can be a significant methodological challenge for those who study the mental health of LGBTQ people. Although non-probability sampling strategies have been identified as an effective way of recruiting gay and bisexual-identified men (Corliss, Cochran, & Mays, 2009), these have been criticised for their tendency to (over)rely on the perspectives of 'easy-to-reach' samples or the 'usual suspects' (Clarke et al., 2010). For instance, given that nonprobability sampling strategies frequently rely on the distribution of research advertisements via community-based organisations, they are more likely to attract those who are actively engaged with LGBTQ communities or services and less likely to generate diverse samples (Ellis et al., 2019). As a consequence, LGBTQ research often prioritises and normalises the experiences of white, middle-class and non-disabled lesbians or gay men living in urban areas.

The rationale for utilising both community-based and online recruitment strategies in this study was to reach and prioritise perspectives not often included in gay and bisexual men's help-seeking studies: those who seek or deliver (specialist) mental health support online. The decision to recruit online procedures was twofold. First, my hope was to generate a diverse sample and include participants from a wider range of backgrounds and, second, to account for the possibility of research fatigue among those connected to my community partner. The latter was identified as a concern by MindOut management early on in the research process as a result of continued exposure to research engagement. Internet-enabled recruitment strategies have successfully been used to reach and retain participants who may not otherwise participate in LGBTQ-related research, such as those in rural communities (Meyer & Wilson, 2009), and those who are not actively engaged in LGBTQ community or the

commercial scene (Gibbs & Rice, 2016). Additionally, previous studies found that online methods provided diverse samples in terms of sexuality and gender identities, race/ethnicity, and engagement with help-seeking (Gibbs & Rice, 2016; McDermott et al., 2013). Despite these efforts, recruiting a diverse sample remained a challenge (see Chapter Seven for a further discussion and reflection on these challenges).

Recruitment occurred in two phases. Eligibility criteria for both were that participants must live in within easy travelling of Brighton and Hove or greater London area, identify as LGBTQ, be aged 18 years and older, and have experience seeking or delivering mental health support online. In the first phase, an invitation to participate was extended to those engaged in digital outreach and support work with gay and bisexual men. Potential participants were contacted through my community partner, MindOut, who promoted the research project internally among full-time staff members and volunteer workers. As a mental health service run by and for LGBTQ people with lived experiences of mental health issues, outreach workers' perspectives offered valuable insights into their digital and social media working practices with distressed gay and bisexual men as well as their own experiences looking for mental health related assistance.

Phase two sought to recruit gay and bisexual men who have gone online to look for help and support with a mental health concern. As in the first phase, MindOut kindly shared information about the study among eligible service users and across their social media networks on Facebook and Twitter. To aid recruitment, I reached out to various UK-based LGBTQ supports groups, organisations and related individuals on Twitter and asked them to help share recruitment materials with their wider networks. Online recruitment materials included a link to the research project website hosted on the university's Edublog platform. Visitors to the blog could access further information about the study, including participant information sheets, consents forms, and list of specialist LGBTQ mental health support services (see Appendix 4).

In all, 18 individuals self-selected to participate in this study. The research sample included nine LGBTQ-identified/specialist digital outreach support workers and nine gay/bisexual male-identified individuals aged 23 to 58, with a mean age of 37. Thirteen participants identified their sexual orientation as gay, four as bisexual and one as

queer. Most described their gender identity as male (16) and two as female. The sample was predominantly White British (15), and the rest white Other (3). Reasons for seeking support included mental health concerns around depression, anxiety, post-traumatic stress, suicidality, and self-harming behaviour.

3.6 Data generation

This study adopted a multi-method qualitative approach to data generation involving both traditional and virtual research methods, and combining visual data and collaborative or exploratory interviewing. Given that feelings of shame often remain unspoken in modern Western societies (Liu, 2017; McDermott et al., 2013), I aimed to utilise this approach in the hope that it would generate rich and detailed psychosocial emotional data, as well as provide participants with some flexibility in how they chose to participate in this study. To that end, I employed a focus group, on- and offline semi-structured interviews, and participant-generated web-based materials as part of my data generation strategy.

I purposefully use the term *data generation*, as opposed to *data collection*, in this section's heading to signify my active role, as researcher, in co-producing or generating the data under analysis, particularly as it relates on online data. Morison and colleagues (2015) differentiate between these two approaches, highlighting that data collection involves researchers taking a passive 'observer' position to online content or already occurring conversations, whereas data generation relates to an active engagement with research participants and co-construction of online data. A good example of the latter approach is a study by Tonks, Lyons, and Goodwin (2015) who investigated young adults' depictions of alcohol consumption on Facebook and combined visual media and collaborating interviewing to understand risky drinking practices. I now discuss and describe each research method in turn.

3.6.1 Focus group

A focus group was used to collect data from digital support workers, volunteers specifically. There were several reasons for this decision. First, as a useful exploratory

tool for eliciting a wide range of views and perspectives (Graham, Treharne, Ruzibiza, & Nicolson, 2015), this method provided an avenue for outreach workers to discuss, compare and reflect on their practices and experiences delivering mental health support online. Second, as volunteers often worked and received training together in groups as part of their work for MindOut, a focus group offered a familiar and less intimidating setting for participants than one-to-one encounters with a researcher. Lastly, given that discussions could potentially involve discussions of upsetting or distressing experiences, a focus group with other support workers provided a naturally emotionally supportive environment.

Initially, seven participants had been recruited for the focus group; however, two were unable to participate on the day due to unforeseen circumstances with one agreeing to be interviewed separately at a later date. Ultimately, five digital outreach workers attended the focus group which was held at MindOut's premises in a private meeting room. I led the focus group in a conversational style asking open-ended questions drawing from four main topic areas to facilitate the discussion (see Appendix 5). Topics explored included their perspectives on gay and bisexual men's help-seeking, their practices supporting these men online, as well as a reflection on their own experiences seeking assistance for a mental health concern. The focus group lasted approximately 60 minutes, was audio-recorded and later transcribed.

Although productive, there were some unanticipated drawbacks to this method on the day and a decision was made to end the session earlier than anticipated[19]. First, the focus group was conducted the day Britain's exit, or 'Brexit', from the European Union was announced[20]. Participants, vocally avid 'remainers', discussed their shock before the session commenced and it was obvious that many felt emotionally impacted by the news. Second, despite cooling fans to combat the summer heatwave at the time, the meeting room was poorly ventilated and became increasingly stuffy. With construction work and scaffolding happening on the outside of the building, it was impossible to crack open a window for fear that the noise would interfere with recording equipment. Rather than postpone given the already tricky logistics in finding a

[19] The session was expected to last around 90 minutes.
[20] June 24th, 2016.

convenient date/time available to all, I decided to press on with the focus group. However, nearing the end of the first hour, I could sense restlessness in the room, and decided to end the session early. I asked focus groups member afterwards if I could contact them with any additional questions I might have, and they agreed to do short online interviews should the need arise. Upon transcription of the focus group data, however, I felt that I had enough information for analysis and decided further follow-up interviews. In hindsight, semi-structured interviews may have been more effective here given the potential for gender-privilege dynamics during the focus group and a further in-depth exploration of personal help-seeking journeys, among gay and bisexual male service providers in particular.

3.6.2 Online and face-to-face semi-structured interviews

Semi-structured interviews were used to gather data from a majority of the participants (see Appendix 6 and 7 for interviews schedules). Widely used, qualitative interviews can provide rich and detailed data on people's perspectives (Yeo et al., 2014), particularly those centred around sensitive or stigmatising topics (Braun & Clarke, 2013). For this study, semi-structured interviews provided a flexible method to explore and probe participants understanding, experiences and construction of their (online) mental health help-seeking relations. Additionally, aware that our conversations could potentially bring up distressing memories or accounts, interviews were beneficial in that they mirrored a 'therapeutic' encounter and provided a space for participants to discuss their experiences with an active listener interested in their journeys. While not directly intended to be therapeutic, three participants expressed this sentiment at the end of our interviews. I must stress, however, that I did not, under any circumstance, communicate to participants that interviews would be a source of treatment or intervention for any current or ongoing mental health concerns.

A choice was offered to participants for interviews to take place either face-to-face and in person or online in a secure and private format of their choosing. The rationale behind the inclusion of virtual interviews were manifold. Given the subject matter and the potential preference for virtual interactions (and a sense of anonymity) given the research topic, I wished to accommodate those who felt more comfortable discussing

difficult emotions or experiences online rather than directly in person. Additionally, virtual interviews offered a convenient and accessible method to facilitate participation among individuals who might otherwise be less inclined to take part in traditional interviews, for example, those faced with time constraints and work demands, geographical restrictions, physical disabilities and/or mobility issues.

In total, 13 participants were interviewed for this study. All face-to-face interviews took place in a private meeting room arranged through MindOut and provided by Community Base[21] where the organisation's offices are located. Located in central Brighton, Community Base offered an accessible location for participants in the local area and within easy reach of major public transport links. Although I was unable to reimburse participants' travel costs due to restricted funds, I was able with the help of MindOut to provide refreshments during interview sessions (e.g., bottled water, coffee/tea, and an assortment of snacks). Interviews lasted between 50 and 90 minutes, were audio-recorded and transcribed soon after. Asynchronous virtual interviews occurred over a 4-week period. While initially cautious of asynchronous methods given past experiences[22], I prioritised participants' preferences for email interviews (as opposed to synchronous modes of communication e.g., real-time 'chat' platforms). Fortunately, online interviewees were quick in their responses, and proved successful with some participants who were cautious to share web-based settings or materials during our initial interviews.

3.6.3 Participant-generated web-based materials

Some interviews also involved the generation and discussion of participant-generated online materials. Here, I drew on and adapted visual research methods, photo-elicitation interview techniques in particular, to explore gay and bisexual men's online help-seeking and 'capture' spaces or materials they thought relevant. Photo-elicitation methods usually involve the use of photographs, or other visual mediums, in an interview setting to help stimulate and promote dialogue about a participant's

[21] See http://www.communitybase.org

[22] I had similarly used email interviews in my research with trans young people during my MA in community psychology, and experienced significant delays in responses as well as attrition among participants.

experience of the topic under study (Bates, McCann, Kaye, & Taylor, 2017). Visual images bring different layers and insights to research interviews in that they facilitate deep emotions, reflection, and evoke tacit or subconscious psychosocial knowledge in a way that standard interview questions might not (Harper, 2002; Pain, 2012). Further, when the data is participant-driven, as is the case here, the researcher attempts to understand the experiences of the participant rather than impose their own framework or perception of a research topic (Bates et al., 2017). Yet, photo-elicitation methods remain relatively underutilised in research contexts exploring mental health (Glaw, Inder, Kable, & Hazleton, 2017; Johnson, 2011), and digital and social media environments (Hutchinson, 2015; Tonks et al., 2015). Elicitation methods offers innovative opportunities to examine help-seeking behaviours as digital and social media spaces provide dynamic visual cultures which incorporate a complex array of mixed media materials (i.e., visual, textual, aural and other articulations) (Schreiber, 2017). Given that shame is often repressed, disguised or hidden, participant-generated web-based materials provided a unique opportunity to help aid discussions around emotional distress. For instance, contrary to face-to-face data, previous research found emotions, such as shame, are 'invoked, stated, claimed and articulated repeatedly' by queer youth in online discussions of self-harming behaviour (McDermott et al., 2013, p. 134). Thus, the combination of visual digital and social media data and exploratory interviewing provided a unique opportunity to explore gay and bisexual men's online help-seeking.

Participants were asked to share any online spaces or content they deemed relevant to their experiences of mental health help-seeking. Participants were invited to use their own mobile devices (e.g., smartphones, tablet computers etc.) or to make use of an Internet-enabled laptop provided at interviews to share, discuss and capture these materials by taking a screenshot or screengrab. While some were hesitant to engage in this activity and opted instead to discuss their online help-seeking experiences more broadly, other seemed to find the process quite enjoyable, particularly insofar as the material involved memes which seemed to bring some levity to the discussion. In fact, and surprisingly, some participants continued to share screenshots with me in the weeks that followed our initial interviews in a series of online exchanges, passing along materials that reminded them of our discussions. I recorded short descriptions of each image in a research diary to chronologically help place these images into interview

transcripts. All screen-captured items were shared with in bulk via email either during or at the end of interviews. In total, 38 images were collected; however, as these varied greatly in quality, I chose to use these sparingly within my analysis chapters. Undoubtedly, the inclusion of digital and social media-based materials in this study raised additional ethical issues that required further consideration which are outlined and discussed towards the end of this chapter.

3.7 Data analysis

Audio recordings were transcribed verbatim soon after interviews were completed. Although laborious, this process was somewhat streamlined thanks to the transcription facilities and resources available at the university's School of Applied Social Science (SASS) Psychology Lab. Following Braun and Clarke's (2013) transcription notation system, I initially produced orthographic transcripts of all recorded face-to-face data. This transcription method involves the written recording of all verbal utterances from speakers, including non-semantic sounds (e.g., 'uhm', 'er', 'mm', 'ah' etc.) and paralinguistic features of the data (e.g., laughter, strong emphasis). However, to enable readability, non-semantic sounds were removed from illustrated extracts in the final analytic chapters. Where interviews involved participant-generated web-based materials, field notes were used to catalogue each item and then inserted into final interview transcripts. All participants were assigned pseudonyms to make individual testimonies livelier, more personable, and relatable; however, I decided against including identifying annotations for reasons that will be explored within the next section. The lengthy transcription process enabled me to familiarise myself with the data, noting initial observations and summaries of each participant's account in an excel document, before proceeding to a more systematic analysis of the data.

Data coding and analysis followed Braun and Clarke's (2006, 2012) *recursive* six phase approach to TA, where I moved back and forth between the data and the analytic phases to develop my analysis and the final themes. Utilising a contextualist approach to TA, coding of the data occurred both at the semantic (i.e., data-driven) and latent (i.e., theory-driven) level. Transcripts were entered into NVivo, qualitative data analysis software, to help assist with initial coding ideas. Given that human

experience and meaning is in and of itself diverse and contradictory, the staggering amount of initial generated codes left me rather hard pressed to ‘embrace [the] messiness’ of qualitative analysis (Shaw, Dyson, & Peel, 2008, p. 188). As result, this phase was revisited many times as my analysis progressed.

As my analysis shifted from codes to themes, I explored different ways to combine codes into themes and (re)drawing thematic maps to get a sense of the data. Initially, I generated two broad overarching and candidate themes: help-seeking as either ‘a relational threat’ and help-seeking as ‘relational relief’. Further refining and reviewing commenced until, ultimately, my analysis generated three overarching themes that I used to organise and structure my analytic chapters, namely ‘failure’, ‘relief’, and ‘support’ (see Appendix 8, 9 and 10 for thematic maps of each). The first overarching theme, ‘failure’ (Chapter Four), related to participant’s feelings of failure and shame which were connected to the negotiation of sociocultural norms: neoliberal norms, emotional norms, heteronorms, homonorms, and masculinity norms. The theme of failure kept recurring in the data where participants discussed feelings of difference, inadequacy, and exclusion in relation to these norms and their help-seeking. The findings within this chapter laid the groundwork for the next chapter by providing a foundational understanding of some gay and bisexual men’s preferences for online help and support as opposed to offline supports mechanisms or services.

The second overarching thematic area related to participants experiences utilising digital and social media to seek a sense of ‘relief’ (Chapter Five). Relief within their narratives reflected a sense of social and emotional connectedness with others online as part of the help-seeking process. This pointed to a desperate for distressed gay and bisexual men to be able to be in relation to others, rather than being alone with their distress. This involved a variety of strategies which included developing or (re)engaging in critical perspective on punishing norms, as well as *safer* facilitation of peer recognition and witnessing of their distress. As I engaged with this overarching theme, I initially focused on predominantly on agentic and adaptive forms of online help-seeking; however, participants discussions of niche GSN apps, particularly all-male platforms, troubled my understanding of this process in that some discussed sexual activities linked to these platforms (e.g., sexual discussions, arranging to ‘hook-up’) as a form of relief (i.e., the theme of ‘respite’). At the time, I struggled to the finding

of ‘respite’ as form of help-seeking to the wider literature as most psychological research implicitly treat help-seeking as an active and adaptive coping process (e.g., Rickwood & Thomas, 2012). Yet, upon rereading several articles that discuss the value of adopting non-adaptive frameworks of help-seeking (e.g., Biddle et al., 2007; Newman, 2008; Wenger, 2011), I came to see some value in ‘respite’ as a theme. Indeed, much to my chagrin, I had read these articles numerous times and yet remained blind to their conceptual insights up until this point. It struck me that my overarching theme of ‘failure’ (Chapter Four) included non-adaptive forms of help-seeking (i.e., non-help-seeking, avoidant help-seeking), and this helped to expand findings within this chapter.

The third and final overarching theme was that of ‘support’ (see Chapter Six). While the preceding themes highlighted the process of gay and bisexual men’s online help-seeking, ‘support’ encapsulated digital outreach and support work by MindOut service providers. Here, I initially engaged in a more inductive analysis of sub-themes highlighting the opportunities and challenges in support gay and bisexual men online across a range of digital and social media platforms. In order not to simply paraphrase the content of the data, I revisited the data at a later stage in order to link findings more conceptually to the affective nature of help-seeking and generate deeper insights into how current and future digital approaches might support or undermine this process.

3.8 Ethical procedures: Considering principles and negotiating tensions

In this final section, I attend to procedural *and* process ethics (Roberts, 2015), highlighting key tensions encountered throughout the research process and discussing my efforts to negotiate these. In line with established traditional and Internet-mediated research ethical guidelines (British Psychological Society, 2014, 2017; Markham & Buchanan, 2012; Morison et al., 2015; Roberts, 2015), and drawing on previous ethical procedures with my community partner (Johnson, 2007), careful consideration was given to four main principles: ‘informed consent’, ‘confidentiality and anonymity’, ‘debriefing’, and ‘maximising benefit and minimising harm’. I was particularly aware that the research raised a number of ethical concerns given the focus on mental health help-seeking, and the collection and reporting of social media

materials in the outputs of this thesis. Further, the involvement of MindOut service users and providers also raised specific issues, in relation to 'informed consent' and 'confidentiality and anonymity', while aiding others, such as 'debriefing' and 'maximising benefit and minimising harm'. Ethical clearance for this research was granted by an internal, departmental ethics committee[23] in February 2016.

3.8.1 Informed consent

A particular concern early on in the development of the research design was the possibility that some individuals would mistake their recruitment and participation in the research for an opportunity to obtain active treatment or counselling support for pressing mental health concerns. Obtaining informed consent was therefore crucial to ensure that participants were aware that they would be required to discuss their (online) mental health help-seeking experiences *retroactively*, and to ascertain whether felt comfortable and confident in their ability to do so in an interview setting without negatively affecting them or causing distress (see Appendix 11 and 12 for participant consent forms, and Appendix 13 and 14 for participant information sheets). As a precautionary measure, however, arrangements were made with MindOut to direct any distressed individuals or those requiring assistance into their services, rather than actively excluding them from opportunities for support. Additionally, a list of national LGBTQ specialist services and helplines was also provided as part of recruitment activities and materials to ensure a range of support opportunities (see Appendix 15).

The involvement of MindOut in the research also raised specific issues. First, there was potential for perceived or felt coercion among participants affiliated with the organisation (i.e., staff, volunteers, and service users). To account for this possibility, I informed participants that: (i) the research was first and foremost an independent doctoral project; (ii) their participation would be voluntary, and therefore there would be no disincentives from the organisation for declining to participate; and, (iii) they were free to withdraw or modify their consent at any point during the data-gathering

[23] College of Social Science Research Ethics Committee (CREC), University of Brighton.

phase. Further to this point, although the charity helped facilitate recruitment and provided meeting rooms, consent procedures took place in a private interview space to minimise the potential for surveillance or coercion that might arise from inherent organisational power relationships (for e.g., real or perceived authority of management over volunteers). Second, because small charities such as MindOut that depend on (short-term) funding streams and grants are by definition vulnerable and constantly under threat (especially in economic terms), there was a need to consider the organisation's reputation as part of the consent process. For instance, while negative feedback by service users/providers would undoubtedly improve the design, planning, and provision of services to gay and bisexual men by the charity, such feedback could potentially hamper future funding opportunities. Thus, although consent was initially negotiated with MindOut's chief executive officer to feature the charity as a 'named' community partner within this thesis, it was agreed that consent would be an ongoing process for MindOut to feature as a named charity in any future publications or presentations resulting from the research findings (see Appendix 16).

Lastly, as research data also included the collection and reproduction of participant-generated web-based materials within the outputs of this thesis, there were additional ethical issues to consider around consent and authorship/ownership. While participants took screenshots, or screengrabs, of their own digital interactions or social media accounts and could therefore consent to the use of these materials, there were dilemmas around third party materials and whether certain online settings constituted public or private space (see British Psychological Society, 2017; Roberts, 2015 for a further discussion around these debates). For example, in one instance, a participant had taken screenshots of several profiles on Grindr and related apps to help substantiate his point during our discussions. The screenshots contained text featured within platform users' biographies and demonstrated a link between mental health problems and sex as a form of relief (see Chapter Six). One biography indicated suicidal intent and encouraged others on the platform to take sexual advantage while they could. Another had written about their struggles with depression and feeling dead inside, desiring someone to 'pound' them back to reality. An argument could be made to include these materials within the outputs of this research on the basis that the data was publicly available within the platform for all to see, and digitally blurring any identifying features or information. However, given the sensitive content, I felt

uncomfortable reproducing these images without consent from non-participants, a process which could be considered intrusive, unwelcome and distressing. Furthermore, there were would also be difficulties around locating these individuals on the apps given their geo-locative features of the platform and users mobility. As such, I decided against displaying these specific images in analysis chapters, opting instead to provide a paraphrased account of these profiles and the participant's discussion around them.

With regards to the web-based materials, an additional consent form was created and given to participants to obtain permission for the use, or reproduction, of their images in the outputs of this thesis (see Appendix 17). On this form, participants had a choice between three different levels of consent. Participants could consent to:

a) the inclusion/display of all collected materials for educational and non-commercial purposes (e.g., thesis materials, reports, academic publications and/or any presentations that result from this research);
b) the inclusion/display of some select materials (e.g., thesis materials, reports, academic publications and/or any presentations that result from this research); or,
c) that no materials be displayed or reproduced (i.e., included for background analysis only).

Participants were advised that they could withdraw their consent for the inclusion of these images at any stage; however, such withdrawal would only pertain to future and/or unfinished outputs from this research.

3.8.2 Confidentiality and anonymity

In addition to informed consent, there were also ethical issues related to matters of confidentiality and anonymity. Given the research topic, complete confidentiality could not be guaranteed in instances of acute emotional distress, adverse events or immediate risk of harm to the participant or others (including myself as the researcher). I informed participants prior to interviews that it would be necessary to break confidentiality in such instances, and that relevant information would be discussed with

a MindOut support worker immediately after interviews to ensure that appropriate intervention or support could be provided. Further, while service providers are well schooled in the importance of confidentiality in the context of their services and practice, I reminded staff and volunteers to avoid discussing any potentially sensitive and/or identifying information related to any third parties during our interviews or focus group.

Anonymity was also a significant concern, and several factors jeopardised the standard aim of protecting the anonymity of (non)participants. Because MindOut is 'named' within this thesis and interview extracts illustrate the research findings, there was an increased chance of MindOut service providers and users being recognised internally within the organisation. Participants associated with the charity were made aware of this possibility; however, no one withdrew from the research on this basis. Taking guidance from Johnson (2007), I resolved to remove identifying annotations from the end of interview extracts in order to provide a little more shelter for my participants' identities (e.g., age, sexual orientation and/or gender identity). The collection of web-based materials also triggered concerns with regards to confidentiality and anonymity. While I decided early on that publicly available digital content would be paraphrased to trouble any traceability of user profiles through search engines (e.g., personally written posts, tweets and contributions in forums), data shared with me primarily (and interestingly) consisted of mass shared or reposted third-party content (e.g., memes, retweets etc.) as a way to communicate or describe their feelings. Usernames or source codes were removed from these materials to protect the privacy and anonymity of participants digital profiles or accounts. All transcripts, audio files, and participant-generated online materials were stored on a password-protected hard drive. Signed consent forms were stored separately in a locked cabinet away from all other data.

3.8.3 Debriefing and minimising harm

In this final ethics section, I discuss measures to obviate or minimise potential risks to participants wellbeing or others, including my own as the researcher, while the research was carried out. Although interview topics focused on past mental health

help-seeking experiences, there was a possibility that interviews could unwittingly contribute to adverse emotional reactions. As such, it was necessary to ensure that participants would be sufficiently supported through a debriefing session if the need arose. To that end, this study benefited from the collaborative nature of the research and the involvement of MindOut where the organisation agreed to support participants who found interviews particularly distressing. Drawing from previous research debrief procedures with the charity (see Johnson, 2007), we agreed that visibly distressed or vulnerable participants would be provided with a post-interview debriefing session with a MindOut support worker. This option was also made available to me, as the researcher, during the data collection process.

Personally, while I often checked-in with MindOut after interviews, at no point did I formally seek a debrief with the organisation. There was, however, an incident that caused some discomfort. A participant had shown up to an interview visibly irate, discussing how they would have liked to bludgeon people with a hammer on the way over. While I offered to postpone the interview, the participant asked to continue and 'get it out of the way'. They remained confrontational throughout much of our interaction and seemed quite exasperated with my line of questioning. Furthermore, while some interviews up to that point had involved discussions around sexual behaviour in relation to niche SNSs, I felt blindsided during this specific interview as the topic of sex seemed unexpected and unrelated to my line of questioning. My impression was that this was done to shock, or even excite me, as direct questions about my sexual orientation and proclivities soon followed. In the end, I kept the interview relatively short for fear of antagonising the participant further. A support worker was on informed directly after to check-in with the participant who had a pre-arranged meeting set up with the organisation. The incident stayed with me in the weeks that followed, and I questioned whether I had unintentionally done anything to upset the participant or if I approached the situation inappropriately in some way. Looking back, I am unsure why I refrained from seeking out a formal debrief with the organisation as the interview clearly affected (this may also be related to my own help-seeking difficulties, see the last section in Chapter Seven for a reflexive account about the research process). I did, however, discuss the incident with my supervisors for my own peace of mind.

Conclusion

This chapter presented this study's alternative framework for researching and interpreting gay and bisexual men's online mental health help-seeking. The first half outlined the interpretative frame drawing on interdisciplinary theory. At the centre of this approach is the complex entanglement of emotion, norms, and subjectivity involved in asking for help with a mental health concern. I began by suggesting that there is an emotional cost to normative subject-making, highlighting the discursive and material production of the rational neoliberal subject and norms which might impinge upon the possibility of intelligibility and recognition for some distressed gay and bisexual men. I then presented this study's conceptualisation of emotion as relational and understood as investments in sociocultural norms. I discussed shame in particular which, I argue, plays a significant role in the online help-seeking trajectories of distressed gay and bisexual men. Thereafter, I considered the suitability of a contextualist thematic analytical methodological framework in bringing the interpretative frame to bear on the data.

The second part of this chapter outlined the research methods used to conduct this research. This included a brief summary of the research design, a description of the research participants and their recruitment, as well as the individual methods of data generation. It then went on to describe the process of data analysis from the early stages coding through to the generation of the final three overarching themes which form the basis for the next three chapters. Finally, the chapter concluded with a discussion of research ethics. The subsequent three chapters present the research findings.

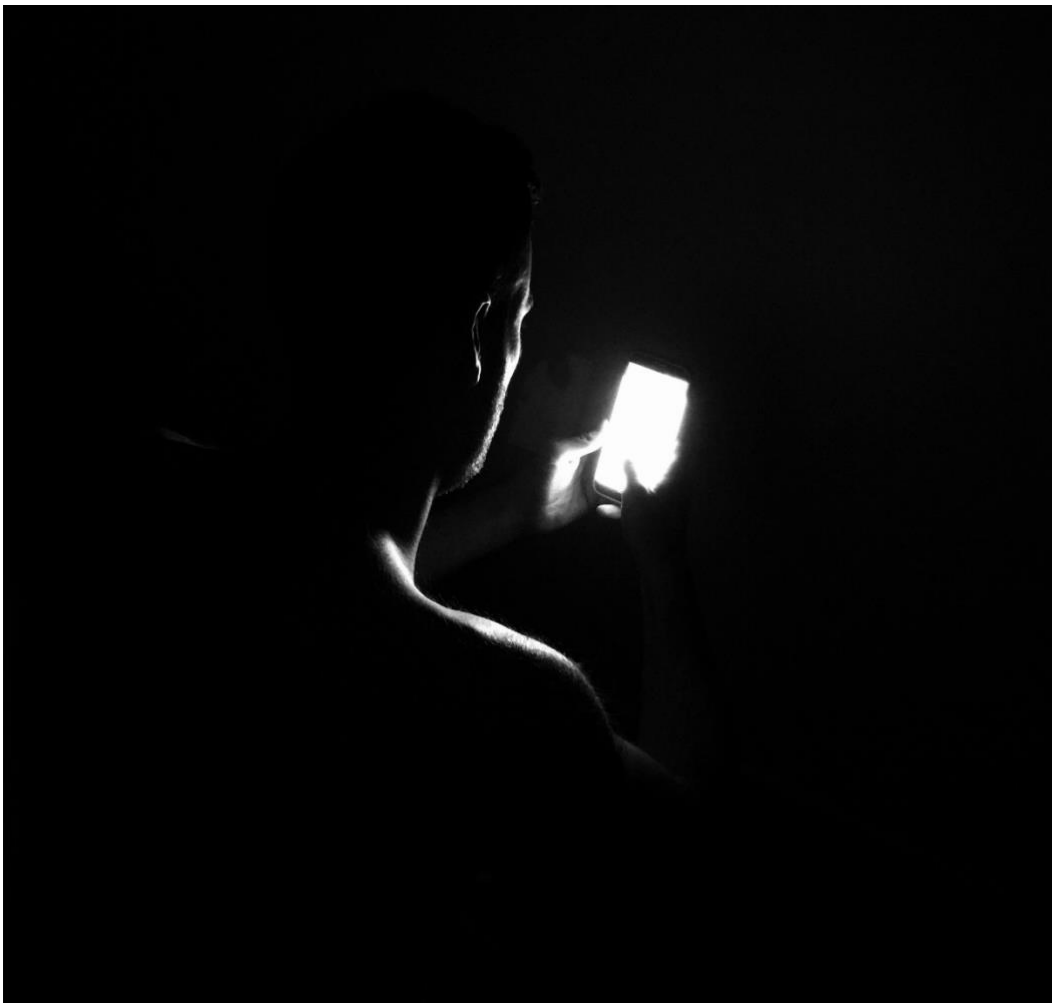


Figure 2. (Dis)connection[24]

[24] (Dis)connection was a research photo submission for the University of Brighton's Festival of Postgraduate Research Photo Competition (June 2018). I include the image here as a transition from the first half of the thesis, which reviews the literature and outlines the methodology and methods, into the second, which offers some key analytical insights into gay and bisexual men's online help-seeking behaviours. The intent behind the staged photo with its light/dark contrast was to visually illustrate the sense of social and emotional (dis)connection that featured in participants' narratives.

4. Failure

In this first analysis chapter, I explore gay and bisexual men's narratives of their mental health help-seeking more widely in order to frame the circumstances under which some of these men come to seek help online. This chapter consider gay and bisexual men's constructions of mental health help-seeking as involving the navigation of multiple sociocultural norms which position them as failed and shamed. It demonstrates that emotions, norms, and relational dilemmas contributes to the difficulties some gay and bisexual men have asking for help from offline support mechanisms and services. This chapter is divided into three themes. First, in *punishing failure*, I examine the affective demands of successful and tolerated gay/bisexual male subjecthood and demonstrate how practices of exclusion and relations between people may generate punishing feelings of failure, shame and distress for gay and bisexual men. Help-seeking, I argue, both reveals and becomes the attempt to repair a fracture in relational space. Second, in *avoiding failure*, I consider how neoliberal discourses of individual responsibility (and blame) feature in participant's narratives of a reported delay in help-seeking relations. I suggest that some gay and bisexual men normalise and cope alone with increasing levels of distress in order to remain within normative strictures for as long as possible and to avoid relational tensions that position them as failed often only seeking help at crisis points. In the final theme, *articulating failure*, I highlight the emotional work required to negotiate sociocultural norms and enable a request for help; and demonstrate how mainstream or face-to-face services might exacerbate the affective nature of help-seeking and reinforce a sense of failure.

4.1 Punishing failure

In this chapter's first theme, I begin to explore exclusions within neoliberal hetero- and homonormative strictures and consider how these are implicated in complex feelings of failure, shame and distress for some gay and bisexual men. I examine participants narratives of successful and failed gay and bisexual male subjecthood and highlight the implications of such subjecthood on their experiences of (mis)recognition and

(non)belonging. I demonstrate how mental distress and help-seeking reveal a fracture within relational space.

Throughout my interviews, participants, like Theo (service user) in the extract below, have raised and discussed managing punishing and difficult emotions associated with (neoliberal normative) failure:

> I feel like I'm a piece of this puzzle that doesn't fit. It's like everyone I know fits into this bigger picture of, I dunno, what life is supposed to be, right? How you're supposed to be as a gay man. You know, normal, or whatever, and then there's me who just can't fit into this picture, no matter how hard I try. It's like this one big race and I'm the poor sod coming in last […] I feel like I don't really fit in anywhere. Even with the [local LGBTQ community]. I don't feel part of it. I try, but I'm invisible to them. It's really fucking lonely.

Theo describes a larger 'puzzle' that he feels unable to fit into. These puzzle pieces that construct the larger 'picture' implies multiple norms or social intuitions that he has to negotiate in his everyday life in order to be a 'normal' gay man. Despite Theo's desperate attempts to fit in with these expected norms, he admits a sense of defeat and failure to be (or feel) 'normal' ('no matter how hard I try… I'm the poor sod coming in last'). He also discusses the consequences of his failure: he is denied recognition ('I'm invisible to them') and a sense of belonging ('I don't really fit in anywhere; I don't feel part of it'). As this extract indicates, experiences of recognition and a sense of belonging can be problematic for those 'failed' subjects unable to comply with neoliberal expectations of 'successful', normative subjecthood.

My analysis in this section draws on critiques of neoliberal homonormativity that illustrate how homonormative politics upholds, sustains and seeks inclusion within heteronormative institutions and values (Duggan, 2003), in order to appear sell an acceptable or tolerable gay/bisexual male subject that is 'palatable, desirable and profitable for wider neoliberal sociality' (Cover, 2012, p. 124). Within this framework, neoliberal schemes of success and failure are responsible for deeming certain

gay/bisexual male subjects as (un)worthy of recognition and sociality or belonging both within LGBTQ communities and more broadly within society. For example, Drew (service provider) remarks on some of these schemes of homonormative success while discussing traditional or conventional mental health outreach work with gay and bisexual men in the local Brighton gay scene[25]:

> I've had some really interesting conversations with men on the scene. Some of which were saying, 'it's great you're doing [community outreach work], I really struggle with my mental health' and these are quite out there, confident-seeming, young, attractive, kind of gregarious people you might see every single night you go out and think 'wow, you're well sorted', and actually them having some struggles themselves. You know, they'd come across as confident, having lots of people around them, seemingly having a wonderful, wonderful time, and quite high profile on the scene because of how they behave or how they look or what their job is, and then go home on Saturday night feeling so awful about themselves and try to hang themselves.

Of note in this extract is Drew's description of a 'well sorted' gay and bisexual male subject, and his subtle surprise that some of these men might struggle with their mental well-being to the point of a possible suicide attempt. We see here how a definition of a successful gay/bisexual male subject remains anchored and entrenched within depictions of financial affluence, aesthetics, and self-sufficiency, in which the 'affluent, white, gender-conforming, fit, straight-mirroring, coupled male' (Cover, 2012, p. 129) becomes the pinnacle of a successful life and the pressures to fit within such expectations. Drew's narrative hints at how neoliberal homonormativity functions as a vehicle for inclusion, community and belonging both within LGBTQ communities and, arguably, in Western society more broadly, and the pressures involved in maintaining and performing such ideals. It's against this backdrop that I now proceed to examine how shame circulates everyday feelings of difference and exclusion, and how some gay and bisexual men come to be positioned as 'abnormal', failed and shamed.

[25] Commercial venues and events that cater for a largely 'gay' clientele.

In the following extract, Joss (service user) discusses his anxiety disorder and social situations that trigger distressing episodes (e.g., panic attacks, nausea and vomiting):

> It's basically social situations where it would be socially weird for me to leave, I guess. Like, on public transport I can't really get off because I have to wait until the bus stops or at work in a meeting I can't really get up and leave. It's kind of socially awkward to do that. I'm thinking how would people react to that? What would they think of me? It's just generally the idea of how people would think of me and how they would judge me. That's the main issue my therapist and I are really stuck on. I guess just being afraid of being judged and treated differently because how people might perceive me or if they judge me as being weird, and that kind of snowballs into this unbearable anxiety. It might stem from the fact of, like, growing up closeted and gay in a very homophobic environment and having the constant fear of like what if someone found out? How would they react? So, I'm constantly very hyper aware of how I talk, how I act around people and, you know, will they think that's gay? It's kind of like stuck.

Reflecting on the image below (see figure 3), Joss presses on and clarifies that:

> I don't really care if people think I'm gay because, yeah, I am. Whatever. I'm fairly open about it. Its maybe stresses over time that built up, kind of like PTSD. It's not one event that causes it. It's kind of like a prolonged situation, so, yeah, if I was maybe like flamboyant, or more gay, I feel like I get judged for it more even if it's not necessarily to my face. So, I always dress normal or whatever, like generically, and act fairly more normal, more straight-ish with people that I'm around. Whether they're straight or gay. It's always been like a defence mechanism, I guess, trying to fit in as much as possible.

Figure 3. After a long of pretending to be straight.

Within these extracts, Joss demonstrates a relentless engagement with acts of self-surveillance and impression management to fit within normative expectations. Despite being out and 'fairly open' about his sexual orientation to family, peers and colleagues, Joss fears negative judgement for overt and unambiguous 'gay' behaviours or expressions that he describes as 'flamboyant' or effeminate and worries about how others would react to open displays of anxiety. We note Joss's determination to remain as close to the (homo)normativity 'as much as possible', that is, the tolerated version of successful gay male subjecthood. He does so to avoid 'unbearable' judgement or exclusion that might follow from both hetero- and homonormative audiences ('treated differently'). 'Normal' for Joss means passing himself of as 'straight-ish' and conforming to gender masculine norms which he describes as a 'defence mechanism' to avoid judgement, exclusion, and shame.

As evident in Joss's narrative, fitting in, or trying to belong, can require strategies that are emotionally uncomfortable. Scheff (2000) describes shame as 'a large family of emotions that includes many cognates and variants, most notably embarrassment, humiliation, and related feelings such as shyness that involve reactions to rejection or feelings of failure of inadequacy… that involve the feeling of a *threat to the social bond'* (p. 96 – 97, author's emphasis). We see in the above account the pernicious effects of shame that remain 'stuck' to Joss's everyday life: his ongoing engagement with, and enactment off, the scripts of normative existence that facilitate a sense of

recognition and belonging, and the pressure for Joss to maintain and remain within range of those normative ideals under the gaze of hetero- and homonormative others. We see how feelings of shame around gender non-conformity get repeated over time (‘constantly very hyper aware of how I talk, how I act around people’), and how these moments of potential failure or transgression can be experienced as bodily injury (i.e.., manifest as distressing and debilitating panic attacks). Shame thus function within Joss’s narrative to reintegrate him back into (hetero- and homo-) normative ideals in moments of possible failure. By following these normative scripts, he remains worthy of social connection and inclusion within wider sociality.

Gay and bisexual men’s spoke at length about their difficulties navigating tenuous relations with other sexual minority men, and these were implicated in feelings of inadequacy, isolation, loneliness, and distress. In the lengthy extract below, Casey (service user) discusses his experiences of exclusion within homonormative communities:

> I find the gay community quite harsh, because I've told a couple of gay guys in the past [about my mental health problems], and they've gone really weird. They walked out my house or they're like ‘better not take you home then’. It made me feel so shit. Everyone’s got mental health problems in their own way, but I feel like the gay community is really harsh on people who are different and who admit to mental health problems. [W: Why do you think that is?] I think a lot of gay men are fickle. I think a lot of us imagine how people are supposed to be. The idea of someone. And then, when we find out that they are not actually like that, or there’s something wrong or they’re not perfect, then we don’t want them. We don’t want to be around it. So, when I was younger, I changed my whole persona because I didn't feel accepted in the gay scene. I was 22 stone and I was 18. I got really badly bullied at gay clubs because I used to be really outrageously gay, you know, bleached blonde hair, buffalo boots, Spice Girls, and all that shit when I was 18, and they bullied me so bad. Never invited me back to chill out and everyone would always leave me on my own. So I lost about 11 stone in about 8 months, and I lost some more

> weight, and I changed my whole persona. I started dressing like a straight boy, and, I am not even joking, the whole scene changed towards me. It was like ‘oh my God, you're so fit when you act butch! You're so hot!’. So, yeah, when I was fat and camp, I was ridiculed, and bullied, and left out, but when I was skinny and good looking and butch, people wanted to know me and spent time with me. It was like I’ve got to be this, and If I’m not this, I’m no one. So yeah, I changed myself to be accepted on the gay scene. I changed my whole persona to be accepted.

In this extract above Casey reflects on how punishing difference can be, and how neoliberalism and homonormativity can limit queer ways of being. He’s failing on multiple levels, and such failure comes with a host of negative affects (Halberstam, 2011). Casey describes his ‘difference’ as accompanied by feelings of loneliness, inferiority, and worthlessness. His admission of mental health problems to other gay and bisexual men leads to judgment (‘they’ve gone really weird’) and rejection (‘they walked out my house or they’re like “better not take you home then”’). Furthermore, he’s bullied, ridiculed, and excluded for transgressing gender norms (for being ‘camp’ and ‘outrageously gay’ as opposed to ‘butch’ or a ‘straight boy’), and the image of what a gay male is ‘supposed’ to look like (for being ‘fat’ as opposed to ‘fit’ or ‘skinny’ and ‘good-looking’). Casey is excluded recognition from, and inclusion with, other gay and bisexual men who he describes as ‘fickle’ and in pursuit of ‘perfection’. He is positioned as ‘abnormal’, failed, and shamed. In order to become constituted as a socially viable subject (Butler, 2004), that is, worthy of connection and recognition, he must transform and manage his identity (‘I changed myself to be accepted) in relation these norms. It would seem that, as Love (2008) suggests, ‘sometimes it seems that the only way for queers to start being happy is to stop being queer’ (p. 62). This emotional toll is evident further along in the interview when Casey discusses a recent distressing episode:

> My mental health is definitely connected to the way I look, and the gay scene is big cause of that for me. So, yeah, I have a body thing. I have an eating disorder. If I don’t look or feel amazing, then I don’t want to

> live. Can't be bothered with it. So last week, I felt really – not suicidal that's a bit extreme – but I felt really, really emotional, and I'm one of those people who don't do emotions. I was getting ready for my first night out in ages. I put on my jeans, they didn't fit. Put on my shirt, and it split. It was a realisation of how far I'd let myself go, and I just felt so shit. I felt really embarrassed. I started crying for no reason. Just sitting for no reason. I just wanted to speak to someone, but I felt like I was making a dickhead of myself.

In the above extract, Casey demonstrates how homornorms connected to the fit, perfected, and idealised body in gay masculine culture can make life (un)liveable ('if I don't look or feel amazing, then I don't want to live. Can't be bothered with it'). Normativity, McDermott and Roen (2016) argue, confers liveability and his (multiple) transgressions here produces a shameful recognition of the inadequate and inferior self as measured against the external constructions of superiority ('I felt really, really emotional'). While Casey is critical of the gay scene and its role in his eating disorder, he attributes his failure to adhere to fulfil these conditions personal blame ('it was a realisation of how far *I'd* let myself go'). His failure is felt not only as being sexually attractive, but, doubling back to the previous extract, in being excluded from the sociality of the LGBTQ community.

Olly (service user), in discussing the meme below (see Figure 4), similarly reflects on issues of (mis)recognition and (non-)belonging within the gay/bisexual male community:

> This sums it up really well. There's definitely a lot of pressure to look and behave a certain way and if you're not this, or close to it, well, then you're not worthy of their attention. There's someone better just around the corner. You're very aware of how replaceable you are if you don't kind of meet these standards. I'm guilty of it too, I guess […] feel like that's the major issue of social media. I'm constantly following really hot, attractive guys on Tumblr or Instagram. They're constantly looking attractive and posting half-naked pictures where they're really fit and hanging out with other gay guys and seemingly having a very

> fun time, all the time. Always going out, having lots of friends, and it's like I only see those good situations that they upload which constantly makes me feel bad about my situation where I don't really have that. I feel like that contributes to me feeling more isolated in a way, feeling more bad about myself.

Figure 4. The sad truth is, if you don't look like either of these, you're worthless to a majority of the white gay 'community'.

Like Casey, Olly discusses the pressures associated with successful gay/bisexual male subjecthood and how elements of subjectivity are policed through homonorms. Olly again highlights for us who's included, validated and lauded within gay/bisexual male communities: those who are white, attractive, fit, and affluent. What I'm suggesting in this theme is that sociocultural norms (neoliberalism, heteronormativity and homonormativity) regulate, coerce and enforce narrow modes of gay/bisexual male subjecthood; and positions as failed and shamed those who are unable to meet these demands and who are less categorisable under these regulatory ideals. Such (punishing) constructions of success and failure fail, however, to account for those social and economic circumstances that facilitate recognition and belonging. My

argument is that gay and bisexual men's emotional distress may materialise from and symbolise unresolved relational fractures.

Thus, if we consider mental health difficulties and distress as symbolising a fracture within relational space, then help-seeking becomes the attempt to repair that fracture. I draw on extract from Charlie's (service provider) interview in which he discusses his own help-seeking experiences to substantiate this point:

> I was really lonely, and I was depressed about being lonely. I also felt very single and didn't have many gay friends, so I was looking similar people going through similar things who I could talk to. Who understand where you're coming from and appreciate what you're going through. I think when people talk to other people about things they can bounce thoughts of them and it kind of gives people a way to organise what they're thinking, because I think when you get stuck in your head, you ruminate. You go around in circles and it gets worse and worse, so connecting with someone else can put things into perspective.

Charlie's account of help-seeking attunes us to the affective and relational nature of this process. Mental health help-seeking involves a search for recognition and a sense of belonging ('similar people going through similar things; who understand where you're coming from and appreciate what you're going through'). Such conditions facilitate a capacity for critical relationality to sociocultural norms that reappropriate experiences of shame and allows one to maintain a safe distance from otherwise punishing norms.

In this section, I have shown how exclusions of neoliberalism and hetero/homo-normativity might be implicated in some gay and bisexual men's (overwhelming) feelings of failure, that is, how some gay and bisexual men come to be positioned as failed and shamed in relation to sociocultural, and how these transgressions impinge on their experiences of recognition and belonging. Mental health help-seeking, I argue, reveal a fracture within relational space. In the next section, I examine how neoliberal

discourses delay gay and bisexual men's help-seeking relations, and how these might further complicate relational tensions.

4.2 Avoiding failure

In the previous section, I demonstrate the emotional cost of gay and bisexual men's attempts to fit within neoliberal expectations of successful homonormative subjecthood, and highlight the discursive and material circumstances in which such subjectood becomes (im)possible. In this section, I turn my attention to an often-reported delay by gay and bisexual men within my sample to engage in (face-to-face, in/formal) help-seeking relations. I examine how the neoliberal imperative to self-manage mental health difficulties or distress is absorbed and enacted within participants' initial non-help-seeking narratives to delay, or avoid, being positioned as failed or shamed. As such, help-seeking is constructed as a last resort often only becoming possible for some gay and bisexual men at points of crisis or increasingly severe distress.

While recognising a need for support, participants described help-seeking as a slowly evolving process marked by periods of delay and often only occurring at crisis point or when gay and bisexual men felt they were unable to cope with increasingly severe levels of distress, as illustrated in the following two extracts:

> I ignored all the signs. I tried to handle it [as] best I could, but I got tired and it was a rough week, and then I started to eat more and not sleep properly. I was exhausted and then the self-harming started. I realised I needed to get in touch and get help because I really needed it. I ended up in A&E and I knew this was far more serious than it's ever been before (Ash, service user).

> I'd been coping on my own for weeks but dropped the ball, I guess. Things got worse and it kind of spiralled from there. I couldn't see a way out of it, and I felt like such a fuck-up, you know? [W: In what way did you feel like a fuck-up?] For not being able to do deal with it. By

> not being able to handle it myself, I suppose. I was embarrassed that I let things get so bad. I had to force myself to make an appointment and see someone because I couldn't keep ignoring it. I was struggling to leave the flat and started having really bad anxiety attacks whenever I was out. I couldn't stand feeling that way anymore. I couldn't stand myself. The depression and anxiety were too much for me and I was, you know, getting scared of what I might do. I was desperate for it to end (Olly, service user).

While support was eventually sought by Ash and Olly, both extracts demonstrate a period of non-help-seeking, a rhetoric of self-management, and practices of self-labour. In the first, Ash takes personal responsibility for avoiding or, as he suggests, 'ignoring all the signs' in the lead up to his self-harm. He attempts to manage and cope alone with increasing distress as best he can; however, ultimately, is overpowered by exhaustion and we see how the defeated and shamed self becomes a site of punishment and pain through self-harm. Similarly, in Olly's account, there is an emphasis on self-management and self-labour. He takes individual responsibility for his failure to cope with increasing emotional turmoil and lays the blame squarely on his own shoulders ('I let things get so bad', 'I felt like such a fuck-up'). Yet, his 'failure' to 'deal with it' follows weeks of self-reliance and repeated attempts to accommodate worsening symptoms and distress thus delaying the need to seek and obtain professional help. Here, help-seeking only becomes possible as he nears crisis ('I was… getting scared of what I might do'). Evident within both accounts are neoliberal ideologies of personal responsibility where the individual is tasked with constant self-improvement, self-surveillance, and self-management with regards to their mental health and wellbeing (Brijnath & Antoniades, 2016).

This neoliberal imperative to self-regulate means that mental health difficulties come to be understood as individual problems requiring individual solutions, as expressed by Chris (service provider) in the following extract:

> For me, in terms of looking for support, it very much depends on feeling like the problem's bad enough. I think there's always been lots

> of problems for me personally and certainly a lot of other people around thinking ‘I should just manage it on my own, other people probably have to manage problems worse than this’. You know, I've been through counselling and support groups before. I kind of know it. I know how to do it. There's nothing new that they can offer me. They'll tell me to go away. I don't have a lot of embarrassment about my own mental health stuff as I've talked about it quite openly, quite a lot, but there is still an embarrassment about being open about things so, yeah, trying to power through.

In Chris’s narrative above we can clearly see how emotional distress and adversity can be delegitimised through strategies of normalisation. Through (a shaming) social comparison, Chris conceives of a more distressed state beyond his current experience thereby normalising his distress as ‘normal’, ‘everyday’ and a transient challenge that many others are capable of managing. Here, the criteria for recognising distress becomes both moveable and subject to interpretation where the ‘realness’ of distress, and need for help, is shifted to a more gradual, extreme category (‘other people manage worse than this’). Also prominent within Chris’s narrative are the difficult emotions involved in help-seeking relations. Despite accessing support and treatment on previous occasions, he experiences shame, or embarrassment as explicitly references within the extract, at the prospect of transgressing neoliberal ideals that emphasise self-labour and self-transformation by requiring further (or ongoing) support and discussing his mental health issues. Too much reliance on mental health professionals is readable here as a sign of failure to manage the self. The experience of shame at the prospect of requiring help thus functions to reintegrate Chris back into these neoliberal ideals and, as a result, we note Chris’s resolution to ‘power through’ distressing situations in order to avoid positions of embarrassment. He therefore resolves to press on and manages his alone until the problem becomes ‘bad enough’ and warrants support.

Chris’s fear of being turned away or being expelled from relational space similarly featured in other participants accounts of delayed help-seeking. Turning to others, or openly acknowledging the need for help, meant likely facing negative judgment from

others who considered them weak or saw them as less acceptable. As a result, help-seeking strained relational space. For example, Sam (service user) discusses negative help-seeking relations in the LGBTQ community in the extract below:

> Brighton is this wonderful and liberal place until somebody is actually in this situation where you need support. I became friends with somebody who was going through a very bad time and helped them with that, and when I was going through my trouble and looked to them, they turned around and went 'I don't have time for people like you. I've worked too hard to have people like you and mental health problems in my life' and that was really hard to hear. That was surprising. So, I was like 'oh, this is the Brighton gay community. I'll be abandoned if I inconvenience someone'. I don't understand that. I'm kind of surprised by it. Like any other group, it isn't as liberal as everyone kind of thinks.

We see in the above interaction how help-seeking can pose a relational threat. In their response to Sam's request for help, the respondent draws on neoliberal ideologies to legitimise their position and denial of support: they've undertaken intensive and transformative self-labour to monitor and maintain their mental well-being ('I've worked hard too hard') unlike Sam who is censured for his lack of autonomy and responsibility. His failure to self-manage his mental health problems is incomprehensible and unintelligible to the respondent who attributes Sam's failure to a lack of individual merit or effort. Sam is thus marked as a shameful 'other' ('people like you') and externalised as morally deficient. Consequently, we notice how shame marks the break in social and emotional connection between the two: Sam's request for emotional support is disavowed, and he's rejected from social connection here for being burdensome, 'needy' and an 'inconvenience'. His sense of participation, community and belonging is thus contingent on his compliance with neoliberal expectations ('I'll be abandoned if I inconvenience someone').

We see similar relational tensions within the next extract. Jordan (service user), drawing on the image below (see Figure 5), worries that people will judge or get ‘fed up’ with him for needing help:

> It’s difficult [seeking help from] friends. You don’t want to make a scene and be judged. I’m sort of used to seeing how people see me. How they see me as being weak. I’m not. I’m ill, and you shouldn’t confuse the two [W: In what way do you make a scene?] By being a charity case. I mean no one likes being around a person who can’t seem to get over their problems or deal with their shit. I don’t want to be that person who’s stuck on the same issues. It’s emotionally draining. So, I feel like I’m taking up everyone’s time when I’m [reaching out for support]. I’ll feel like I’m being selfish for talking about my stuff and burdening them. I worry I’m putting too much on them and they’ll get fed up with me. So you kind of just have to bottle it up.

Figure 5. You’re making a scene!

Again, we see help-seeking relations described as a threat to participant’s sense of belonging. Jordan expresses fears that by seeking help he’ll be causing ‘scene’ and this will invite scrutiny, exposure and negative judgement: his problems with depression and anxiety will be seen and read as signs of individual weakness (‘I’m sort of used to how people see me, how they see me as being weak’). We see how

his experiences shame are related to neoliberal norms: the prospect of reaching out and being a 'charity case' positions him as failed and feckless, and such a positioning threatens his ties to the social bond ('no one likes being around a person who can't seem to get over their problems or deal with their shit'). Asking for help will reinforce Jordan's feelings of neoliberal normative failure, and in doing so he'll be considered 'selfish', as a 'burden' and as a 'draining' individual to others. Thus, to avoid shaming relational tensions and having his failure witnessed, Jordan suppresses his emotional expression and restrains it within himself ('you kind of just bottle it up').

As illustrated thus far, a common response to the experience of fracture or perceived threat to relational space within participants' narratives was strategies of concealment and shame-avoidance. That is, to evade (neoliberal normative) failure and to remain within conventional normative categories for as long as possible. Ahmed (2015) explains why being seen to fail can be so devastating: 'to be witnessed in one's failure is to be ashamed: to have one's shame witnessed is even more shaming. The bind of shame is that it is intensified by being seen by others *as* shame' (p. 103). Shame and feelings of failure or inadequacy are intensified when witnessed. Thus, to avoid judgement and further feelings of inferiority, participants remain silent and described their engagement with a variety of coping and emotion-regulation strategies. For example:

> I do things that are probably not too good for me when things get pretty rough. Like, I'll do a lot more drugs, be out there all the time, drinking, doing things I probably shouldn't be doing, go to chill outs[26] [..] I guess it's about me being involved and not on my own. Just distracting myself from my mental [health] issues and loneliness (Theo, service user).

> I use sex badly if I'm having a bad time and take more risks which is quite interesting in its own way. This is probably the first time that I've really admitted to it as well. I'm quite happy and liberal about sex, and not bothered by it for the most part. Because I'm so anxious, I don't get

[26] Refers to chemsex parties. 'Chemsex' is a colloquial term used to describe sex under the influence of psychoactive substances (Bourne, Reid, Hickson, Torres-Rueda, & Weatherburn, 2015).

> the opportunity to get to it all that often, but I certainly know that I've looked for it at the wrong moment when I'm having a bad time. I won't question what someone else is doing because I'll feel nervous to there already. So, like, if somebody tries to have sex without a condom even if I don't want them to, I won't say anything because I fear I'll upset them. So, it can be really bad but at the same time I do have friends that I might sleep with every so often and actually that's really nice and makes me feel a lot better and is really kind of comforting (Olly, service user).

In both extracts, we see emotion-regulation strategies that shift participants' attention from mental health problems or stressful life circumstances to immediate sensations or pleasures. These proximal goals facilitate temporary escape or distraction from negative affect. In the first extract, Theo engages in substance-related coping (e.g., drugs, alcohol, chemsex) to temporarily regulate his moods and to distract himself from his troubles. He indicates that these activities serve a social function and allows him to retain some sense of connection and relationality ('it's about me being involved'). In the second extract, Olly discusses utilising sex in response to negative emotions or when having a 'bad time'. While concerned about his sexual behaviour, particularly with regards to unprotected anal intercourse, sex serves as a distraction from or regulation of negative affect and provides a temporary means of emotional support or validation ('it makes me feel a lot better and is really kind of comforting'). Again, we see the desire to be in connection, included and valued within relational space. In both scenarios, however, these strategies provide short-term effects to momentarily escape those pressures that make them feel unworthy or that they have failed.

Combined, this closing off of the legitimacy to seek support and the relational threat help-seeking can pose, participants' repeated attempts to delay a sense of failed neoliberal normative subjecthood take a considerable emotional toll where non-help-seeking can both incredibly isolating, risky, and deadly for some gay and bisexual men:

> It's a slow progress to becoming more and more isolated, and not being linked in with services because of mental health difficulties. [Gay and bisexual men] isolate themselves and then isolate themselves. It makes, you know, your mental health worse. You get into this rut where you can't see how it would be to access the services or talk to other people. Maybe you're too afraid or embarrassed to do that. You're worried how people are going to perceive you and then it all becomes too overwhelming (Robin, service provider).

Of note in both extracts is how help-seeking can come to be constructed as a last resort: how this process is avoided or postponed to the point of 'distress or 'crisis' due to the affective nature of help-seeking relations. Robin describes the vicious cycle of isolation ('becoming more and more isolated; 'you get into this rut') and how 'overwhelming' feelings of shame and failure and worries of judgement intensify distress ('you're worried about how people are going to perceive you). For many participants, the point of crisis or when they felt unable to cope with overwhelming feelings of failure occurred in, what I term, 'lonely hours': those lonely and isolating stretches of time when participants were alone with their thoughts without interruption, distraction or companionship (e.g., weekday evenings or over weekends). During these periods, they repetitively focus on their experience of emotion or distress and its causes and consequences as they engage in rumination (abstract, self-evaluative self-focus).

This section has demonstrated how the policing of neoliberal norms around individual responsibility come into play during help-seeking, and how shame often functions to delay this process. In order to avoid negative visual judgement and evade being positioned as failed and shame, I have shown how participants often cope and manage increasing distress alone and without expectation of support. Given that help-seeking can pose a relational threat for some, the process becomes a last resort often only occurring at crisis points. In the next section, I look at how gay and bisexual men come to communicate feelings associated with neoliberal normative failure.

4.3 Articulating failure

In the previous section, I demonstrated how gay and bisexual men often postpone and delay help-seeking to the point of increasingly severe levels distress or crisis in order to remain, or fit, within normative strictures and evade a failed subjecthood. Here, in this chapter's final section, I explore the emotional (and resistance) work required to resist a shamed and failed subject position, and to enable a request for help. Furthermore, I highlight gay and bisexual men's experiences and engagement with mental health services and consider their role within the help-seeking process.

Initiating (face-to-face) help-seeking, or accepting that you need support, is, as Danny (service user) puts it, 'a really big job' for some gay and bisexual men. Participants narratives indicate that part of the reason some gay and bisexual men might find it so challenging to seek help is that this process requires admitting to, and articulating complex emotions around, neoliberal normative failure. For example:

> When I first got diagnosed and talked about my problems, it made me feel really lonely. I think when you accept that you have got mental health problems you feel like [sighs] well, I felt like I wasn't good enough and that I was a bad person. I must admit my narcissistic bubble popped when I finally accepted there might be things wrong with me. There's nothing wrong with me exactly, but I am a different sort of person compared to other people and that's hard thing to admit to because it made it real in a way (Danny, service user).

In the above extract, Danny discusses how 'hard' it was for him to admit to, and communicate, feelings around difference or non-normativity. To articulate failure, McDermott and Roen (2016) points out, is to begin a process of subjectification: it is through the telling of the self that the failed subject is brought into being. Drawing on Danny's narrative, by telling himself as 'a different sort of person', he is admitting to having personally failed to 'fit' within normative conventions ('finally accepting there might be things wrong…. I am different') and this failure to be a normative subject comes with a host of negative affects: he feels intense loneliness and 'wrong', not

‘good enough’, and that he is a ‘bad person’. In failing to live up to social ideals, Danny feels shame and this shame, or feelings of failure, are manifested and reinforced by asking for help: he both confirms and takes up a position of moral failure. His failure becomes, as he puts it, ‘real’.

For gay and bisexual men who transgress multiple sociocultural norms (neoliberalism, heteronormativity and homonormativity), there is the possibility of failure on many levels. As such, help-seeking involves considerable emotional and resistance work for some gay and bisexual men to negotiate prevailing and often punishing norms, to reject the notion of personal failure, and to position the self as a subject worthy of help (worthy of recognition and belonging). However, as Chris (service provider) reminds us:

> There’ll be some men who’ll be really comfortable with being open [about their mental health problems or distress] and then you’ll get some who just don’t want to talk about it and who are very stalwart or shtum, I suppose. You know, the spectrum of embarrassment or shame or feeling like you’re good enough to be called mentally ill or that kind of thing.

Help-seeking processes involves, what Butler (2004) calls, a ‘critical relation’ to (sociocultural and emotional) norms that make help-seeking possible for some men. Thus, as Chris indicates in the extract above, some gay and bisexual men, like Joss (service user) in the extract below, may find the threshold to help-seeking less punishing other than others:

> I’ve never had like a fear of therapy or anything like that. Like, when you see in movies when people are in therapy and they’re always against it and like ‘I don’t want to be here! I don’t want to do this!’ and I was like ‘yeah, I wanna talk about my shit! I need therapy!’ [laughs] I wasn’t worried that my therapist might be homophobic or anything.

We remember Joss from the first theme where he discussed his anxiety disorder and ongoing acts of self-surveillance and impression management in order avoid being positioned as non-normative and failed. Despite his anxieties around negative social or visual judgement fuel, in the extract above, Joss indicates that he had 'no fear' of therapy or talking about his feelings of failure and the ensuing anxiety. Drawing on the above meme, he discusses his openness to talk about his shame ('I wanna talk about my shit! I need therapy!).

For others, this process remains more complex. In the previous section, Sam (service user) discussed using sex 'badly' when struggling with his mental health. Here, in the following extract, he discusses feeling unable to raise issues around sex or intimate relationships during therapy and attributes this difficulty to his struggles with masculinity:

> When I was young, and I came out, I was super quick to point out that I'm masc[27]. That I'm gay but not like *those* gays. I'd say that all the time. I'm glad I got over that, but I still have my own kind of issues with masculinity […] I'm seeing a therapist at the moment and we don't really talk about certain aspects of my life. I did not tell [them] about my ex for about 6 months and then when I finally broke down about him leaving, they were like 'what the fuck? You realise your relationship that you've been with for three years just ended? Regardless of how messed up you were, like, that's perfectly fine but why don't you talk about it?' and I was like 'I don't know.' It's a little bit gay. All my stories, I'm very open about being gay but I don't talk about my relationships, I never mention sex. A lady today said I think you should speak to your therapist about sex and I still don't think I can do that and that's more to do with the masculinity issue, I think. Crying really upsets me. There's a part of me that would never judge somebody for crying in front of me necessarily, but I still feel uncomfortable doing it. It's not the masculine thing to do.

[27] He identifies as masculine.

While Sam is able to seek help and his therapist seems quite open to talking about his relationship, Sam remarks how his attachment to (or investment in) certain cultural masculine and emotional norms impact his (in)ability to express emotions around experiences of intimacy, vulnerability, pain, loss, and grief because 'it's not the masculine thing to do'. Open displays of emotions such as crying, for example, fills him with feelings of discomfort, of shame, as it goes against the grain of masculine stoicism: 'it's a little bit gay'. As a result, Sam finds himself unable to speak about or engage with discussions about his sexual behaviours and relations (for example, his break-up, and using sex as a coping mechanism to regulate difficult emotions).

The capacity for critical relationally is facilitated through collective discourses that articulate an alternative, minority version of counter-hegemonic sustaining norms which enable gay and bisexual men to live their lives (McDermott & Roen, 2016). As Casey (service user) explains:

> In the last three years, I've accepted that I'm not perfect and that I actually miss being that happy guy. So, I've kind of gone back a bit from the real like 'oi, mate, you got a problem?'. I've gone back to the middle now. I dress still quite casually, quite masculine, but I'm back in the middle now with my personality being me. So, protection on the one side, and then the naïve, blonde bimbo on the other.

Available resources for mediating and re-appropriating experiences of shame through affective reconnection can be limited for some gay and bisexual men. We know from this chapter's first theme, *punishing failure*, that emotional distress and help-seeking can reveal a fracture within relational space, and highlight a desperate need for recognition and a sense of belonging. What I'm suggesting here is that another reason why some gay and bisexual men feel unable to seek help relates to the way mainstream services respond to their emotional distress and mental health concerns.

We know from the literature that LGBTQ people have challenges accessing mainstream mental health services and support mechanisms. Gay and bisexual men

often report stigma and other negative experiences related to their sexual orientation and/or gender identity, and are less likely to report feeling satisfied with treatment compared to heterosexual populations (Ash & Mackereth, 2013; Guasp, 2013). Nick (service provider) comments on these difficulties:

> LGBTQ people have difficulties accessing services. We get pathologised. So much gets blamed on our gender identity and our sexuality. Even if it's not, we're kind of thinking it might be sometimes. So, some people really find it hard to engage with sort of statutory mental health services or find the help they are looking for within those services because they'll get misinterpreted. I mean, lots of people that use MindOut either have nothing to do with statutory mental health services and have quite a significant mental health needs, and they don't have any kind of support outside of MindOut. Sometimes that's by choice. Sometimes because they're fighting to get that help and support, and they're just not getting it.

As this extract indicates, accessing support can be difficult for some gay and bisexual men difficult' for gay and bisexual men particularly as it relates to the transgression of sexual and gender norms. Additionally, Nick also cites fears and worries of misinterpretation, pathologisation and blame of gay and bisexual men by mainstream mental health professionals. Drawing on Butler's (2004) notion of intelligibility, some queer lives cannot be told heteronormative audiences. Certain non-normative sexual or gender identities, behaviours or experiences may appear unintelligible for those how bear witness to gay and bisexual men's requests for help. For example, Ronnie (service user) highlights how a previous counsellor kept circling his sexuality during treatment despite his iterations that he was happily gay and had no issues with his sexuality:

> I know when I first went to see a counsellor - I saw her for a year, it was once a week, every day for a year - she kept coming back to the gay thing, and I was like 'this is not an issue, stop trying to talk about it', and she was like 'but you kiss girls when you're on your nights out

> and you must have some level of attraction' and I was like 'I just do it because I'm drunk and it's fun'. I'm not questioning my sexuality. I am definitely gay. She kept trying to make an issue and it wasn't. Being gay for me is a such a non-issue.

In the next extract, Jordan (service user) comments on a recent negative experience looking for support from mainstream services:

> It's hard reaching out to [mainstream] services if you're gay. I've never really felt particularly satisfied with them. I've recently had to count on them, and the person I saw didn't really value what I had to say or make an effort to understand where I was coming from in any way. He made me feel like I was being silly, and extra sensitive or dramatic, and making a big deal simply for the sake of it and that wasn't supportive at all. He seemed really uncomfortable with me and I left there in a bad way. I was left to manage on my own.

In Jordan's extract we see how he is constructed as an emotionally excessive subject by the 'uncomfortable' mental health service provider: Jordan is made to feel 'silly' for making 'a big deal' of nothing and being overly 'sensitive' and 'dramatic'. Jordan is made to feel irrational and his distressing experience is un-recognisable here in this interaction. As a result, he's made to feel shame for reaching out and left to his own devices.

Casey (service user) raises similar issues of unintelligible issues with mainstream services, and discusses his preference for enlisting support from MindOut:

> If I've said all the things I've done in my life to a straight person, a woman in her 40's, she'd probably be like 'oh my God!'. Everyone [at MindOut] was like 'oh yeah I know, I've been there'. We have that understanding of each other rather than go somewhere where that person has no understanding of how bad we can be [laughs] but in the gay world it's normal, do you know what I mean? That's a big thing.

> Different kind of culture. Completely. To a gay person, they're like ‘oh my god, girl, yeah, I've done that as well’. You can tell the truth rather than have to bring it in and not be yourself.

In this extract, Casey discusses how a heterosexual person in their 40’s would be unable to relate or comprehend some of his life experiences, that is, they might appear unintelligible, incoherent or shocking. What might these unintelligible and ‘bad’ experiences or practices be? If we remember from the previous theme, Casey alluded a range substance-related coping that included chill-outs/chemsex. Moreover, he’s also discussed experiences of homelessness, escorting, and acting in pornographic films. Such experiences may be a far cray from an accepted or tolerated homonormative gay male subjecthood rooted/anchored in domesticity and consumption (Duggan, 2002). He hints at how, under the gaze of heteronormativity, he would have employ practices of silence and secrecy or camouflage his non-normativity (‘bring it and not be yourself’) in order to remain intelligible and recognisable to a heteronormative audience. However, in need of queer intelligibility, Casey sought help from MindOut. With an audience of like-minded queer people who have gone through similar experiences, non-normative subjectivities can be recognised. Here, he states that he can be himself, engage in genuine interaction, tell the truth, and have his experiences be nuanced, intelligible and recognisable (rather than being stigmatised or marginalised). It is through this experience of recognition that he is constituted as a socially viable human being (Butler, 2004).

Again, throughout these extracts, we see how help-seeking might intensify feelings of failure or shame and threaten existing fractures within relational space. For those non-heterosexual desires, behaviours, and identities that deviate too far from the norm, there seems to remain a violent split from rationality and intelligibility within/by mainstream mental health services. Certainly, LGBTQ+ mental health services provide opportunities for queer intelligibility as Casey suggests above; however, even with the (limited) availability of such services we are reminded that:

> Some [gay and bisexual] men just don't feel robust enough to use our services. They don't feel accepted. Don't feel confident. Whatever it

> might be. Just because we're an LGBTQ mental health project, it doesn't mean LGBTQ communities are particularly supportive of mental health […] as large as we talk about the LGBTQ community in Brighton being, it's still a small community, and everyone sort of knows of each other or have seen one another on the apps, so it can be hard coming forward and talking to someone about their mental health (Drew, service provider).

Drew highlights the importance of understanding the affective nature of (non-)help-seeking relations, and the emotional work required to seek help. For him, help-seeking requires a certain psychosocial security in their identity to enable them access support and partake in the in the transformative elements of shame. Furthermore, Drew highlights service users concerns over confidentiality given the small size of the local LGBTQ community and hints at the role homonorms might play in shame-avoidance strategies and non-help-seeking ('it does not mean LGBTQ communities are particularly supportive of mental health).

In conclusion, this section has demonstrated the emotional and resistance work required in relation to hegemonic norms to resist a shamed and failed subject position, and to articulate a request for help. Additionally, I have also examined gay and bisexual men's experiences engaging with mental health services and how these might exacerbate those feelings of failure and shame some gay and bisexual men are grappling with. It is here that the virtual spaces may provide a significant resource for troubling hegemonic norms and enable help-seeking, particularly in those lonely and isolating periods, and this will be explored in the next chapter.

Conclusion

This chapter considered gay and bisexual men's constructions of their mental health help-seeking more widely in order to foreground the circumstances under which some men come to seek help online. The findings presented illustrate how emotions, norms and relational dilemmas are central to gay and bisexual men's help-seeking difficulties in their offline worlds. Help-seeking, I argue, involves complex negotiation of norms

connected to neoliberalism, heteronormativity and homonormativity. Struggling against all of these normative pressures simultaneously means that there is the possibility of failure on many levels and this restricts the type of help-seeking possible. Help-seeking both reveals and becomes the attempt to resolve a fracture within relational space. This process, however, can intensify feelings of failure and complicate experiences of (mis)recognition and (non-)belonging. As a result, help-seeking is often postponed to the point of crisis or severe distress in order to remain within normative conventions for as long as possible. In the next chapter I turn my attention to gay and bisexual men's experiences seeking help online.

5. Relief

Following on from the previous chapter which foregrounded some of the circumstances under which gay and bisexual men come to seek help online, this chapter deals with the particular nature of seeking help online. It will build on insights from the previous chapter which highlighted the role of shame and failure in relation to gay and bisexual men's (non-)non-help-seeking in face-to-face or offline contexts. Under the rubric of relief, this chapter considers participants' narratives of online help-seeking as a process of social and emotional (re)connection. It is important to emphasise that the help-seeking trajectory described here is not intended to suggest a simplistic or linear pathway from offline/distress to online/relief, as this process is far more complicated. As this chapter will demonstrate, the spaces in which gay and bisexual men feel they can ask for help can be restricted both in face-to-face and online settings. However, given the research sample's predominantly positive views or experiences seeking help online, discussions of the negative aspects of online help-seeking was rather limited.

This chapter focuses on three aspects of gay and bisexual men's online help-seeking experiences that have emerged from the data: first the co-existence of relative anonymity and peer recognition, and feelings of connectedness, which I describe as safer wit(h)nessing; second the capacity for critical relationality that may develop in online environments; and lastly, honing in on participants' discussion of sociosexual relations and practices within online spaces as offering the potential for respite from negative affect or distress, as well as opening up possibilities for a variety of help-seeking strategies.

5.1 Safer wit(h)nessing

In Chapter Four, I established how gay and bisexual men's mental health help-seeking involves a complex negotiation and navigation of regulatory discourses and constraints with regards help-seeking and how this positions some of them as failed and shamed subjects. Some expressed difficulty negotiating these emotions and become distressed, while others do not. Transgressing or struggling against multiple

norms simultaneously not only contributes to the immense difficulties some gay and bisexual men have asking for help, but also impacts on their expectations of any potential help and support they might receive. Furthermore, we have also seen that offline help-seeking can intensify rather than alleviate their emotional distress. In an effort to avoid further feelings of shame or failure they repeatedly normalise increasing emotional distress and engage in a range of coping strategies to facilitate avoidance. Consequently, offline help-seeking behaviour may only be initiated during higher levels of stress and close to or beyond the point of crisis. On the basis of these insights, the following sections considers gay and bisexual men's experiences seeking help and support online regarding their distress and mental health difficulties. In this first section, I argue that part of the attraction of online help-seeking lies in the tension between relative sense of anonymity and peer recognition, and feelings of connectedness. To encapsulate this, I introduce the concept of 'safer wit(h)nessing', by which I describe how participants feel safer expressing emotions online anonymously and feeling that they are being heard, *and* that they are less alone with the burden of their distress or battling of (multiple) normative pressures.

As with offline help-seeking behaviours more generally, participants' narratives indicated that the threshold for online help-seeking was usually crossed when they experienced higher levels of mental distress and nearing or at a crisis point (e.g., suicidal and serious self-harming behaviour, nervous breakdown, severe depression etc.). These crisis events often occurred during what I will refer to herein as 'the lonely hours', that is, periods of time when social interaction and supports, including mental healthcare services, are typically less available (i.e., during the evenings, late at night and/or over weekends). For example, Ronnie (service user) discusses his preferences for online help-seeking rather than a helpline with respect to suicidal distress:

> When I'm at that level, I'm really in crisis and feeling suicidal and needing help straight away. It's not normally just depression that's at play in that moment, but my anxiety is a big issue as well. So, the last time it happened, this was a few weeks ago one evening, I was afraid to leave the house and I also didn't want to change my environment because of the depression. So, I was kind of stuck with the symptoms of both illnesses and picking up the phone is an issue for me then

> because I'll feel anxious about talking and actually speaking with someone on [the NHS] 111 [emergency helpline]. In that moment, I feel like I'm taking up everyone's time and that I'm kind of selfish for talking about my stuff and that I should be better at managing what I'm feeling. I would much rather just type and reach out that way. You can feel less judged if it's online whereas if you are talking to someone over the phone you might hear notes of sympathy in their voice instead of empathy which can make you can feel worse. You might detect things like that [over the phone] which you can avoid online.

In this first excerpt, Ronnie discusses how severe distress – suicidal ideation in this instance – prompts his online help-seeking behaviour. Central to his account is an emphasis on the difficult emotions involved in having to talk about his concerns with someone ('I'll feel anxious about talking and actually speaking with someone', 'I'm selfish for talking about my stuff'), as well as the self-blame and self-criticism for failing to cope and manage his distress alone ('I'm taking up everyone's time', 'I should be better at managing what I'm feeling'). Help-seeking here involves the transgression of neoliberal norms of self-management and personal responsibility which contributes to Ron's emotional distress and difficulties seeking help. Weighing his options for support, Ronnie notes how asking for help online reduces the risk of potential judgement or pitying sympathy (as opposed to empathic understanding) at the other end of a helpline; verbal or subtle reactions which may intensify his distress and reinforce feelings of failure and shame ('can make you feel even worse'). Additionally, Ronnie also opts for online help-seeking as it means he can do so from his home, a place where he feels safer and better able to manage his anxiety and depression.

Similar to Ronnie, Ash (service user) discusses using online settings for ongoing support during the lonely hours when he is more likely to experience distress and engage in self-injurious behaviours:

> I tend to use [MindOut's online support service] about once a week, sometimes twice a week before bed. If I'm in a right state, that's when I need help with this and that's when I normally go online because you get the immediate response and you're not left hanging. I know there

> are helplines, but I don't talk to them. I'm scared it might escalate and I worry about being hospitalised if people find out what I'm doing because, in terms of what I'm going through, it's worse than it's ever been. because I've never done it to the stage where I've had to get medical treatment. I've been in A&E twice and I went to a burn clinic and then also doctors' appointments which I hate. It's difficult with friends because I've only got a couple of friends because I haven't lived here [in Brighton] that long and you never know how people are going to react to or what they might think of you. You know, sometimes I have stigma as well for not coping well and doing this. There's also a queer mental health group on Facebook I often use. Like [this past] Sunday, say 6 or 7 o'clock at night, I was in a situation and I couldn't find MindOut so I used the [Facebook] group instead and that was good to do and I got a few replies on there. I still wound up self-harming in the end, but it delayed it and gave me a chance to try and talk out my feelings with people who have been through it themselves which is what you really need to do because when you bottle things up that's when it gets really dangerous.

In this second quote, the level of distress or problem severity is again framed as a strong predictor of online help-seeking. Ash illustrates how the affective nature of help-seeking, that is, feelings of fear ('I'm scared'), failure or inadequacy ('I have stigma as well for not coping and doing this'), and shame ('what they might think of you'), can make asking for help from offline and in/formal supports seem impossible. In addition to the imagined or actual negative reactions from new friendships, Ash also worries about the potential for coercion (as opposed to individual choice), hospitalisation and psycho-medical intervention where helplines or face-to-face services might enact their duty of care to individuals at risk of immediate and significant harm (i.e., break confidentiality and disclose relevant information to emergency service providers). By contrast, specific digital and social media spaces that connect with similar others such as MindOut's online support service and a mutual self-help support group on Facebook, enable agentic help-seeking during 'crises in progress', and provide an opportunity to get helpful responses quickly. The benefits of and desperate need to 'talk out' his feelings in order to alleviate some of his distress is another critical aspect

of this quote. We know from the psychological and sociological literature suggests that shame is often repressed, disguised, hidden and unspoken in modern Western societies because to recognise shame is to invoke shame (Probyn, 2005; Scheff, 2003). Within this excerpt, Ash discusses how particular online settings provide spaces where ‘transgressive’ emotions such as shame and fear can be articulated, repeatedly, rather than being restrained or ‘bottled’ up inside. In this way, the intense affective state can be released via communication and a sense of connection with a supportive or similar other rather than internalised.

Part of the attraction of online help-seeking is the relative anonymity that certain online environments provide. In the following extract Jordan (service user) discusses how anonymous online forums dedicated to mental health issues offer some relief from punishing norms that might otherwise inhibit help-seeking behaviour:

> I mostly use online forums because they are available through the night which is often when I feel like chatting to people or when I’m feeling really bad. Particularly American ones because there’ll be people active on there during the night that you can talk to. They are anonymous which helps a great deal. I'm fairly okay with going into [support] groups or talking one-to-one and being open about my own mental health history, but it’s a bit of a relief sometimes to have that level of anonymity. You might feel more okay talking about things you generally feel more reserved. So, for instance, I've had an eating disorder since I was very young. It's been a problem that I've had on and off throughout my life so going to groups can be quite intimidating and difficult because you feel like you are going to be judged for how you look as soon as soon as you walk in. Online, you can be quite honest and not feel judged for somebody looking at you thinking, ‘oh, you're too old’, ‘you're too young’, or, now, looking at me and going ‘ooh, male? Really?’. They mostly helped me through talking. The advice or support people gave me was almost not as important as just saying it out there and knowing somebody had read it. Really what I liked seeing was that people had read it, and when they said things like, ‘thinking of you’ or ‘that's really hard to hear’, that almost didn’t

> mean that much. I kind of just wanted to know that somebody was reading it and me getting it down and sending it out there was more of the point than hearing back from other people.

The above extract recognises mental health help-seeking as an ongoing, interactive process of engaging with another – or multiple others – in an 'intensely personal' pursuit to obtain support (Rickwood et al., 2005, p. 8). Although fairly comfortable engaging with offline supports and open to discussing his mental health history, Jordan notes how 'intimidating' and 'difficult' the help-seeking process can be throughout life, particularly in so far as it relates to social disapproval and the transgression of multiple norms in seeking support. Using his eating disorder as an example, Jordan highlights the possibility for visual judgement on multiple levels: body image ideals ('judged for how you look'), age- and mental health-related norms ('you're too young', 'you're too old' to be struggling with an eating disorder or mental health problems), and dominant gender and masculinity norms ('Ooh, male? Really?'). Struggling against all of these normative discourses means there is the possibility of failure on many levels which restricts the type of help-seeking possible, with online settings framed as one of the few options available to Jordan when he is 'feeling really bad' or in distress.

Crucially, Jordan's account also illustrates how a sense of anonymity not only enables him to communicate his feelings, but also facilitates a safer recognition or witnessing of his distress. In McDermott and Roen's (2016) view, is the tension between anonymity and recognition which makes online help-seeking a viable option for some distressed individuals as online settings offer spaces 'where you can choose not to be *seen,* but you can *known*' (p. 134, authors emphasis). Jordan points out how a certain 'level of anonymity' enables an honest disclosure and discussion of his mental health difficulties because there are no visual witnesses to his transgressions or failures. This contrasts with face-to-face settings where he can be seen to be, or positioned by others as, as failing. As we have seen in the previous chapter, shame is a particularly effective enforcer of sociocultural norms because to have your shame witnessed is to have your feelings of inadequacy intensified. This is not to suggest that rejection or judgement does not occur online. Rather, the mediated setting can potentially reduce the imagined or actual sting of such judgement. In addition to feeling more able to communicate his distress online, Jordan also expresses a desire to feel

heard and have his difficulties or experiences recognised (‘knowing somebody had read it’) in dissipating acute feelings of distress. For him, the opportunity for emotional reflexivity (‘me getting it down and sending it out there’) and experience of recognition by another is more important or beneficial here than being helped (‘know[ing] that someone was reading it’). Drawing on Butler’s (2004) ideas of intelligibility and recognition, we can appreciate how difficult it may be to express one’s distress or concerns when you feels outside the norms of recognition. Given his potential transgression of multiple norms, Jordan’s emotional distress may be unintelligible to others and not easily comprehended or taken seriously. In response to this likelihood, Jordan goes online in search of safer and respectful recognition. Online, Jordan be both intelligible and emotional.

In addition to a safer witnessing or recognition of overwhelming feelings such as shame and failure, participants also highlighted how a sense of digital togetherness, or ‘with ness’, as part of the help-seeking process helped ease intense feelings of distress and isolation. For some, like Jordan above, direct interaction is considered less important and prefer a ‘spectator experience’ instead; knowing that their emotional turmoil or pain did not go unnoticed and that they weren’t suffering in silence. For others, a sense of connectedness with an/other was more important; knowing that they weren’t alone with the burden of their distress or mental health problems, and that there was someone else going through a similar experience (i.e., a sense of affective solidary or being ‘alone together’). For example:

> It's like you're not the only one suffering and that, you know, someone else is going through self-harming or anxiety or depression. You can follow the thread and contact them. If somebody puts something up and I think I can contribute or help, then I'll reply. There are times when I put my own [post] up particularly if I'm going through a really tough time and the MindOut [virtual support] helpline isn't on that night or it's too late. I’ll put something on there, hoping someone might reply and give me an idea or just a bit of support. You do get some good responses on there. I had one where I was putting up about the self-harming problem I've got and someone put something up saying ‘I'm sorry you're going through this’, and ‘have you tried this distraction?’

> or ‘who are you in contact with?’. You know, things like that and, you know, just people replying to that [post]. It's about getting that little bit of support which I need because it's not great at the moment (Ash, service user).

In addition to sharing and receiving support for his difficulties, Ash also describes helping others manage their emotional reactions to stressful situations. While it is likely that such contributions can generate psychological benefits (i.e., practice and hone emotion regulation skills, which can then be reapplied to their emotional lives) (see Doré et al., 2017), in the main this extract highlights how a sense of togetherness or with ness (rather than isolation or ‘apartness’) can play in generating some relief from their mental health challenges and feelings of isolation (‘it’s like you’re not the only one suffering’, ‘someone is else is going through [it as well]’). This emotional connectedness is based on sharing or coming from similar positions in terms of their mental health problems and/or being LGBTQ. In this way, the intense affective state can be ease via communication and a sense of connection with supportive/similar others who seem to care and understand, and does not blame them for their difficulties. This relational reciprocity helps bridge the double movement shame undertakes ‘towards painful individuation [and] uncontrollable relationality’ (Sedgwick, 2003, p. 37).

Upon reflecting on our discussion, Ash shared the following meme in a later online interview (see Figure 6 below). Although not adding any additional commentary, the image aligns well with the above extract. Here, we can we how connection, validation and acceptance – the anonymous other validating a person’s feelings and expressing empathy for their negative experiences – can offer some relief for those who are coping with emotional distress or mental health-related difficulties. This co-presence is a restorative form of sociality which can ease feelings of disconnection, marginalisation and isolation. Altogether, the findings within this section points to the importance of online help-seeking interventions that generate a sense of emotional and social connectedness for gay and bisexual men, particularly during the lonely hours.

Figure 6. Validation from people I don't even know on the Internet.

To summarise, this section has established how a sense of safer wit(h)nessing, that is, the co-existence of relative anonymity and peer recognition, as well as feelings of connectedness, allows for agentic help-seeking during 'crises in progress' (Webb, Burns, & Collin, 2008). Online help-seeking provides access to spaces which trouble hegemonic sociocultural norms and a less threatening recognition of 'transgressive' emotions such as shame and failure. Furthermore, the threshold for online help-seeking was often crossed at a crisis points and more likely during 'the lonely hours' when little in/formal support was available to them. This particular finding corresponds with gay and bisexual men's help-seeking behaviours more generally as evidenced in the previous chapter. Yet, where asking for help from offline support mechanisms or services can reinforce a sense of failure, online resources provide spaces for emotional reflexivity and the unburdening of emotional turmoil.

5.2 Critical relationality

In addition to safer wit(h)nessing, distressed gay and bisexual men also use digital and social media to (re)engage in, or help facilitate, a critical relation to punishing sociocultural norms as part of the help-seeking process, and to alleviate their distress or feelings of failure and shame. As a starting point to this section, it is worth noting

the early adoption of digital and social media settings by gay and bisexual men when dealing with distressing emotions. For several participants within this study, online spaces presented a crucial lifeline or resource during the coming out process; a process which can be particularly isolating, anxiety- and stress-provoking time for some:

> So, when I was a teenager, most of the people I came out to was through MSN and MySpace and only to people I trusted. I think I met my first boyfriend on MySpace. If you are straight, you can meet people and have relationships, and it is kind of just normal. But when you're gay you are almost too scared to do that because there's so much homophobia around and you'll be questioning whether the person you like is actually into men. It's just so much shit you have to figure out, especially when you are a teenager. It's just too much too process and it was just so much easier for me to talk to people online and, to be honest, that hasn't changed much. I don't know how to meet people in the real world, really. I don't know how that works. I don't know how to flirt [laughter]. I do pretty much all of my dating online first, initially, because I've never really learned to do it any other way. I've always been a bit of an introvert and my anxiety and stuff has always been a bit of a blocker for me […] There's a certain element of risk-taking involved and I think when you suffer from an anxiety disorder, you don't want to take risks ever. I don't feel like I'm as stunted, if that's the right word, like I was back them, but I definitely do rely on [social media] a lot still (Sam, service user).

This quote demonstrates that the online environment is generally associated with a sense of safety when compared to other social environments. It was the preferred environment for Sam to take the step to come out. And it is their preferred environment for social activities that have elements of risk, such as risk of rejection or risk of miscommunication, or risk of embarrassment, such as dating. So, we see here how participants situate their online help-seeking within a larger history of digital and social media use, particularly during stressful periods such as the coming out process. Although Sam describes his fears of homophobic rejection in navigating and

establishing different relationships, the wider issue of heteronormativity suffuses this account as Sam discusses how heterosexuality is configured as public and perceived as normal or natural. As is evident in this account, a navigation of these contexts can take a considerable emotional toll (it's just so much shit you have to figure out… it's just too much too process').

Another participant's statement also illustrates how important the internet is to them as an emotional resource in a wider sense and not limited to particular moments of emotional crisis:

> I found out about being trans when I was twenty-three and found that out through the Internet. I was googling for something else and came across a trans website and I was like 'oh my God, this make so much sense'. I don't think there was any other way or resource at that time that was available to me. I mean, like, occasionally there would be stuff on TV, but, yeah, it was through that website that I sort of found that out through that and that changed my life quite a bit [laugh]. It was a FTM[28] Yahoo forum group which doesn't exist anymore and it had people from all over the UK on it. That became my base really for quite a while. It's where I got all the information, and again there was nowhere else really where I could have gone and hung out with other trans people. I mean, there may have been other groups, but they were hard to find and weren't around twenty-four hours a day. This [forum] was a place that was just there, open 24-7, where you could search for answers and get some support. It was a lifeline, really (Chris, service provider).

Chris emphasises how the internet has been more or less the only place for gender questioning individuals to access information that is produced by the trans and non-binary community for the community and as such it provides a unique resource described here as transformative. The social dimension of online counter publics is

[28] Female-to-male

also emphasised as a ‘lifeline’ in that it is experienced as a support that is ‘always there’.

In the next quote, Sam (service user) discusses how he came to think differently about his difficulties with anxiety through online help-seeking and engaging with online supports:

> The main thing that I take from it is that anxiety is a normal thing to feel. That it’s a side effect of stuff you've experienced and I think, for me, putting that into perspective and making it seem rational when, you know, the message you get from people is that it’s abnormal and not the right way to feel. That there’s something very wrong with you. But they’ve made me realise that when you look at it like you've had traumatic events happen to you and this is why you are anxious, you can kind of rationalise it a bit. That’s kind of come through with my conversations with other people online, and it’s good to be reminded of that when you are kind of going through it.

In the above extract, Sam illustrates how anxiety is generally regarded as an abnormal psychological state and a sign of individual or personal pathology (‘it’s abnormal and not the right way to feel… there’s something very wrong with you’). It is through his conversations with similar others online that he comes to forge a new understanding of his anxious or distressing feelings. Within this example provided, anxiety is reframed as an understandable response to traumatic events or stress which is beyond his individual control. It is through this reframing that he avoids or distances himself from being positioned as a failed, shamed subject. Similarly, in the following quote from an interview, Theo (service user) talks about his reasons for reaching out to MindOut’s online support service, as well as an ongoing engagement with other online supports who have been through similar experience:

> It was covering both angles, I suppose. I was admitting that I had mental health issues and struggling with my sexuality and mental health, so obviously I thought, well, [MindOut is] where I need to go. Double whammy, covered. I suppose I was hoping that it would help

> me learn to accept it. I've also been searching for other people online who've been through aversion therapy and I'm chatting to a few of them who have been telling and sharing their stories with me. It's been good to hear someone else's journey […] That's really helped, because you're talking with people who are likeminded, who can understand the issues that gay people have. That can understand how a gay person thinks, the problems they might have where the heterosexual person might not be able to get their head around.

In his need for queer intelligibility – both in terms of his sexual orientation and mental health-related difficulties – Theo discusses going online to seek help and support. In addition to using MindOut's online service, Theo is also looking to make sense of the harmful impacts of gay aversion therapy by searching out and sharing his own narrative and journey with others online. Through these interactions, new terms of understanding can be forged where normative pressures are put into a different perspective. As a result, a critical perspective on heternorms becomes possible.

The broader point within these narratives is that recognition online takes place through communication and virtual interactions where struggling or distressed gay and bisexual men can develop or (re)engage in, what Butler (2004) calls, a 'critical relation' to punishing norms. The capacity for critical relationality online involves access to collective discourses that articulate an alternative or minority version of counter-hegemonic norms which enable some relief from shaming affective practices, whether only temporarily or in a more sustained capacity. It is through these interactions and collective negotiation that a reworking of negative affect becomes possible where emotions such shame may be open to 'reframing, refiguration, transfiguration, … and deformation' (Sedgwick, 2003, p. 63). Consequently, new ways of responding to norms can emerge. Yet, as Johnson (2015b) notes, and is evident in participants accounts, such experiences are highly dependent on accessing cultural resources that enable the reconfiguration of the affective state.

Another point in participants narratives is the that the spaces in which gay and bisexual men feel they can ask for help or discuss their mental health-related challenges seem restricted, both in face-to-face *and* online settings. In the following quote Joss (service

user) compares several SNSs and discusses his preferences for Tumblr in relation mental health help-seeking:

> I feel the most included on Tumblr, I think. I prefer it. I think's it's one of those spaces where I've found like a lot of like-minded people. It's one of the spaces I feel the most comfortable and free to be in. It does have its bad side, I guess. People still stick with it because of the environment it is. I feel like twitter is more for following celebrities and talking about what's happening in the world. Facebook is difficult because it's more like friends and your family. So, you are less able to be free on those two, where[as] on Tumblr people are able to be themselves more freely. It's very gay and people can go on rants. They talk about most aspects of their lives. It's not just about portraying the best version of yourself, because it's more anonymous. They talk about their depression, their anxiety, their feelings and the issues they face, and that's where I post when I feel bad and when I feel depressed [Willem: What do those posts look like?] I mainly reblog things. I feel other people can articulate things better than I can. I feel like I can't say things in the most accurate way, but I feel like a lot of the posts I see they really analyse things in a succinct way that I like.

In the above extract, Joss demonstrates an awareness of implicit social norms and how these operate differently according to specific SNSs. Facebook and Twitter are both positioned by Joss as spaces in which he is less able to be himself in terms of his sexual orientation, emotions, and mental health difficulties. Facebook, in particular, is problematic in this respect as it involves 'known networks' (i.e., family and friends). Although Facebook promotes access to diverse social contacts who serve as emotional support providers, Facebook users indicate that posting overly emotional statuses in order to receive support is a violation of implicit norms on the platform (McLaughlin & Vitak, 2011). The appeal of Tumblr for Joss revolves around its relative anonymity and its function as a virtual counter public, that is, a discursive space that enable marginalised groups' articulation and 'interpretations of its members' identities, interests, and needs' in opposition to a dominant public (Warner, 2002, p. 119). As

Joss notes, not only is Tumblr 'very gay', but it's a space where he and other users are able to explicitly and directly vent their affect and discuss their mental health problems. Tumblr provides a space for Joss to escape the punishing requirements of having to maintaining the best or idealised version of himself. Joss also expresses his difficulties articulating feelings related to his depression. The notion that men, in general, are socially conditioned not to engage in emotion-based communication and, as a result, experience difficulty seeking help and communication emotional pain in therapeutic or other settings is a common theme literature (Seidler et al., 2016). For Joss, the textual and visual materials published on Tumblr by other platform users in relation to their mental health difficulties provide a creative means for him to not only access emotional reflexivity but communicate or express his personal challenges and mental health experiences by reposting these materials onto his microblog.

Other participants discussed using SNSs as a way to facilitate critical relationality among their social networks. In the following quote, Casey (service user) discusses his motivations behind creating his own private support group on Facebook during an interview:

> I've made my own support group. There's only 7 or 8 people on there so it's really small but, for me, it was about my family and friends. I wanted them to understand because they don't ever seem to understand. They just think I'm being unreasonable and a cunt sometimes when I'm not. Sometimes I do or experience things differently than other people, and I want them to look into it a little more and understand why I am the way I am, you know? It's a way for me to explain or give them information about my anxiety and agoraphobia, and ADHD[29]. I mostly put up funny pictures or funny little quotes or useful information and links I've found. I'm always making something funny out of something bad in my life and I use the group for that. I think the way to get people to understand is to make it normal, and the way to make it normal is to laugh at it or to find some way to relate, you know, some common ground.

[29] Attention deficit hyperactivity disorder

In this above extract, Casey, rather differently from Joss, discusses taking advantage of context collapse. Importantly though what is described is an intentional collapsing of contexts, or what Davis and Jurgenson (2014) describe as, context collusions. Establishing an online forum, in this case a Facebook group, to inform close family members and friends about their mental health struggles, often through positive (e.g., affiliative and self-enhancing) humour[30]. In doing so, he hopes to become more intelligible and less stigmatised within his immediate support network. In addition to using humour as an adaptive coping strategy to reappraise negative emotions or situations within his own life, he uses humoristic digital artefacts to reframe norms and shaming affective practices within his immediate relational context. He notes how his family and friends fail to understand his different ways of being and doing and position him as nonnormative, unintelligible, or, as he puts it, an irrational 'cunt'. By using humour and by mediating his own discourse via the Facebook group, he hopes to become intelligible by fostering or facilitating a critical relation among his family and friends, which also involves facilitating a critical reflection of hegemonic norms that can hopefully lead to a reinterpretation of his mental health difficulties.

In this way, social media can offer a modest and contingent social intervention where norms can be reworked to reframe distressing emotions and situations through affective practices. The concept of 'affective activism' is particularly useful here in elucidating how textual and visual social media content as a form of mental health activism can open-up possibilities for critical relationality. Originally proposed by Allison (2009), affective activism refers to practices that offers the potential for surprising, hopeful and sustaining connections across identity differences. Drawing on this concept, Johnson (2011, 2015b; 2013) demonstrates how a visual and aesthetic projects – a photo exhibition featuring images and text by LGBTQ mental health service users – offered a social intervention via the affective realm. An analysis of viewer feedback suggesting the event enabled an 'affective connection' between viewers and research participants, where viewers described being 'moved' and 'touched' by the display. Representations of gender and sexual identities were

[30] Compared to more negative (e.g., aggressive and self-defeating) humour styles (see Samson & Gross, 2012).

downplayed in viewers' responses, focusing instead on their own memories and narratives of psychological distress. For Johnson (2015b), affective activism 'opens up to the possibility of finding new forms of relating across identity differences, while remaining how we might be presented' to others (p. 170). In other words, Casey uses these digital artefacts to explore and find commonalities, to cut across identity differences and engaging in subversive action, in order to disrupt often uncontested normative practices and provide spaces to become intelligible.

This section has demonstrated how gay and bisexual men use digital and social media to (re)engage in, or help facilitate, a critical relation to punishing norms as part of a more (broader)conceptualisation help-seeking process which does not solely encompass the initial act of seeking help, but additionally involves participants' experiences of online support. This critical perspective, facilitated through counter-hegemonic sustaining norms, enables a potential reframing of those pressures which make them feel that they have failed and thereby providing a sense of relief from it. While the first two themes within this chapter has focused on more active help-seeking strategies, the next and final section will consider how online help-seeking may be directed by a variety of strategies.

5.3 Sociosexual respite

Thus far, this chapter has considered gay and bisexual men's digital and social media use more widely in relation to active or intentional mental health help-seeking and a variety of online settings (e.g., forums, Facebook groups, one-to-one live chat interventions, Tumblr etc.). In this final section, I restrict my analysis to sociosexual networking sites or apps that specifically cater to gay, bisexual and other MSM (e.g., Grindr, Gaydar, Scruff, Recon, Fitlads etc.). Specifically, I consider some participants discussions of sociosexual relations vis-à-vis these spaces as offering some respite from negative affect or distress, as well as opening up possibilities for help-seeking and support through varied pathways (i.e., how help-seeking can be directed by a variety of strategies).

In the following quote from an interview, Drew (service provider) discusses how gay and bisexual male service users described their use of niche SNSs to him in relation to their mental health difficulties:

> Some of the men that I've spoken to say they use things like Grindr and other apps and would say 'I just wanted a shag' or 'I just wanted sex' or whatever. But, when you actually start scratching the surface a bit more there with them, some men have spoken to me about their lack of confidence, their social anxieties, their lack of self-esteem, the difficulties they have meeting people socially. So, these apps kind of bridges some of that in that allows men to approach other men in a way that they feel safe doing. That they wouldn't do in any other context. It might be about trying to have a shag in that sort of instant, quick way, but if you kind of scratch the surface more with them they start to talk about the some of the reasons why they are looking to make that contact in the way they are. Some of our service users have told me that they use the apps as a way of distraction when they are feeling suicidal or as a way to get through those feelings, or in the hope that someone will give them the attention they feel they need to, you know, feel a little bit better about themselves. They might engage in a conversation with someone on the apps who might be supportive, or they might try and arrange to meet up with someone to have some contact, you know, physical contact, that might make them feel better.

The above extract highlights two important points that will resonate throughout this section. First, it provides a nuanced understanding of these spaces and into gay and bisexual men's relations with one another which construct 'a specific sphere of sociability and amiable acquaintance among men in urban centres that prioritises sex as a principle mechanism for connection and sociability' (Race, 2015, p. 271). As Drew points out, while erotic encounters are often foregrounded by gay and bisexual men using these platforms, they can lead to social and communal potentials. In other words, sexual encounters can mediate a sense of sociability and connectedness among gay and bisexual men (i.e., a sexual sociability). Second, it illustrates how mental health help-seeking can be directed by a variety of strategies. For instance,

Drew's perspective reflects understandings within the psychotherapeutic community that view some gay and bisexual men's casual or compulsive sexual activity as due to emotional pain or woundedness. That is, sexual thoughts and urges can be used by some men as method of avoidant-orient help-seeking and coping in response to negative emotions or mental health concerns (Jerome et al., 2016). Additionally, the quote also highlights the potential for informal sources of support on the platform ('they might engage with someone… who might be supportive'). This contrasts with public debates that generally position gay/bisexual male-specific SNSs as negatively impacting on gay and bisexual men's mental health (see Turban, 2018, for example). These varying help-seeking strategies will be explored in further detail below.

Similar to Drew's account, some gay and bisexual men within this study suggested that niche SNSs provided a way to cope with, or distract from, feelings of isolation, loneliness, and increasing distress. For example:

> It's surprising that we're talking about this because I've recently noticed that I maybe don't use apps like Grindr in the most appropriate or healthiest of ways, especially when it comes to my mental health, I guess. It's been rough lately because I've been going through a breakup, feeling depressed and having really anxious spells where I have difficulty leaving the house and getting on the platform at the train station because there's too many people looking at me. So, yeah, I have been feeling quite isolated and in a pretty bad way, and I would notice that it's these kind of moments when everything reaches a boiling point that – before I even realise what I'm doing – I am on Grindr chatting away in a very sexual manner or trying to get someone to come over to mine for some fun. You can feel really good after. I've had some good experiences where I've met really hot guys and you feel better about yourself because they are attracted to you and want to spend time with you, and it could lead to other things. Other times, you feel guilty or awful after […] I'm not quite sure what to make of it, to be honest. I guess I am kind of use them as way not to be on my own and forget everything else that's going on with me. There's

> always someone on [the apps]. Doesn't matter the time of day (Olly, service user).

What is apparent in this account is the ways in which shame can inform practice. Not only does Olly's account demonstrate a desire for concealment particularly in so far it involves dealing with crowds of people and the potential for visual judgement ('I have difficulty leaving the house and getting on the platform at the train station because there's too many people looking at me'), but he looks for ways to navigate and minimise his distress and shame. In large part, this involves an engagement in sexually compulsive behaviours ('before I even realise what I'm doing') at what he describes as 'boiling points', or high levels of emotional distress and an intense sense of isolation. For Olly, such sexual interactions help facilitate escape or avoidance of negative affect and stressful life circumstances. In this way, sexual encounters can be used to shift one's attention to immediate sensations and proximal goals. As is evidenced within this account, such forms of avoidant help-seeking can be positively reinforced as it increases the likelihood of having a sexual experience that serves as a source of sexual pleasure or emotional validation. Alternatively, the guilt and shame engendered by sexual compulsive acts may also lead to more stress, anxiety, or depressed mood. Given earlier findings within this chapter that online help-seeking is more likely to occur during the lonely hours, the capacity for sexual encounters – whether on- or offline – as a distraction/escape-oriented strategy is perhaps more available and accessible than offline supports during these periods given that these spaces are at their most active on weekday nights (see Goedel & Duncan, 2015, for example).

Perhaps to bolster the above extract, Olly passed along several images in a follow-up online interview. Accompanied by the message 'see? I'm not the only one', some of these included screengrabs of other user profile biographies on gay/bisexual male-specific apps which suggested a similar link between mental health difficulties and sex as a form of escape. For instance, one profile states the user's suicidal intent and encouraged others on the platform to take advantage while they still could. Another indicated difficulties with depression and longed for other men to 'pound' him back to reality. While I have excluded these from reproduction here for ethical reasons (see Chapter Three), another image was particularly relevant to this discussion (see Figure

7 below). Showing two men engaged in sex, the widely circulated GIF or meme is captioned ‘when you’re mid hook-up and you realise the intimacy you’re experiencing only temporary’. The comment ‘don’t cry, stupid’ reflects both masculine gender role socialisation expectations of restrictive emotionality, and avoidant or escape-oriented coping strategies to assert and preserve their masculinity where sex is seen as a way of coping with stress among men (Liddon et al., 2018). Consequently, sexual compulsivity as a form of avoidant help-seeking can limit men’s ability to address concerns in the short-term and, in some circumstances, contribute to longer-term vulnerabilities (or it may not). Furthermore, the GIF also highlights arguments that mobile technologies has led to the commodification of intimacy whereby committed relationships are replaced by fleeting connections (Bauman, 2003). This echoes the often temporal nature of gay and bisexual men’s sociosexual relations where these GSN apps are designed with a focus on short-term attraction based on geographic proximity (Albury, Burgess, Light, Race, & Wilken, 2017)

Figure 7. When you are mid hook-up and realise the intimacy you are experiencing is only temporary.

For others, the need for validation from others is less focused on actual sexual contact, and more so on random chat to distract from difficult periods. For instance:

> I talk a lot, and I don't meet people. I'm one of those people who in the moment are like 'yeah, yeah, okay cool, yeah', and then I lose my confidence [to meet]. I just bottle it and I'm like 'I can't do this'. I literally can't do this because I'm fat. It's one of my things, that my weight is connected to my mental health. It's weird, I use them quite a lot and I talk to people, and I come across as a bit of a whore, but I'm not. I talk a bit like a whore. I don't mean to, but I actually do. People must think 'oh, you're a dirty slut', but I haven't had sex in like forever. So, for me, it's more like I just want people to message me. I want that connection. It's nice going on there and having people text you and be like 'oh, you're really attractive. I'm really into you'. It usually turns sexual very quickly. Even if the conversations I have is to make friends or whatever. It's a good distraction to have from whatever else is going on and making me feel bad, I suppose (Casey, service user).

A prominent form of exclusion from neoliberal sociality produced through homonormativity relates to men and body image norms where the fit, masculine, and toned body in queer masculine culture operates as a measure of norm (Cover, 2012). While ultimately hesitant to meet other users offline because of his body image dissatisfaction, Casey discusses engaging in random sexual chat to gain a sense of connection and validation from others ('I want that connection'). Again, we note how sexual interactions serve as a form of distraction from 'whatever else is going on and making [him] feel bad', and provide a mechanism for a sense of connectedness and sociability with other gay and bisexual men.

In addition to nonadaptive or avoidant help-seeking, other help-seeking practices were also apparent in participants narratives. In the following quote from an interview, Danny (service user) discusses how Gaydar opens up the possibilities for self-disclosure to other users and 'honest conversations' around his difficulties with PTSD:

> I'm a gay guy who's struggling to accept being a gay guy. I'm not straight. I'm gay. I'm sort of trying to force myself to accept it because I'm fed up with being in the middle. At 22, I had conversion therapy and now I have this kind of block which really pisses me off. I'm sort

> of wanting to be found attractive, wanting to be liked, but can't cope with too much involvement from other [gay, bisexual or MSM]. That came from the PTSD diagnosis last year. I struggle with wanting a relationship, but I can't seem to have one at the moment, because of this. The aversion therapy really did its job. The bastards. There's probably about four guys on there that I chat to in a private chat, and they're very attractive sexy guys, and because they are far away, it's safe. It's nice to know you can have a chat with someone who's what I call safe, who is okay. They are quite a way away so we're probably not gonna meet up. They aren't suddenly going to be in my life. Even though we haven't met, I can have really honest conversations with them. You know how when sometimes you are in despair and you suddenly meet a stranger, you'll talk whatever because you don't know them and there is no emotional connection? It's a bit like that.

Danny's anger and frustration with harmful after-effects of conversion therapy is clearly apparent within the above extract. As evidenced here, Danny continues to experience difficulties in accepting his sexual orientation as a gay man and forming relationships with other gay or bisexual men. Wanting to be found attractive or liked but unable to cope with what he describes as intrusive social and emotional involvement, a sense of distance and emotional safety is particularly important for Danny in opening up the potential for uninhibited, 'honest' and in-depth conversations with others on the platform. In the next quote, Danny discusses how sexual sociability can enable different types of help-seeking strategies:

> I have had a few conversations on there about my mental health. This one guy I talk to is in a relationship, and he likes leather and kink. He likes to dominate. We were talking about sex and I was having a really indecisive day and with a lot going on and he said, 'what's going on? I can tell something is up', and responded 'well, do you really wanna know? It's quite heavy?', and he said 'no, that's fine. Tell me'. Well, I started talking about my PTSD and he said that he understood and knew where I was coming from. So, we had this really surprising chat then and there which was really helpful to me in the moment. It was

> good having someone to talk to. We have had some really in-depth chats on there since then. He said he hasn't gotten anyone to talk to who likes to go into it deep, and I do like to get into deep conversations as part of my sensitivity, so we have some really good chats, and then I might not speak to him for a couple of weeks. I've also have another friend on there, well, I call him a friend even though we haven't met, and we've talk about it as well. He's shared his difficulties with depression with me. We also talk about sex as well. So, yeah, there's two people I feel safe discussing it with.

The above narrative indicates how mental health help-seeking can involve varied pathways such as chance, that is, where some gay or bisexual men such as Danny may not actively or intentionally seek help for mental health concerns but become the recipients of help and support. Discussing another acquaintance, Danny points out how they share their experiences and provide each other with mutual support. Again, the temporal nature of gay and bisexual men's online interactions with one another are noted in the extract above, where Danny and his friend might have some really good and supportive conversations, and then not speak again for weeks.

Similarly, and to circle back to Olly's earlier example of the screengrabs of other user profile biographies, public-facing mental ill health disclosures on the platform can be read as a way to 'welcome care' from others on the platform. For instance, in the following quote Olly (service user) responds an individual experiencing suicidal ideation:

> Sent a message to the suicidal guy to check if he was okay because I was worried [and we] talked about MindOut which he didn't know about. Checked if he wanted their website and online support [service] details and sent a [hyper]link through to him. He appreciated me looking in on him and wrote that he got in touch with them.

The above extract reflects a 'supported choice' pathway, where individuals actively decide to seek support with the advice and encouragement from others. Here, Olly, with the permission of the individual experiencing suicidal ideations, offers contact

information of an appropriate service (i.e., MindOut). Mental health disclosures on these platforms may be more prominent given the sliding scale of anonymity of anonymity provided, as well as the more common occurrences of mental health difficulties among gay and bisexual men.

To summarise, this section has demonstrated how sociosexual relations on niche SNSs targeting gay and bisexual men may offer some temporary relief from feelings of isolation and mental health-related concerns. The broader point within this section is that a variety of mental health help-seeking strategies are occurring in gay and bisexual male-specific SNSs and this suggests opportunity for intervention where help-seeking services or resources can be put in their pathway. As such a presence on these platforms may be an essential dimension for organisations or services engaged in mental health outreach work with gay and bisexual men. The potential for these spaces in facilitating online peer-led outreach and support work with gay and bisexual men are considered in the next and final analysis chapter.

Conclusion

This chapter illustrated gay and bisexual men's experiences seeking help online for mental health-related difficulties. Once again, it suggests that emotions, norms and their management are central to some gay and bisexual men's mental health help-seeking, and their preferences for online help-seeking in particular. The analytical insights indicate that gay and bisexual men go online to seek relief online from their distress or negative affect through a range of help-seeking practices which involve safer wit(h)nessing, critical relationality, and sociosexual forms of respite. Taken together, these help-seeking strategies point to a desperate need for gay and bisexual men *to be in relation* with others, rather than being in isolation, shame and distress. That is, relief is experienced through a sense of social and emotional connectedness. In this way, online social and cultural resources can offer some relief and escape from punishing norms, even if only temporarily.

Importantly, gay and bisexual men's preferences for relationally oriented and peer focused online supports stands in stark contrast to the prioritisation of individually targeted e-therapies or self-help interventions by policy and practice (see Powell,

2016; Rozbroj et al., 2014, 2015). This may reflect previous findings that sexual minorities are among those who most need and benefit from supportive social relationships. For instance, Hsieh (2014) suggests that, due to increased family and peer rejection, sexual minority men are more likely to have restricted social networks and reduced levels of social support and, as consequence, may reap more mental health benefits from social and emotional support (Hsieh, 2014). Therefore, relationally oriented digital and social media interventions may be better placed to help facilitate gay and bisexual men's help-seeking and improve their mental health outcomes.

That online help-seeking is often prompted by higher levels of distress and crisis points, during the lonely hours in particular, is another important finding. This extends previous research and understandings of help-seeking more generally to online forms of help-seeking (Dearing & Twaragowski, 2010; MacKay et al., 2017). While the threshold for help-seeking may be pushed to a point where some gay and bisexual men struggle to initiate offline help-seeking, the findings indicate that space- or subject-specific online settings allow for agentic help-seeking and provide opportunities to work through 'crises in progress'. While crisis points or events can of course occur at any time, participants narratives suggest that these often peaked during the lonely hours as has been found elsewhere (Mental Health Taskforce, 2016). It may be that social interaction during the day can aid distraction or escape from emotional turmoil and generate feelings of connectedness, whether it is simply being around or interacting with other people. By contrast, night times or weekends generally offer limited social interaction or support for those who are more socially isolated, and feelings of disconnectedness, shame and failure can spiral into intense distress if the affective state cannot be released via connection and communication with an/other. Furthermore, given the limited availability of social and after-hours LGBTQ-specific support late at night and over weekends, it is not surprising that these are often described as particularly difficult hours for dealing with distress especially among those gay or bisexual men feel more socially isolated. Although gay and bisexual men report high A&E service utilisation for acute distress related to mental illness (Sánchez et al., 2007), research suggests that emergency service providers are often underprepared in responding to their unique needs and this results in poor healthcare experiences (Blackwell, 2015; Hudson-Sharp & Metcalf, 2016). This sense of disconnection from services and people that matter means that 'alternative' online

connections become very important as part of the help-seeking process for some gay and bisexual men.

Following on from these insights, the next chapter considers the possibilities and challenges of online outreach work with gay and bisexual men in the context of community-based and peer-led mental health services.

6. Support

While there has been increasing research and debate on the potential of online ICTs in mental health support, limited data has reported on the working practices of community and voluntary sector organisations operating online (Elison et al., 2017), particularly those that specifically cater to the needs of sexual and gender minority individuals (Fantus et al., 2017; Haas et al., 2011). In this final analysis chapter, I examine the ways in which online settings are currently utilised by a LGBTQ mental health support service to facilitate help-seeking among gay and bisexual men. Following on from the insights in the previous chapter which highlighted the importance of relationally oriented digital interventions with this group, this chapter addresses the possibilities and challenges of digital and social media to help generate and support outreach work with gay and bisexual men in the context of peer-led services.

The data presented in this chapter is based on the digital practices of my community partner, MindOut. While I have provided a description of the organisation and detailed their involvement elsewhere (see Chapters One and Three), a quick overview here might help contextualise some of the discussion further along in this chapter. As a reminder, MindOut is a Brighton/UK-based mental health service run by and for LGBTQ people with lived experience of mental health problems. The charity offers a host of services including information and advice, advocacy, peer support groups, peer mentoring programmes, suicide intervention, wellbeing courses and workshops, and, more recently, an in-house counselling service[31]. Online, MindOut operates across a broad range of digital and social media platforms. As such, the organisation presented a unique opportunity for the investigation of digital outreach work with gay and bisexual men. The images presented in this chapter and hereafter as it relates to MindOut are my own screengrabs of their outreach initiatives.

[31] While the majority of MindOut's service are free at the point of delivery, their counselling service is operated at a cost with fees calculated on a sliding scale based on an individual's income and circumstances.

This chapter is structured according to three sections. I begin by outlining the development and delivery of MindOut's bespoke online support service, noting how factors related to anonymity, confidentiality and formalised peer support encourage gay and bisexual men's help-seeking. Thereafter, I explore the organisation's social media outreach practices across a range of platforms, both mainstream and niche, and noting how their thinking is directed towards increasing rather duplicating their outreach efforts through these means. Finally, I illustrate the (productive) tensions in undertaking online outreach work with gay and bisexual men.

6.1 Delivering a peer-led digital mental health intervention

In Chapter Five I established that the threshold for online help-seeking by gay and bisexual men is usually crossed through the occurrence of crisis or (increasingly) severe mental distress during, what I describe as, the lonely hours, that is, more socially isolating periods when interactions with others or services are typically less available. This vacuum of after-hours LGBTQ-specific or sensitive support was similarly noted by MindOut as part of their practice and served as a catalyst behind the development of their bespoke online support service. As Drew (service provider) recounts:

> There was an opportunity to apply for funding and we had a conversation whether we could do an online support service or not. What we were heard from people using our services was that there was a need for an out-of-hours service that could provide advice and information, and also emotional and crisis support. They were saying that there wasn't enough support around, especially after working hours and certainly not anything LGBTQ-specific. They found it quite hard to talk to people during these times and were feeling quite isolated. Weekends can be very, very lonely times for people, can't it? I mean, if you're already feeling isolated, you can feel even more isolated on a Saturday, can't you? Weekends are particularly difficult for people that aren't well, or are isolated, or can't access support at any level. You've got sort of emergency response services, but you

> might not want them or feel that's appropriate for what you need or want. Certainly, if you're feeling suicidal, it can be very difficult for people who are obviously trans or obviously gay to go to A&E in the early hours of a Sunday morning because it's often there for people who have been in bar fights and it could feel quite threatening and unsafe. People don't have great experiences there because of those things or how they are treated by staff, and they might not want to go to A&E anyhow. We felt that an online service would be a good way to meet those needs. On a more practical level, we don't have much office space available during the day for volunteers to come in and use. So, it was good use of the office space to have volunteers come in [during] the evenings and weekends.

Recognising the need for queer intelligibility and connection with others to overcome their marginalisation and isolation, MindOut's online support service fills an important gap in LGBTQ-specific service provision in the local area. As Drew points out, it can be particularly challenging for gay and bisexual men to access culturally relevant support during these more precarious periods given the dearth of mental health interventions specifically tailored to them (Haas et al., 2011). With limited opportunities to release or communicate their negative affect with an/other, these feelings of loneliness, isolation and distress can intensify and consume the subject ('if you're already feeling isolated, you can feel even more isolated [over the weekend]'). In addition to an identified need for it, Drew also elucidates how the service, on a more practical front, best fits the organisation's current capabilities given complications around restricted office space during the day and the availability of volunteers.

Available since June 2013, MindOut's online support service is accessible via their website and comprises of an individualised and anonymous one-on-one conversation conducted by a trained online outreach worker (see Figure 8 below). Online outreach workers are LGBTQ community members who volunteer their time to help respond to synchronously to questions, provide informational and emotional support, crisis intervention and offer referrals to other agencies and services. At the time of data collection. At the time of data collection, the online support service usually operated

early weekday and Saturday evenings (e.g., 17:30 – 19:30pm) and Sunday afternoons (e.g., 2 - 4pm).

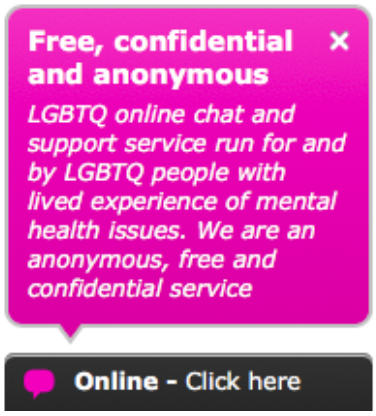


Figure 8. Pop-up banner of MindOut's online support service (as seen on their website).

Part of the attraction of the online support service in encouraging help-seeking relates to its ease of access and the capacity for service users to receive service provision through anonymous and confidential means as is evident in the following quote lifted from a focus group:

> When it comes to making that first step when you're looking for support, going online might seem safer for people. They can do it in their own home, they don't have to go out and do it. They may even have physical disabilities which means that they can't go out and make contact. Perhaps, they don't like to speak on the phone or they feel too overwhelmed to do that, so the online chat [service] kind of bridges some of those barriers. It's like putting their toe in the water and testing the water. So, they'll come online and engage with us and think 'oh, this is actually okay' and from that they could go on to using our peer support groups, using the peer mentoring, using the advocacy service, because they think 'oh, I can trust this service. I could use more of this service'. The fact that it's non-committal and confidential is really important. Especially if someone has never spoken to anyone about a problem before. I've had a few cases where

> they’re not actually even sure if they do have a problem, where they’ll come online and say, ‘I don’t know if I’m just being silly, but I think this is happening to me’. It’s just that first wave that they can maybe check themselves, I suppose. It’s a real informal way where they don’t have to betray their identity or anything like that, but just sort of explore what’s something without being committed (Lou, service provider).

In the above extract, Lou discusses how online help-seeking might seem like a ‘safer’ option for some gay and bisexual men. This is particularly important given the affective nature of help-seeking where Lou notes how overwhelming feelings and the possibility of judgement from others might inhibit offline help-seeking. By contrast, online help-seeking provides a means to access support and advice with less risk of having their negative affect intensified. Furthermore, the anonymity of the platform ensures that it is commitment-free and there is less potential for coercion or measures to compel service or treatment uptake. Thus, the individual seeking help has more control over how much information they want to disclose or share. In this way, the design and structure of the platform provides an ideal environment in which to safely explore their difficulties and uncertainties which, with the help of trusted sources, may, in turn, lead to an engagement with their offline services and embarking on more formal, offline help-seeking pathways (i.e., supported choice help-seeking). Within this example, help-seeking is understood as a relational and not as individualised phenomena.

Charlie (service provider) expanded on this discussion during the focus group noting the importance of anonymity as a way of avoiding minimising shame regarding their sexual and gender non-conformity and mental health difficulties:

> It’s really, really important that our online service is anonymous and confidential, I think, because going online might seem safer for people. They are making contact because they’re not out about anything to do with their gender identity or sexual orientation, or about their mental health problems and the issues they’re having or the fact that they might be feeling suicidal a lot of the time. They’re making contact with the online service because they kind of want to contain where that information goes. With something like a forum, for

> example, you're sharing that information with a larger group of people and that might not sit comfortably for you, certainly if you're local and in Brighton where lots of queer people know each other, whereas with our chat [support] service you can talk to someone directly and feel confident that some of that information isn't going out any further.

Again, discourses of 'safety' – or 'safe space' – in relation to mental health help-seeking feature prominently in outreach workers narratives. In the above extract, Charlie suggests that some service users make contact because they may be struggling against a range of norms: sexual and gender norms, mental health norms, and emotional norms. Charlie also compares the affordances of an instant messaging service with an online forum or discussion boards, suggesting that the latter can cause discomfort for service users by opening up intimate conversation to wider audiences. Such exposure, they note, can be likely, particularly in minority groups which are small by definition and whose daily social lives are more easily observed and noted among other participating community members. By contrast, a private chat or instant messaging services offers a 'safer' platform where personal information and difficulties are protected from wider public scrutiny, and thus productive in facilitating more 'honest' discussions. In this way, the online support service provides a space which troubles what might otherwise be punishing norms and enables a request for help. It enables a resistance to the pathologising of emotional distress, sexuality, and gender that may be experienced elsewhere.

Another salient aspect of the service is that it provides access to peer recognition and individuals with similar identities and lived experiences of mental health problems:

> We often hear from a lot of people who use our services that it's easier for them to reach out and talk to us, because we kind of get where they're coming from. So, some of the work is already done in that sense because you can talk to anyone at MindOut about anything to do with your sexuality or gender identity, and not feel like you'll be questioned or that you have to explain anything around that. Sometimes you hold back information with [mainstream] services because you're worried of being judged or discriminated against.

> Many of them don't feel like they're being heard or valued. With us, it's a different story LGBTQ-specific services are quite rare and all the volunteers here are very well equipped with their own knowledge and experiences when it comes to being an LGBTQ person and having gone through some mental health struggles themselves. We know ourselves how hard it can be for the people who make use our services (Alex, service provider).

Here, Alex discusses the negative experiences gay and bisexual can experience when accessing mainstream mental health services (i.e., judged, discriminated against, being ignored, being made to feel invisible), where their experiences may be denied recognition and rendered unintelligible or 'othered' by heterosexual service providers. Contrastingly, a peer-led approach facilitates help-seeking vis-à-vis a non-clinical and non-judgmental approach. With an audience of like-minded queer people, recognition for different ways of being, doing and knowing gay and bisexual male subjectivities becomes possible. This is done through collective discourses that articulate alternative, counterhegemonic sustaining norms that offer a capacity for critical relationality (Butler, 2004). Thus, outreach workers are able draw on a range of knowledge relations - embodied, experiential, critical reflexivity and empathy – of queer subjecthood and mental health distress in their online practice. In this way, gay and bisexual men's experiences can be validated, accepted, and made intelligible.

Indeed, MindOut's approach provides the possibility of recognition on many intersectional subgroups:

> We've also been doing themed online shifts with some of our volunteers and workers who are from specific minority ethnic groups, you know, BAME, or trans people, for example, and who might experience additional difficulties to provide more specific support where individuals from those group can chat to someone who share and understand their experiences or backgrounds more fully in ways that, say for example, a white, cis[gender] and abled person might not be able to (Nick, service provider).

Thus, the organisation's approach not only offers spaces for the recognition of sexual and gender diversity and with respect to mental health difficulties, but a range of gay and bisexual male subjectivities in relation to race/ethnicities, gender identity etc. These mirror their offline peer support group services facilitated by experienced LGBTQ group workers, and include groups focused on GBTQ men, BAME individuals, trans, and age groups (e.g., over 50s and under 30s group).

An understanding of the emotional or affective dynamics of help-seeking is central to outreach workers digital practice with distressed gay and bisexual men. The following two quotes demonstrate how the online support service provides a space for the unburdening of emotional of emotional turmoil and where their feelings are taken seriously:

> We tend to focus on their immediate feelings and explore what's going on for them in that moment. I tend to ask, like, 'is there anything you'd like to talk about?' or 'would you like to talk about that more?'. We can give advice, information and signpost them with their permission, but it's very passive in that way because it's a volunteer role, you know? It's not active like what you would do when you are a counsellor or psychologist or something, I imagine. That's not what we do. So, a lot of it is [employing] active listening skills and trying to reflect your understanding back to them in a way that is empathetic and makes them feel heard basically (Pat, service provider).

> I start by giving them a space to talk, particularly if it's someone who is suicidal or self-harming or something like that. If they've actually managed to contact us, then they want the help and they want talk about it rather than be distracted from it. A lot of times, they're not really being or feeling heard. So, it's about giving them the space to talk but also asking questions about how it makes them feel or how they feel about certain issues. So, it's about trying to open up that conversations around rather than kind of shutting them down. Giving them a space to feel that they are being heard, and that their feelings are being validated. To let them know that yourself and others have been through

> it to and needing help is nothing to be ashamed about (Mel, service provider).

Within these two accounts, participants mentioned ‘talking’ as central to feeling connected and alleviating emotional distress. Communicating one’s distress is made harder by the isolating impact that emotions such as shame because of the cultural obligation to hide and repress shame (Probyn, 2005; Scheff, 2003). Getting the service user to articulate and acknowledge their distressing emotions, rather than avoiding their shame, is crucial to outreach workers digital praxis; however, for this to be helpful there needs to be a sense of connection and acceptance where their concerns. Peer recognition here works in powerful ways to facilitate a sense that the service user is accepted *despite* the source of shame or supported in resisting the idea that they have anything to be ashamed of. Furthermore, peer recognition helps to normalise shameful experiences and feelings as something that has happened to others too. This is a productive step in redefining these distressing experiences or feelings. The broader point here is that feelings of failure, shame and distress can indeed be transformative in the context of relational reciprocity (Liu, 2017), where the intense affect can be released and reframed through reparative and restorative forms of sociality.

Talking varied in terms of whether gay and bisexual men were looking for immediate support with a situation or whether they were requiring some sense of sociability to dissipate acute feelings of isolation, as Chris (service provider) noted with some surprise:

> More and more people are just dropping by to check in. They're saying ‘hi, I just wanted to stop by. I come by here once a week. I just wanted to say everything's fine’. Yeah, they're not coming online because they're having a hard time. They're almost just touching base. Just to say hello. Just wanted to know that we were there. Just to know that somebody was maybe sitting at the end of the computer. They've come by for five minutes, they're just like ‘yeah everything's fine. I had a nice day and took the dog for a walk. It was nice. Anyway, hi, I’m gonna have dinner now’ and off they go. And people definitely weren't using it like that to begin with. In the start it was very distressed people

> wanting very specific information and it still is, but now also we have regulars that just come by to chat and touch base. The longer the service has been there, the more people have found it and the more people are using it in a variety of ways to support themselves. I don't think we could have anticipated that when we set it up. We just set it up. I don't think we could have anticipated people would be using it like one of those hot dog stalls that cab drivers use, you know, that they just stop by to get a coffee and have a quick chat. That it's part of their routine to kind of swing by.

While the online support service is intended for and certainly used by 'distressed people wanting very specific information', Chris notes how some service users check come online to check in outreach workers on the platform. This form of communal talk, or 'touching base', generates a feeling of connectedness or belonging where service users may feel less alone in their isolation simply by knowing that someone who cares is willing to listen and is available and there if required. This was similarly remarked upon by Alex (service provider):

> Sometimes there's a very specific issue that they're dealing with at that moment and they want to talk through that sort of quite intensively, and other times they might come online because they are quite isolated or lonely at that point, and they wanted to have a conversation, I think that's quite useful as well because it can then lead on to other things. So, if someone is coming online and just wants to have a general kind of conversation about things often what comes after is that they are experiencing some difficulty. It may not have been the reason they come initially, but once feel more comfortable they just kind of open up a bit.

Thus, these random or general kinds of conversations can lead to establishing a genuine, trusting connection which can lead to more active or actual help-seeking and support. This description by Alex echoes notions of 'muddling through' (Pescosolido et al., 1998), where the service user ends up seeking help though they neither indicate an initial or active intention to do so, but in the end decides to seek care.

To summarise, MindOut's bespoke online support service tripartite focus on confidentiality, anonymity and peer recognition underscores the importance of relationally oriented digital interventions with gay and bisexual men in a mental health help-seeking context. This corresponds with findings in the previous chapter where gay and bisexual men's help-seeking strategies pointed to a need to be in relation to supportive others, rather than alone with their distress or concerns. The next section considers how the organisation harnesses social media platforms for outreach purposes with gay and bisexual men.

6.2 Social media (out)reach with gay and bisexual men

In addition to their bespoke online service, MindOut also utilises a range of SNSs, both mainstream and niche, to work more effectively within a community of existing digital users as part of their outreach activities. In the following extract, Chris (service provider) lists the main SNSs utilised by the charity on a daily basis and their reasoning behind these specific (mainstream) platforms:

> With social media, it's really just Facebook and Twitter with a much more predominance on Facebook. Those two are our main social media. We have some bits on YouTube but it's not something we use regularly. We don't go across all social media that we could use because we don't have the time or capacity, and they're not all suitable for the kind of information that we wanna put out. We don't have time or money to make short cute little films, so we're not going to be using YouTube. If we had the time and money it would be a great a way to reach people and to spread the word of our services and break down stigma, but we don't have the time. Obviously, national Mind do that. They have that money. They're always making videos. But we limited ourselves to primary social media that we thought could best meet the way that we needed to get information out there to the most people and that was also sort of an all-round service. With Facebook, posting once a day is a really good way of targeting people. You put up a short news

> item and a big picture. You can schedule a bunch all at once which is great as well because it means if you've got one story that you're promoting over a month, like 'here's a new support group that's coming up', 'here's the time of the online service today', or 'here's a new job vacancy'. I schedule 15 over the course of 6 weeks and then just forget about it. I don't have to remember every single day going onto Facebook, typing the same thing, putting it up. I can dot it around, like say, three posts during the week. One on the weekend. Mostly around 5.30pm because that's when Facebook gets very popular, but I'll throw a few in late at night or early in the morning just to mix it up.

As illustrated here, MindOut's approach to social media involves a pragmatic engagement with mainstream SNSs that best align with the organisation's outreach objectives and available resources. Focused on promoting and disseminating information about their services among LGBTQ populations more widely, as opposed to gay and bisexual men more specifically, Facebook and Twitter activities currently dominate social media outreach work by the organisation as part of 'catch-all' approach. Salient aspects of these two specific mainstream platforms for the organisation is their cost effectiveness and evidence high levels of user engagement/activity[32]. Thus, for small charities dependent on (short-term) funding and grants these platforms have much potential in terms of reach. Both Facebook and Twitter are largely utilised by the charity for one-way, outward-facing communication with information delivered out to existing or potential service users and reflecting digital health promotion strategies more broadly (Capurro et al., 2014; Ramanadhan, Mendez, Rao, & Viswanath, 2013). Facebook provides a better 'all-around' platform for ongoing or prolonged interaction with platform audiences as it allows the charity to schedule multiple and targeted content or posts, streamlining their day-to-day digital outreach activities.

In addition to mainstream SNSs, MindOut has also recently begun to tentatively incorporate niche SNSs, specifically gay, bisexual and other MSM-specific GSN apps,

[32] Facebook and Twitter continue to rank as two of the most popular and active SNS. Facebook boasts over 2.13 billion worldwide monthly active users (Facebook, 2018), while Twitter reports 330 million monthly active users (Twitter, 2018).

into their digital outreach programme. This novel approach is particularly pioneering within a mental health context when considered alongside the growing body of work from sexual health promotion initiatives that dominate and operate across and within these platforms in terms of digital outreach. Consequently, MindOut represents one of the few, if not one of the first, mental health services to employ these spaces for outreach purposes.

In the following quote, Drew (service provider) discusses the organisation's utilisation of these spaces to target gay and bisexual men and to promote their bespoke online support service:

> We've contacted lots of different dating apps, LGBTQ ones obviously, and we've got quite good relationships with some of them apps. We wrote them and said 'hi, this us. This is what we're doing. We don't have a lot of money. We're looking for people to give us some free advertising space. Do you have anything available?' and a few of them got back to us. Scruff, Recon[33], Wapo and Wapa[34] are some of the apps that are sort of championing us at the moment. They've given us free space and advertising on the apps themselves. Some have given us full screen adverts where others gave us banner ads and stuff like that link people directly to [MindOut's] website where they can then access the online support service. Others offered us space when their paid adverts have run out of money because their paid adverts can only take up so many hours on their system and when they get these gaps they're able to put different charities and things like that on there […] So we're able to choose certain geographic locations around the UK, like Brighton, London, and Manchester, for example, or even more further afield, and then have our adverts pop-

[33] While niche apps like Scruff and Wapo target queer men more broadly, Recon caters exclusively to a sub-group of sexual minority men who are interested in meeting similar others for fetish sex (e.g., leather, rubber, BDSM and kink).

[34] Wapa is a popular dating app for lesbian, bi or curious women. I include the mention of Wapa here to demonstrate the organisation's engagement with niche SNS as part of a wider 'catch-all' approach to reach LGBTQ populations beyond that of queer men.

> up while it's running for people in those areas when they're logging onto the apps.

As with mainstream SNSs, MindOut currently harnesses niche SNSs in a unidirectional fashion with a flow of information from the organisation to wider audiences vis-à-vis geo-targeted broadcasting and banner advertising strategies (see figure 9 below), focused on urban areas with a high density of gay and bisexual men (e.g., Brighton, London, Manchester etc.). These strategies are dependent on formal partnerships and the goodwill of these corporate or commercial platforms to provide access to their service and platform users. While MindOut's efforts have largely been 'championed' by an array of niche platforms that offer the charity recurring free in-app advertising, other platforms have been less forthcoming and demonstrates how privately-owned, commercial platforms might act as gatekeepers. In the next quote, Drew (service provider) distinguishes between support received from Wapo and Grindr, and discusses the popularity of both platforms with gay and bisexual men:

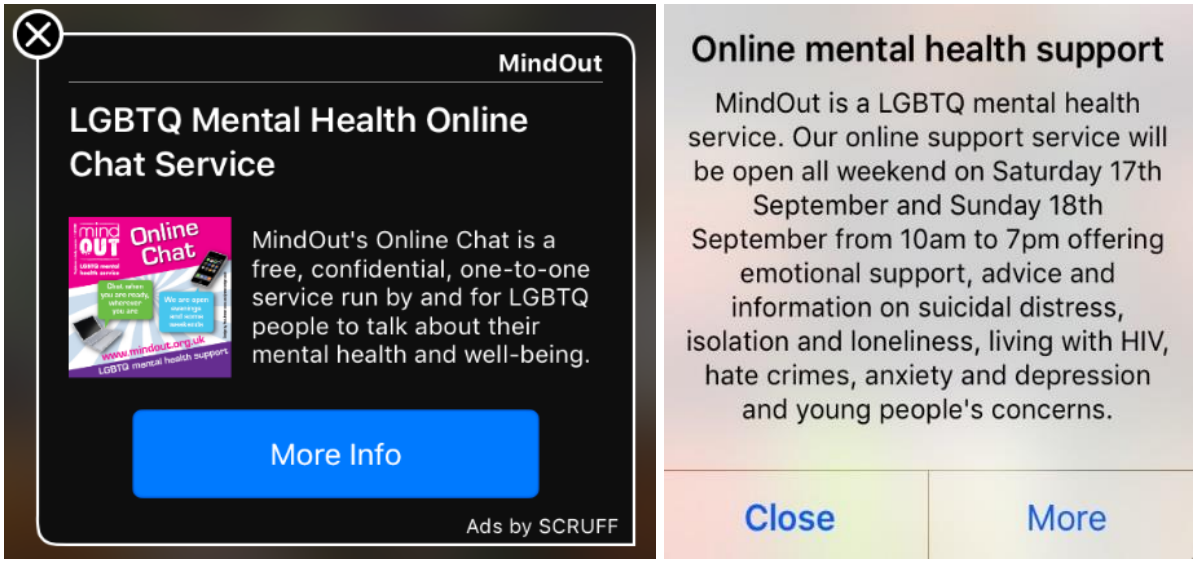


Figure 9. MindOut broadcast adverts on Scruff (left) and Grindr (right).

> Wapo's been particularly supportive of us and have given us a full screen ad for as long as we need and want it. They're pretty much up for doing anything we want to do with them really, so we've been really lucky with them. It's quite a massive gift they've given us, actually. Wapo isn't so popular in the UK, but they certainly rival Grindr around

> Europe. Certainly, in Spain. I mean it's quite massive in Spain. So, what they're doing for us at the moment is they're advertising us around the UK and targeting larger expat communities around Europe. Grindr, on the other hand, didn't want to advertise us for free, but they gave us a little taster, a free-trial advertisement, for a day or so. We noticed a real surge in traffic on our website and the online support service. I can't remember the figures, but the number of hits on both just shot up. It spiked just like that [snaps fingers]. So, we got a really good response from that ad. Grindr certainly does reach a lot of people, a lot of men, but it's expensive for us to be on there. We've got some funds at the moment, so we want to be able to advertise the online service over [the Brighton] Pride [festival] to be able to reach lots of people.

In this extract, Drew highlights the power of popular niche services in generating and supporting mental health outreach work with queer men within the contexts of their services. Grindr, the world's largest queer social network[35], has vast potential in reaching and engaging large cohorts of queer men as indicated by Drew's testimony of 'spiked' engagement statistics, or 'hits', on MindOut's website and their online support service; however, that reach comes with a literal price that determines the charity's capacity to do outreach work with queer men within that platform. While mobile-based queer social networking apps often operate on a 'freemium' business model where a basic level of usage is available to product users without cost, their revenue is dependent on subscriptions to premium services and advertising (Albury et al., 2017). As such, market forces can undermine community outreach efforts undertaken in these spaces. This is can be particularly challenging for small charities and community groups who are strained in economic terms and dependent on funding streams.

[35] While billed as the world's largest all-male social network exclusive to gay, bi or curious men at the time of interviews (i.e., late 2016 and early 2017) (Grindr, 2017), Grindr has since expanded their gender identity categories in an effort to be more inclusive of all genders and sexualities on its platform. As such, the app now offers cis, trans and non-binary options in its user profiles and is accessible to a wider array of users including queer and straight women (Hall, 2017; Herzog, 2017).

Overall, MindOut's formal partnership with niche platforms appears to have proven effective in generating outreach work with gay and bisexual men and facilitating help-seeking among this population. As Robin (service provider) states:

> The response has been great. It's been really good and positive for us. We keep getting good figures in relation to the apps and some people have told us that they've been in touch with us because they've seen some of the ads on one of the apps. What we know with MindOut is that people don't always make contact with us immediately. [The apps] kind of plants a bit of a seed. It's not unusual to hear some people have seen an ad and haven't made contact straight away. They just remember the name 'MindOut' and google us somewhere down the line when they feel they're able to make contact. The other interesting thing about the apps is that, they're considered gay male apps but, of course, you know, so many different men use them, you know, bisexual men, trans men and women, genderqueer people, and MSM too, you know, men who have sex with men, single men, and couples who have open relationships as well. It feels like everyone's on them apps using them to meet other men.

From this extract it would appear that niche SNSs are an effective tool for reaching large cohorts of gay and bisexual men and facilitating mental health help-seeking among those who are vulnerable, isolated, or distressed in this population. We know from the literature that gay, bisexual and other MSM use multiple niche SNSs and spend significant time on them, particularly in the evenings or late at night (Goedel & Duncan, 2015). By incorporating these spaces into their outreach programme, Robin suggest that they are able plant 'a seed' among potential service users and help initiate future help-seeking strategies. Their presence in these spaces helps build familiarity and trust among queer male audiences who seek out the charity's services when the need arises or when they 'feel they're able to make contact'. We know from the previous two chapters that gay and bisexual men often engage in avoidant help-seeking strategies (see Chapters 4 and 5), and that some men might use these spaces to facilitate sociosexual respite in the face of adversity in addition to other help-seeking strategies (see Chapter 5). I would therefore argue that MindOut is taking their help-

seeking resources (i.e., a direct link to their online support service) out *to* gay and bisexual men, in fact, putting them in their pathway.

While niche SNSs appear to be highly effective in reaching and accessing potentially large cohorts of gay and bisexual men, the organisation's use of these is tentative and cautious at best at present:

> I think we've got a lot more work to do with the apps. A lot more thinking to do because the apps are quite new to us. It's been an ongoing conversation about whether we should be more active on apps like Grindr. We spoke about having [user] profiles on some of the apps like, you know, THT[36] who have profiles on Gaydar and Grindr, I think. They've had some negotiation with those companies to get that kind of going. It might be a road for us to go down in the future, but at the moment it would take too much managing for us. It would demand too much from the staff and volunteers. We're a relatively small charity and there's certain things we don't have. We don't have a smartphone, for example, which we're in the process of getting. We'd need certain things in place in order to provide a service like that (Chris, service provider).

Referring to sexual health promotion outreach work where profiles are formally authorised by digital providers and used to deliver advice via chatrooms or direct messaging facilities, Chris notes how deeper and more active engagement within these spaces would strain the charity's already limited resources (e.g., financially, available staff/volunteer hours). Such work would undoubtedly duplicate outreach efforts by the charity as it would involve multiple platforms with varying architecture. Thus, at present, the organisation's thinking is directed towards increasing rather than duplicating their outreach efforts.

This section has demonstrated how social media platforms are utilised by MindOut to help generate outreach work with gay and bisexual men in the context of their services.

[36] Terrence Higgins Trust (THT), an HIV and sexual health charity.

At this stage, and as with community-based health promotion organisations more generally, much of MindOut's SNSs use, both mainstream and niche, for outreach purposes appears to be unidirectional flow of information from the organisation to the audience. However, the organisation takes a proactive approach by targeting niche SNSs and putting help-seeking interventions in gay and bisexual men's COA pathways. Given the apparent effectiveness of such strategies in terms of reach and response, I would argue that an online presence – if not deeper engagement – on these platforms is an essential dimension for organisations working with gay and bisexual men in a mental health capacity. The next section considers the challenges – or productive tensions – in terms of digital outreach work.

6.3 Challenges to online outreach and facilitating peer support

While it can be argued that digital and social media may be essential for generating mental health outreach work with gay and bisexual men, particularly niche SNS or GSN apps as illustrated in the previous theme, there are limitations to the type and quality of support that can be made available online by peer-led community-based organisations. In this final section, I highlight some of the challenges encountered by MindOut. around (i) facilitating emotional reflexivity, (ii) managing expectations and new cultures of engagement, and (iii) avoiding context collisions and norm violations.

6.3.1 Facilitating emotional reflexivity

One significant issue involved the emotional architecture of digital and social media, that is, how the design of platforms and the tools of communication available within those virtual spaces impact emotional support work. While the filters of digital mediation have positive effects that benefit help-seeking under certain conditions (see section 7.1), they also complicate the embodied and emplaced expertise of online support workers. For example, despite having considerable experience supporting distressed queer people, Robin (service provider) describes finding the online support service somewhat cumbersome at times:

> I've found the online support surprisingly [pause] challenging. Maybe 'challenging' isn't the right word, but I thought given that I've got a fair amount of experience supporting people that I could transcend those skills onto the online chat and I didn't really think it would be difficult. I don't struggle doing it, but I do find it is a skill that I will need to develop. You're trying to convey what you're normally doing face-to-face through text and that takes work. So, sometimes you feel like there's a bit of a time issue because if you wait a bit too long to respond [the system] says, 'there has been no chat for a while' and you think 'ooh, this person's waiting', and you are kind of pressed to get back to them quite quickly especially if they are in crisis. I'm doing a cyber therapy course at the moment so that's really useful for me to get the practical experience of actually providing support online but, yeah, it's takes real skill and work to be able to convey tone and empathy through that medium that would otherwise be much easier, I think, in person.

What Robin refers to here is the inability to draw on a repertoire of visual and embodied communication tools (i.e., cues or gestures) more traditionally relied upon in face-to-face support settings. Formulating responses to service users that rely solely on written communication to convey both empathy and information requires a substantial amount of skill and labour from online support workers, particularly if, as Robin notes, help-seekers are in crisis. Evident here are the challenges posed by, what Mowlabocus et al. (2015) terms, 'filtered embodiment'. While the filtered embodiment allows for help-seeking interactions in which gay and bisexual men feel less inhibited discussing their anxieties or distress, it also challenges to the work of online outreach workers, like Robin, when responding to this increased level of self-disclosure. Online outreach requires the development of digital expertise in order to 'transcend' those skills often drawn on in their offline intervention work to create a sense of connection, understanding and warmth.

Mel (service provider) also echoed these sentiments in a focus group, and discusses the challenges involved in drafting responses that seeks to open up conversations ed encourages service users to engage in emotional reflexivity:

> People are not always very easy to engage with in the chat so there's kind of like a distance you need to overcome. They can be there saying how awful they're feeling right now, but also giving you very one-worded answers or disappear during a conversation and then coming back much later on in a session. It's difficult trying to engage and build a conversation with them and have a tone to your writing style that is chatty but not too informal, and then also formulating broad, open-ended questions. That's all hard when it's just typing especially when the responses you get are quite blunt. I mean, they've arrived [online], they clearly wanna talk, but they're finding it hard to put it into words straight away. So, there's a sort of teasing process going on where you're trying to get them chatting about what is happening in their lives. Then you get other times where people arrive with four dense paragraphs of text discussing everything that's happened to them over the past year and you're like 'whoa, okay, how are things today?'. It can be really varied.

Similar to Robin, Mel describes the challenge crafting responses that seek to open up conversations with some service users and deal with the immediate problem (or most pressing concern) and help bring about emotional relief. This requires a 'teasing process' and careful consideration of communication styles in order to encourage ongoing conversation. This can be particularly difficult with gay and bisexual men who, despite arriving online, may be hesitant to engage in self-disclosure or who are struggling to find the right emotional vocabulary to communicate what they're feeling.

These challenges are further complicated when you consider delivering mental health support and intervention via/through the emotional architecture of social media platforms. While the platform design of MindOut's online service provides a supportive medium for intervention work by enabling lengthy conversations, social media sites provide a less productive context for such work. For example, when discussing the possibility of delivering services through social media such as niche SNSs during the focus group, Lou (service provider) seemed opposed to the idea:

> I wouldn't want to do that. It would be too restrictive. [Willem: restrictive how?] It's more about the expression you can achieve with digital characters. I don't think you'd be able to achieve what we do with the online chat [service].

As was Alex (service provider):

> I think it's the same thing with Grindr. I mean if you've seen the conversations on there, they're normally quite, you know, 'hey', 'hey', 'alright?', 'alright', 'have a pic?', 'sure'. It's very stunted like that. Very short and matter of fact. Very little attempts at an actual conversation. If we had to work on there [pause] I'm not sure what that would even look like. I'm not sure how it works for THT, but it'll be a very different thing for us because of the kind of work we do because a lot of it is crisis intervention.

As evident in these discussions, social media platforms are not often constructed with mental health outreach objectives in mind (Jenzen & Karl, 2014). In these extracts, the short SMS-style communication tools available on niche SNSs undermine mental health support work with gay and bisexual men within those spaces. The architecture of the services – often built around a simple instant messenger format – and style of communication engendered on the platform – short-form text messaging and image sharing – may create challenges for mental health outreach work, particularly as it relates to crisis intervention and generating and maintaining in-depth or deeper intervention work on these mobile platforms.

6.3.2 Managing expectations and new cultures of engagement

Another issue related to the management of expectations that comes increased access and new cultures of engagement. As previously demonstrated, help-seeking – both online and more generally – often occur at crisis points and during the lonely hours. It was during these times that gay and bisexual men expressed a need for responsive online mental health support. For instance, while discussing his use of

MindOut's online support and the platform's current operating hours, Ash (service user) wearily asked:

> It could never be available 24/7, could it? [deep sigh] It should be open a little longer, to be honest. Probably more like 4 to 9pm. You know, the time people are people are getting home from work. Also, maybe sometimes late at night. I always find that when I start getting tired and have nothing to keep me busy that that's when it starts to get dangerous. I always seem to self-harm just before I go to bed. It doesn't have to be open all night, but more probably up until 11[pm] or midnight. You just need more volunteers for that though.

Ash's request that the service run 24/7 reflects one of the bigger challenges of delivering mental health support services online and this relates to the accessibility of that support and the expectation that contact is available at all times. Such expectations are particularly tricky when it comes to social media. For example, Chris (service provider) compares how service user expectations might differ with regards to contact modality:

> Sometimes we get Facebook messages from people who are very distressed who we don't pick up until Monday morning. They sent the message late on a Friday night and, even though that would happen with email as well, Facebook, I think, for the person sending the message feels 24 hours and an email simply doesn't. If you send an email to an office you wouldn't expect to hear back straight away, would you? There would be a delay there. Facebook, you might think, 'oh, it's right there. Why haven't they seen it? Why aren't they getting back to me?'. We did consider that maybe it was not okay to have our Facebook inbox open like that but, on the other hand, it felt like a route in for people who perhaps contacted us that way because they had a good reason to do it that way or perhaps that was simply the way they wanted to.

In this extract, Chris illustrates how, for people using older ICTs methods such as email, a short waiting period or delay in response is customary; however, with social media, Facebook as specifically mentioned in the example here, service users exhibit heightened expectations of immediacy (a ‘right now’ culture) and urgency when it comes to accessing services. Thus, while the medium fulfils a need for safety and control that opens help-seeking possibilities where someone might contact the charity looking for immediate support outside of working hours, it can be particularly challenging for a small community organisation. As Chris (service user) explains:

> We don't offer support through social media because it just doesn’t feel like there are a lot of boundaries there. It’s just too unpredictable and we can’t control that environment in a way like we can the online service where have specific time slots and people running that service. Nobody staffs our Facebook message account around the clock because we’re a small team. There's no need to because people aren't sending us messages on there all the time, but if somebody did start chatting me while on Facebook I would have to tell them ‘this is not my role, I can't talk to you right now. This is how we operate. I can send your details to the appropriate worker or I can suggest the Brighton and Hove LGBTQ switchboard or the switchboard in London or the Samaritans. If you're in dire need go to A&E’. I know this what I would to encourage them to do if they were desperate and unhappy, but I can't chat on there. I can't have it open for that because I have other duties. it's an informal space and it creates the feeling of a relationship that I don't think exists. You could feel like the person you were chatting to becomes your friend, and that's not what we are. We are staff. So, I think Facebook would feel too informal for us.

As indicated here, while social media like Facebook aids the organisation in quick intervention, no-one staffs their social media accounts ‘around the clock’ given the small size of the staff team. This contrasts with the online support service that has a dedicated volunteer team running it and set operating hours. Furthermore, the platform creates a potential boundary problem for the charity given its unpredictable and informal nature. Chris is particularly concerned about having the account open for ‘a

chat' given his numerous duties. As demonstrated earlier (see section 7.1), some service users draw on the online service as a source of community and belonging and engage in informal chat within that space. It's for this very reason that MindOut may be hesitant about deeper engagement and service delivery via SNS beyond more 'traditional' forms of digital outreach work (i.e., maintaining a social media presence through public-facing adverting and promotion of the organisation, and a bespoke service).

6.3.3 Avoiding context collisions and norm violations

Lastly, conducting online outreach work may also trigger concerns regarding confidentiality and anonymity particularly as it relates to mainstream SNSs and issues of context collapse. For digital outreach workers, assuring client confidentiality is an important component of helping service users feel safe and protected; however, there are limits in how confidentiality and anonymity can be maintained on SNSs such as Facebook which is predominantly used by the organisation. Because social networks on Facebook often mirror offline networks, Zhao, Grasmuck and Martin (2008) characterise the platform as a 'nonymous' – that is, the opposite of anonymous – online environment, where 'people are more likely to present their selves as being in line with, or close to, normative expectations' (p. 1831). Similarly, research comparing mainstream and niche SNSs use among sexual minority men suggest that Facebook is considered the most public and least anonymous social medium (Gudelunas, 2012; Light, 2014). As such, the platform may be tricky to navigate in a mental health help-seeking context, at least for those who find it crucial to maintain distinct contexts in which they disclose their mental health difficulties as well as their gender and/or sexual identities. For instance:

> We had someone that logged onto Facebook and they were in a certain amount of distress, and shared stuff they probably didn't want to share on Facebook, and then we messaged them via Facebook, and said if you want to talk to us then go to the MindOut website and talk to us that way and explained that, you know, the wall on Facebook is seen by everybody who can see the Facebook page so you might not want to do that. You might not want to share that because there

> might be negative reactions to the post from his side. So, you know, to keep yourself safe and secure, please go to the website and log on to chat that way, and they did so. In the moment, they didn't actually realise because they were distressed. They just posted stuff and put it on Facebook and without thinking. They didn't realise what they did. They then started chatting via the online chat service, because they were in distress. Anybody that could see the MindOut page was able to read it, and it didn't dawn on them (Pat, service provider).

Of primary concern in this extract, is the threat of 'context collisions' (Davis & Jurgenson, 2014), an unintentional collapsing of contexts, where a public request for help or sharing of private information may be viewed or amplified by known networks associated with the service user or those connected to MindOut's page. For Pat, the distressed service user's safety and security is of the utmost importance as he notes the potential for negative judgement to intensify the individual's distress or feelings of shame. To prevent this, Pat redirects the conversation to the online support service in order to offer support and protection for the individual's identity, as well as advise them against sharing their emotional distress on Facebook. Yet, this extract also demonstrates how outreach services may be implicated in upholding and adhering to the norms of a specific platform. For example, Facebook users frequently indicate that posting overly emotional statuses is a violation of norms (McLaughlin & Vitak, 2011). Drawing on Brownlie (2018), the service user's public disclosure can also be read as a way 'welcome care' from social networks on the platforms, whether known to them or connected to MindOut, who may be able to offer some assistance or support. Because of this, there is a need for organisation's and service providers to carefully consider the potential for outreach work to be *both* silencing and amplifying and of the sensitivity of the tipping point between keeping a digital eye out and emotional surveillance.

Conclusion

Following on from the previous chapter which highlighting the need for relationally oriented digital interventions with gay and bisexual men, this chapter considered the

use of digital and social media help generate and support outreach work with this group by a peer-led LGBTQ mental health service. A key feature emerging from MindOut's online outreach practices is the importance of confidentiality, anonymity, and queer recognition/intelligibility in facilitating mental health help-seeking among gay and bisexual. This chapter also demonstrated my community partner's utilisation of SNSs for outreach purposes – both mainstream and niche – which prioritises efforts to reach gay and bisexual men, rather than active engagement within these platforms. Much of the use of social media tools by the organisation involve unidirectional and outwards-facing flow of information from the organisation to the audience as has been witnessed with community-based health promotion organisations more widely (Ramanadhan et al., 2013). As this stage, the use of digital social media is still relatively restricted and restrictive in relation to mental health outreach work (Jenzen & Karl, 2014), particularly as it relates to issues around facilitating emotional reflexivity, managing expectations and new cultures of engagement, and avoid context collisions and norm violations. Consequently, MindOut's thinking around their SNSs use is directed towards increasing rather than duplicating their outreach efforts.

An important finding in this chapter centres around the actual/potential reach of niche SNSs in targeting large cohorts of gay and bisexual men and facilitating help-seeking. To date, research investigating outreach efforts via these platforms have predominantly focused on sexual health outreach initiatives (Mowlabocus et al., 2016). MindOut's success suggests that these spaces may be an essential dimension for online mental health outreach initiatives targeting this group. In doing so, help-seeking interventions will be put in their pathway and easier to access. Such initiatives will ultimately depend on formal partnerships with such platforms and/or funding.

7. Conclusions, Implications and Critical Reflections

Despite international evidence suggesting elevated rates of mental health problems, research investigating the mental health help-seeking behaviour of sexual and gender minorities has been rather limited (McDermott, Hughes, & Rawlings, 2017b). Although the nascent literature offers important insights into service engagement patterns and barriers to care experienced by sexual minority people, there have been critical gaps in our understanding. In addition to insufficient attention to different *within* this population and a restricted focus on professional or mainstream service engagement patterns, much of the extant work has been limited by a narrow conceptualisation of the core concept of help-seeking as a deterministic response (i.e., emphasis on efforts to predict or explain help-seeking behaviours). To address these gaps, this thesis offers a dynamic understanding of gay and bisexual men's online mental health help-seeking relations.

As illustrated in Chapter One, I focused on gay and bisexual men specifically as more research has been devoted understanding the online help-seeking experiences of sexual minority women and LGBTQ youth (see McDermott, 2015; McNair & Bush, 2016, for example). This relative lack of attention is disconcerting given the large burden of unmet mental health needs and poor quality healthcare among this group, as well as evidence suggesting that gay and bisexual men might benefit from online help-seeking interventions (e.g., Hooper et al., 2008; Pachankis & Goldfried, 2010; Pachankis et al., 2013). While there have been calls for the development of interventions tailored to specific LGBTQ subgroups and efforts to encourage help-seeking (Haas et al., 2011; Smalley et al., 2016), this is not possible until the unique experiences of different subgroups are understood more fully. This thesis therefore contributes to closing a knowledge gap enabling or leading to appropriate and relevant online support interventions for gay and bisexual men.

Chapter Two of this thesis offered a critical review of the theoretical and empirical work on gay and bisexual men's mental health help-seeking. It outlined two main orientations to the conceptualisation of help-seeking, namely, the dominant rational choice approach and the dynamic approach (Pescosolido, 1991; Pescosolido & Boyer,

1999), and illustrated how research on gay and bisexual men's help-seeking has predominantly been framed within the first perspective. Stemming primarily from psychological and psychiatric rationalist perspectives reliant on quantitative or positivist methodological approaches, dominant approaches conceptualise gay and bisexual men's help-seeking as an individual, voluntary, and rational decision leading towards or away from mental health services. This leads to an emphasis on efforts to predict and explain help-seeking as researchers focus on profiling users, tallying service outcomes, and measuring broad factors influencing service use. Within this broader orientation, I identified three further frameworks researchers draw on to explain gay and bisexual men's (non-)help-seeking, namely, the disparities and minority stress explanatory framework, the barriers and facilitators model, and masculine gender role socialisation interpretations. Although such efforts have merit, the argument is made that research focus on a single decision point where minority stress, barriers, and masculinity norms act as determinants of (non-)help-seeking threatens to oversimplify theoretical and empirical understandings of how gay and bisexual men experience and respond to mental health difficulties. This not only individualises mental health problems and help-seeking process, but excludes a host of complex and interconnected social, cultural, and economic factors which may influence help-seeking.

In order to develop a richer understanding of gay and bisexual men's mental health help-seeking, Chapter Two also outlined dynamic approaches which view help-seeking a subjective, relational and ongoing process. By adopting this framework, the study of help-seeking can be considerate of how individuals engage with multiple others or communities to recognise and define their needs, decide to seek help (or not), evaluate a diversity of supports, and acknowledging the process as varying in strategies, methods and outcomes (i.e., a broad conceptualisation of help-seeking) (Wenger, 2011). Yet, my review also notes how existing dynamic approaches of sexual minority men's help-seeking remains couched in minority stress explanatory frameworks and barriers to care (e.g., MacKay et al., 2017). To overcome these challenges, I drew on interdisciplinary work which recognise the influence of emotions, norms and normalisation processes on help-seeking behaviour (Biddle et al., 2007; McDermott, 2015; McDermott et al., 2017a; McDermott & Roen, 2016). This approach

critically expands the research terrain and engages with the complexity of gay and bisexual men's help-seeking more fully.

In addition to outlining my multi-method qualitative approach, Chapter Three also set out the thematic analytic frame used to highlight the normative and emotional dimensions of gay and bisexual men's online help-seeking relations. Drawing on the work of McDermott and Roen (2015; 2016), this study's framework works with the notion that, despite improvements in LGBTQ equality, some gay and bisexual men experience difficult emotions connected to a range of sociocultural norms. The chapter focuses on the discursive and material conditions under which subjectivation take place and highlights a range of norms that may impact upon gay and bisexual men's mental health and help-seeking behaviours. The chapter also presented this study's conceptualisation of emotional distress as located in the psychological and socio-political rather than solely figured in the individual as exclusively psychological or psychobiological.

The next two sections outline the main analytic contributions made by this thesis to our understanding of gay and bisexual men's online mental health help-seeking. The first section answers two of my research questions: how is mental health help-seeking is constructed by gay and bisexual men, and how do they experience their use of online ICTs to seek help for mental health-related concerns? Gay and bisexual men's constructions of mental health help-seeking involved the navigation of multiple sociocultural norms which position them as failed and shamed on multiple levels. To avoid such subject positions, gay and bisexual go online where they experienced relief through opportunities for social and emotional (re)connection. The second section answers another research question: how do LGBTQ specialist mental health services utilise digital and social media to support gay and bisexual men? The findings suggest that organisations such as MindOut are taking an alternative approach to mainstream help-seeking interventions, prioritising relationally oriented digital supports and working with an understanding of help-seeking as an affective process. It also addresses the possibilities and challenges of digital and social media to help generate and support outreach work with gay and bisexual men. Thereafter, this concluding chapter considers the implications of the research findings for practice, policy, and corporate social media platforms targeting gay and bisexual men. Finally, the chapter

concludes by critically reflecting on this study's approach and offers directions for future research into this understudied topic area.

7.1 An expanded framing of gay and bisexual men's mental health help-seeking: Affect, norms, and online help-seeking

Dynamic approaches to the conceptualisation of gay and bisexual men's mental health help-seeking has thus far been limited. This study fills a gap within the literature by offering a broader conceptualisation of gay and bisexual men's online help-seeking (i.e., adopting both adaptive and non-adaptive frameworks of help-seeking), and focusing on the relational and subjective process of help-seeking. In addition to this, this study paid specific attention to the normative and emotional dimensions of help-seeking relations; a perspective has been underacknowledged in the literature on help-seeking for mental health problems (Fullagar, 2005; McDermott & Roen, 2016). By taking this approach, my study addresses two limitations that characterise dominant models within the field, that is, (a) the narrow conceptualisation of help-seeking as an either/or decision; and, (b) a limited integration of deep understandings (meanings, processes, practices). My analysis suggests that emotions, sociocultural norms, and relational difficulties are central to some gay and bisexual men's preferences for online help-seeking with regards to their mental health difficulties or distress.

In Chapter Four, I focused on the circumstances under which gay and bisexual men come to seek help online. I argue that gay and bisexual men's mental health help-seeking involved the navigation of multiple intersecting norms which can ignore, marginalise or, alternatively, confer recognition: neoliberal norms, heteronorms, homonorms, masculinity norms, and emotional norms. Struggling against all of these norms means that there is the possibility of failure on many levels. Not only does this sense of failure intensify gay and bisexual men's emotional distress, but it narrows their expectations from traditional or conventional support mechanisms and services. Participants' narratives also demonstrated how asking for help can reinforce a sense of failure and shame, particularly as it relates to the potential for social disapproval. They also described how help-seeking made them less acceptable to others, how it

exacerbated conflict, or cemented their isolation within their immediate context. In this way, offline help-seeking posed some relational threat, and could lead to (further) social and emotional disconnection. Altogether, these factors can restrict the type of help-seeking possible.

As a way to avoid or minimise these punishing norms and shaming affective practices, some gay and bisexual men go online to seek help for their distress and negative affect. Chapter Five demonstrated how gay and bisexual men's online help-seeking involved a variety of strategies that offered opportunities for relief from their distress or negative affect through social and emotional (re)connection. These strategies included a safer wit(h)nessing of their emotional distress, critical relationality, and sociosexual forms of respite. The concept of safer wit(h)nessing related to narratives which suggested that participants felt safer discussing their emotions online anonymously, and benefit from feeling heard and less alone with the burden of their distress. I also demonstrated how subject- or space-specific online settings help facilitate a critical relationality, where gay and bisexual men discussed engaging in emotional reflexivity and bringing a critical perspective to punishing norms by accessing an alternative, minority version of counter hegemonic sustaining norms.

Additionally, the findings in Chapter Four and Five also suggest the threshold to help-seeking – both on- and offline – is often at the point at which gay and bisexual men feel they can longer help themselves and they are in crisis. These crisis events often occurred during what I will refer to herein as 'the lonely hours', that is, periods of time when social interaction and supports, including mental healthcare services, are typically less available (i.e., during the evenings, late at night and/or over weekends). Gay and bisexual men engaged in a variety of coping strategies to facilitate avoidance, including sociosexual forms of coping vis-à-vis niche SNSs. That some men may be tangled in loops of avoidant-oriented coping before embarking on a help-seeking pathway, suggests an important opportunity for intervention and outreach via these spaces.

The broader point here is that gay and bisexual men's help-seeking highlights a desperate need for social and emotional connection with others in tension with the inevitable difficulties inherent in that connection. The findings demonstrate how

vulnerable or distressed gay and bisexual men look for ways to be in relation to others, rather than being in isolation, shame and distress. These narratives highlight the importance of relationally oriented and peer focused digital interventions with gay and bisexual men who are experiencing mental health-related difficulties. Furthermore, my findings add to arguments that online settings should be recognised as an increasingly legitimate source of help and support with gay and bisexual men experiencing mental health difficulties (McDermott, 2015; McNair & Bush, 2016).

This thesis expands on and develops McDermott and Roen's (2015; 2016) interpretive frame in the following ways. First, this study applies their framework, which is limited to a younger sample of LGBTQ-identified individuals aged 13 – 25, to a wider age demographic. Participants in this study ranged in age from 23 – 58. As such, this study is – to the best of my knowledge – among the first to apply their analytic approach to the help-seeking behaviour of an older (and understudied) LGBTQ population sample. Second, this thesis builds on their contributions by offering a richer, more detailed understanding of the impacts of homonormativity on LGBTQ people's mental health help-seeking. Although McDermott and Roen (2016) contend that queer youth may have trouble conforming to both hetero- *and* homo-normative expectations, their examination primarily focuses on the influence of heteronormativity and homo/bi/transphobia on help-seeking given the age of their sample. Regarding homonormativity and online help-seeking, the authors critique the resounding individualism and culture- and class-specific assumptions of the 'it gets better' discursive constructions (i.e., the promise of future well-being) offered by some LGBTQ young people. They argue that 'such understandings dangerously marginalise diverse realities, potentially leaving many queer youth feeling that they are failing precisely because they are not achieving the homonormative (consumerist, neoliberal) dream' (McDermott & Roen, 2016, p. 142). This study integrates a more nuanced and qualified understanding of homonorms in relation to help-seeking. It examines how gender norms and relationship norms among gay, bisexual and other MSM's influence their help-seeking relations or pathways, thus not just the embracing the more general neoliberal values on help-seeking (see Chapter 4, section 4.3 and Chapter 5, section 5.1 and 5.3). In doing so, it demonstrates how these norms drive (initial) non-hep-seeking or avoidance of help-seeking, as well as difficulties articulating emotional distress in face-to-face settings. As a result, this thesis has made an important

contribution in expanding this analytical framework as it relates to gay and bisexual men.

7.2 Digital community outreach work with gay and bisexual men in a mental health context

One of the most under-discussed and under-researched forms of online support within the mental health help-seeking literature are those delivered by LGBTQ community groups and organisations. This thesis helps fill this knowledge gap within the literature by examining the ways in which digital and social media are utilised by MindOut, a Brighton/UK-based LGBTQ mental health service, to reach and engage with gay and bisexual men. As illustrated in Chapter Six, MindOut is taking an alternative approach prioritising relationally oriented and peer-led supports as opposed to individually targeted self-help interventions. In developing their bespoke one-to-one online support service, their tripartite focus on confidentiality, anonymity and queer recognition and intelligibility (i.e., lived experiences of sexual and/or gender minority identities and mental health difficulties) allows for agentic help-seeking among gay and bisexual men. The platform's ability to preserve matters as confidential and anonymous troubles sociocultural and emotional norms that might otherwise inhibit help-seeking. This is also particularly important given that service providers are often insiders, both living and working within the communities they serve. Furthermore, in Chapter Four I indicated how the experience of recognition may be particularly precarious for some gay and bisexual men. To that end, Chapter Six demonstrates how MindOut's online support service offers the possibility for various kinds of recognition. Thus, while it has argued that mainstream services and support mechanisms may fail to support sexual and gender minorities because they are not designed to address the difficult emotions some subjects are experiencing (McDermott & Roen, 2016), this thesis demonstrates that LGBTQ specialist initiatives and online outreach workers work with an understanding of gay and bisexual men's mental health help-seeking as an affective process.

While social media are not primarily built with outreach objectives in mind (Jenzen & Karl, 2014), organisations such as MindOut pragmatically use these platforms to best

serve their needs and capabilities. Currently, much of the use social media tools by the organisation involves a unidirectional and outwards-facing flow of information from MindOut to audiences as is more common with community-based health promotions organisations more generally (Ramanadhan et al., 2013). As such, MindOut's thinking is directed towards increasing rather than duplicating their outreach efforts, where mainstream and niche SNSs are utilised to reach large cohorts of gay and bisexual men and linking them with their services, their online support service in particular. The organisation's early adoption of niche SNSs and broadcast or banner advertising for outreach purposes is particularly innovative given that these spaces have largely garnered attention from sexual health promotion initiatives and suggest that these are an effective means to reach this target group. Given that gay and bisexual men's practices within these sociosexual spaces can be directed by a variety of help-seeking strategies, it can be argued that outreach initiatives such as the one discussed here put help-seeking services or resources in their pathway. However, my findings also illustrate tensions around prolonged or deeper engagement and in-depth intervention work vis-à-vis SNSs as it relates to social, commercial, and architectural dimensions of these digital environments. In light of this, I would argue that a presence within these spaces is an essential dimension for mental health outreach initiatives targeting gay and bisexual men; however, such approaches require careful consideration in terms of the available resources of charity organisations, as well as issues related to digital inequalities/exclusion, 'disconnective practices' (Light, 2014), market forces, and typically underserved gay and bisexual men (e.g., those who racial or ethnic minorities, live in rural areas etc.).

Lastly, the desperate need for culturally appropriate after-hours LGBTQ- mental health support was a recurring theme within the data (see Chapters Five and Six). This is not surprising given the scarcity of LGBTQ-specific services or interventions and poorer mental healthcare experiences in mainstream healthcare settings among this group including A&E services (see Chapter One and Two). The need for online resources may be even more pressing nationally outside of the Brighton 'bubble'. As a result, this does not necessarily entail limiting outreach to the 'lonely hours' but to ensure that formalised peer supports are available online to help facilitate gay and bisexual men's help-seeking if and when mental distress occurs.

7.3 Promoting gay and bisexual men's online mental health help-seeking

This study's findings have several implications for research, community-based initiatives, policymaking and funding bodies, as well as existing corporate social media platforms targeting gay and bisexual men. Before I engage with these, I need to address concerns within the research literature that a greater focus on, or promotion of, digital and social media mental health initiatives might replace conventional mental health services or divert attention away from improvements to or funding for such services (Lal & Adair, 2014). To be clear, this thesis does not advocate for the replacement of important and much needed face-to-face services or resources with exclusive online support for gay and bisexual men. Like previous research, this study's findings suggests concerted action aimed at improving the quality and availability of culturally appropriate care from mainstream mental health services, including A&E services (Blackwell, 2015; Byron, 2019; Haas et al., 2011). However, the findings do highlight the importance of online resources in facilitating help-seeking, crisis intervention, and ongoing support among isolated, vulnerable and distressed gay and bisexual men, particularly where LGBTQ-specific and sensitive services may be limited or unavailable. To that end, online approaches need to sit alongside conventional services working in tandem to ensure appropriate and relevant supports for gay and bisexual men.

7.3.1 Implications for LGBTQ community-based organisations

One important implication from the findings is the need for culturally relevant online resources, and for such resources to be both peer-led and available after hours. As indicated in Chapter Five, the lonely hours can be particularly challenging times for gay and bisexual men especially those with relatively few social outlets. The men within this study were fearful of, or had experienced of, negative reactions from traditional after-hours support services (e.g., helplines, A&E services) which restricted their help-seeking options (see Chapters Four and Five). Combined, online settings and formalised peer support can provide a safer environment in which to seek help with less fear of judgement or coercion. Relationally oriented digital interventions can act as a gateway for crisis intervention and later in-person support, as well as a means

to supplement such help. Additionally, mainstream and niche SNSs specific to gay and bisexual men are an effective means for reaching this target group and should therefore be an essential dimension for organisations working with gay and bisexual men in a mental health capacity. However, such strategies require careful consideration and complimentary offline approaches to engage with hard-to-reach groups of gay and bisexual men.

Yet, there's only so much LGBTQ organisations can do in economic terms or demand from their outreach workers. In an effort to provide more consistent after-hours support and develop social media outreach strategies, MindOut has recently been able to secure funding to employ an online outreach support worker in a more permanent and ongoing capacity. While a salient aspect of (some) social media may be that they are free, these platforms cannot compensate for the decline in funding more generally. Additionally, as small charities often rely on voluntary models with few part-time staff and trained volunteers, after hours initiatives – particularly those that run late into the night or early hours of the morning – would undoubtedly stretch resources relatively thin. In light of this, there may be value for organisations to link with or actively supporting already existing online peer support groups where distressed gay and bisexual men can engage in safer wit(h)nessing and critical relationality.

7.3.2 Implications for policymaking and funding bodies

The critical role of community and voluntary sector organisations in supporting the mental health and help-seeking of LGBTQ people has been recognised in recent policy documents (GEO, 2018a; Mental Health Taskforce, 2016). While the underuse of digital and social media platforms in the NHS has been raised by the publication of a 5-year plan to reshape mental health care delivery and expand access to digital services (Mental Health Taskforce, 2016), the national LGBT action plan remains largely silent about their outreach potential with gay and bisexual men despite noting considerable challenges in accessing mainstream mental health services (GEO, 2018a). As the findings in this thesis demonstrate, online support can be a crucial lifeline for distressed gay and bisexual men to work through 'crises in progress' and get helpful responses quickly, especially after hours when crisis points seemed more

likely as has been found elsewhere (Mental Health Taskforce, 2016). That many sexual and gender minorities benefit from online support is significant and this should be recognised as an increasingly legitimate source of help (McDermott et al., 2016; McNair & Bush, 2016). In light of this, mental health policy should be adjusted accordingly and explicitly address the value of digital and social media in generating and supporting outreach work with gay and bisexual men in a mental health context.

Additionally, gay and bisexual men's preferences for relationally oriented and peer focused supports (see Chapter Five) sharply contrasts with policymakers and commissioners broader interest in the delivery of low cost, highly scalable, and low-intensity mental health interventions, often automated self-help/monitoring digital programs or apps (Powell, 2016). Furthermore, these are designed for the population in general and seldom incorporate the unique set of mental health challenges gay and bisexual men face, thereby contributing to minority stress (Rozbroj et al., 2014). Moreover, the offering of individually focused solutions to meet mental health difficulties reinforces neoliberal notions of mental health as largely an individual achievement and responsibility rather than consider the broader social, cultural, and economic determinants which influence mental health and help-seeking (Dickinson & Adams, 2014). To that end, policymaking and funding bodies should ensure that relationally oriented and formalised peer support digital interventions are prioritised with gay and bisexual men. Such initiatives need to be sufficiently funded in order to ensure that small charities with few full-time staff and trained volunteers are capable of delivering sustainable and ongoing support. This is not to suggest that individually targeted or self-help interventions are unhelpful; however, it is imperative that these provide referrals or signpost to LGBTQ-specific or sensitive services for gay and bisexual men, both on- and offline, given that they benefit from them.

7.3.3 Implications for corporate social media platforms targeting gay and bisexual men

Finally, as demonstrated within this thesis, corporate or commercial SNSs targeting gay, bisexual and other MS are spaces in which mental health-related concerns are communicated and where a variety of help-seeking strategies are enacted (see

Chapter Five). Additionally, these platforms not only offer an unparalleled opportunity to engage with cohorts of gay and bisexual men but also enable help-seeking interventions or services to be placed in their pathway (see Chapter Six). While this study illustrates the well-intentioned and laudable efforts of numerous niche SNSs in supporting community-based efforts, it also notes tensions where more popular platforms may be less forthcoming in supporting small charities without compensation or formal partnerships (see Mowlabocus et al., 2016 for further examples of 'commercial gatekeeping'). Of course, these platforms are driven by commercial imperatives and often depend on revenue from advertising and/or user subscriptions to premium services (Albury et al., 2017). Consequently, there may be tensions between the platforms' commercial interests and the outreach objectives of small charities that are by definition vulnerable and constantly under threat in economic terms as they reliant on (short-term) funding and grants. To that end, it is imperative that commercial niche SNSs and apps recognise their corporate social responsibilities by actively supporting organisations such as MindOut by providing better service integration for community outreach work and ensuring a sustained presence on their platforms.

Again, there have already been some improvements in this regard since the time of data collection. For example, Grindr has recently launched the Grindr for Equality (G4E) program, a social justice initiative focused on the promoting the health and safety of LGBTQ people and working alongside community-based and voluntary sector organisations targeting this group[37]. With the program's assistance, Grindr users logging into the platform now receive a broadcast advertisement courtesy of G4E about MindOut's services including a hyperlink directing viewers to the organisation's online support service (see figure 10 below). These broadcasts are time-limited in nature and typically decided by advertising availability. The obvious implication here is that the presence of community-based services on this and other platforms may fall outside peak advertising hours, especially during the evenings or late at night when these platforms are most active (Goedel & Duncan, 2015), and when mental health crises are likely to occur (Mental Health Taskforce, 2016). To that end, online SNSs and apps specifically target gay and bisexual men should therefore work

[37] See https://www.grindr.com/g4e/

to ensure the presence of specialist support services during these periods as they may be a lifeline to someone in distress or crisis by opening up help-seeking possibilities. Of course, such strategies will entail consultation with community-based organisations to best fit their capabilities but could, for example, involve broadcast or banner advertising of their services during these peak hours.

Figure 10. G4E MindOut broadcast advertisement

7.4 Critical reflections and future research opportunities

This thesis has offered an expanded conceptualisation of gay and bisexual men's mental health help-seeking. In doing so, it has drawn upon the experiences and perspectives of 18 self-identified sexual and gender minority individuals who have sought and/or delivered mental health-related assistance online (i.e., 9 gay and bisexual men, 9 LGBTQ digital outreach workers). While the research outcomes may resonate with the experiences of gay and bisexual men in Western societies, this study does not claim to be representative given the specific research context and research sample (see Chapter One and Three), nor do I mean to suggest that gay and bisexual men use digital and social media in the same way or for the same purposes. Indeed, some gay and bisexual men may not use online settings for mental health-related

assistance or even access the Internet[38]. This thesis does, however, provide a starting point towards a broader conceptualisation of gay and bisexual men's mental health help-seeking. To my knowledge, this thesis is one of few studies to highlight the affective nature of help-seeking relations (Fullagar, 2005; McDermott, 2015; McDermott & Roen, 2016), and one of the first to specifically focus on gay and bisexual men.

The dearth of research on the topic means that there is a great deal more to be learned about the ways in which gay and bisexual men seek help for mental health problems. Also, because digital and social media and how individuals use these changes so often, ongoing investigation will be necessary to keep up with the ever-changing landscape and to remain relevant to those who use it for mental health-related assistance. This may be particularly true for gay and bisexual men given their investment in, and pervasive use of, online technologies. In concluding this thesis, this final section critically reflects on the strengths and limitations of this study as well as suggest several avenues for future research.

7.4.1 Moving beyond the 'usual suspects'

A particular strength of this study is that it includes a sample with a diverse age range (ranging from 23 to 58 years of age with a mean age of 37), whereas previous work on LGBTQ people's online mental health help-seeking primarily focused on LGBTQ youth (e.g., McDermott, 2015; McDermott et al., 2016; McDermott & Roen, 2016). Also, by including the experiences and perspectives of LGBTQ digital outreach support workers, this thesis offers insight into under-discussed form of support within the literature. Despite efforts to diversify the research sample (see Chapter Three), one notable limitation of this thesis is that participants primarily consisted of 'the usual [LGBTQ research] suspects' (Clarke et al., 2010), that is, individuals who are mostly urban, White, gay, cisgender, non-disabled and already linked to sexuality-based organisations. This is problematic because other factors such as race, ethnicity, cultural backgrounds, bisexual and/or trans identities are likely to influence help-

[38] According to Ofcom (2019), 13% of UK adults are non-users of the Internet. Those aged 55 and over and/or in the DE socio-economic group remain less likely to be online (i.e., semi-skilled and unskilled manual workers, state pensioners, casual and lowest grade workers, unemployed with states benefits).

seeking but these have received more limited attention. Furthermore, while research has shown strong associations between socio-economic disadvantage, mental health problems and a reticence for help-seeking (Seidler et al., 2016; Smalley et al., 2016; Storholm et al., 2013), this study did not ask participants to disclose or discuss their socio-economic status in relation to help-seeking. Thus, this study is ultimately subject to the same convenience sampling critiques that befall LGBTQ-related research more generally (Clarke et al., 2010; Meyer & Wilson, 2009).

Future research focusing on gay and bisexual men's (online) mental health help-seeking experiences should therefore bring a greater lens of intersectionality to the discussion and recognise the diversity *within* this population. This is particularly true for bisexual and/or trans men who, despite obvious psychosocial differences, are often collapsed with their gay and cisgender peers for research purposes with little attention paid to their unique help-seeking pathways and experiences (Parent & Bradstreet, 2017). Furthermore, there is a need to examine help-seeking in relation to diverse racial and ethnic backgrounds, socio-economic status, geographic locations and those with long-term physical impairments (Lee et al., 2017). Online approaches to recruitment and data collection may be particularly beneficial in delivering more diverse samples than those encountered via traditional methods (e.g., Lelutiu-Weinberger et al., 2015; McDermott et al., 2013); however, such strategies require careful consideration given that online methods are also culpable – as has been evidenced here – in generating an overrepresentation of the usual suspects. To that end, future researchers are well advised to utilise a diversity of social media, both mainstream and niche, as part of their recruitment approaches. Where sufficient funding is available, paid Facebook advertising campaigns have proved to very effective recruitment strategies, especially in targeting specific underrepresented LGBTQ groups (e.g., bisexual men, people in geographically remote areas etc.) (Nodin et al., 2015). Additionally, broadcast and/or banner advertising via niche GSN apps or sites may also be helpful, but time-limited and dependent on formal partnerships with such services. Alternatively, a more targeted and purposeful recruitment strategy via direct messaging on these platforms may be advisable. Such strategies have attracted diverse gay and bisexual male research samples (Gibbs & Rice, 2016; Goedel, Brooks, & Duncan, 2016, for example). Of course, the success of

such strategies will depend on the ingenuity and mobility of researchers as they will require a review of user profiles and/or travel to different geographic locations.

7.4.2 Moving towards a diversity of help-seeking pathways and research methods

The heavy focus on LGBTQ specialist service providers and service users was both a strength and limitation of this study. Given that MindOut prioritises peer-led and peer-focused approaches within the context of their support services, both on- and offline, my analysis may have oriented around the needs for and benefits of relationally oriented supports and actual or eventual help-seeking among gay and bisexual men. More research is thus needed to examine a diversity of help-seeking pathways/trajectories. One, the allure of low-cost and highly scalable automated interventions to the delivery of mental healthcare is undeniable in light of increased demand and financial pressures. Ongoing research is thus necessary to assess the applicability of such interventions for gay and bisexual men. To that end, a review of current web and smartphone apps used and recommended by the NHS[39] may help better illuminate whether these interventions cater to the unique mental health needs and experiences of sexual and gender minority men. Second, this study has focused on those who have at one point or another sought help, both on- and off-line, for a mental health concern. While insights are offered into participants' hesitancy to look for help and support from (in)formal resources within their offline contexts, my analysis is restricted to experiences of help-seeking and tracking pathways to mental health support, LGBTQ specialist or peer support in particular. Follow-up research is necessary to examine some gay and bisexual men's reasons for not seeking help, whether online or from LGBTQ services where available, in periods of distress or crisis in order to illuminate further opportunities for intervention. Importantly, such work needs to move beyond the concept of 'barriers' as a common currency for explaining non-help-seeking among sexual minority men and towards a greater understanding of the perceptions or interpretations that move these individuals away from online or

[39] See Bennion et al. (2017) for a range of web- and app-based interventions used and recommended for depression, anxiety and stress by the NHS through their referral services or the online NHS Apps Libraries.

LGBTQ-related forms of support. As this thesis has shown, this expanded frame can lead to new opportunities where interventions are concerned. As such, there are opportunities to consider how avoidant help-seeking practices can limit gay and bisexual men's ability to address mental health-related difficulties.

By utilising a multiple qualitative method approach, generating both online and face-to-face data, this study addressed a key limitation in previous online help-seeking research (McDermott, 2015). The use of online elicitation methods helped generate extended contact with some research participants which provided further insights into the help-seeking process, while qualitative methods allowed for in-depth probing of their experiences of this process. However, by focusing on retrospective reporting this study may not fully have engaged with distressed gay and bisexual men's immediate experiences of which may be crucial to an in-depth understanding of (non-)help-seeking behaviours. Future research focusing specifically on online data and covert research methods may elicit different types of data, immediate and unmediated by researcher/participant interaction (McDermott et al., 2013). Future researchers are cautioned, however, that resistance may be encountered in photo elicitation interviews where the generation of online materials are an active part of the interview process as such activities may be considered invasive, unwelcome and/or distracting. Predominantly, participants within this study preferred to discuss their experiences, rather than engage in a 'show and tell' style conversation (i.e., a conversational wall through of online material and pages). This may reflect participants' need or preference for social and emotional connection with an/other, and the opportunity to engage in 'therapeutic' type of conversation about their difficulties and experiences. Even in this study where participants were forewarned that interview activities would involve photo elicitation methods, some felt uncomfortable sharing particular online spaces, content or interactions with me which they viewed as private, revealing or inappropriate[40]. As such, researchers may do well to ask participants to collect and share online materials before or after interviews, or as part of asynchronous interviews (e.g., Hutchinson, 2015). Furthermore, the collection and reproduction or publication of such materials raises a host of ethical challenges that must be worked out in

[40] One participant, for example, felt uncomfortable sharing niche SNS which involved sexually explicit images and/or interactions, stating 'I can't do that. There's porn on there [laughter]. Its graphic, that.'

practice. Ethical and research guidelines will be especially welcome in this area to inform future research efforts.

7.4.3 Reflecting on analytical choices: Approaching the study differently

With the benefit of hindsight, there are many ways in which one could have approached this project differently. In this concluding sub-section, I reflect on how I might have generated a more nuanced understanding of gay and bisexual men's online help-seeking by paying greater attention in my analysis to the following factors: digital and social media affordances; bisexuality; whiteness; generational experiences of using technology; and, a greater focus on the affective nature of service providers experiences. I elaborate on each of these points in turn.

First, this thesis focuses greater attention on the emotional and normative dimensions of help-seeking at the expense of a more critical consideration of the affordances of specific digital and social media platforms and their impacts on online help-seeking. The concept of affordances, while multivalent, is generally used to understand and analyse the relationship between the materiality of media and human agency (for an overview of the different but related ways in which affordance has been conceptualised in scholarship, see Bucher & Helmond, 2017). Put simply, the concept focuses attention on the dynamics or types of communicative practices and social interactions afforded – or constrained – by these platforms, interfaces and/or features. Because of the affordance of anonymity offered by MindOut's bespoke online chat service hosted on their website (i.e., a bounded space/platform), participants were able to express their distress or feelings in less stigmatising ways. By comparison, the affordances and prevailing positivity norms of other platforms such as Facebook, which typically mimic offline networks and encourages emotional self-expression with their larger network (e.g., status updates), may mean that negative emotions are perceived or responded to more negatively (Waterloo, Baumgartner, Peter, & Valkenburg, 2018). Similarly, the possibility of seen or heard negative judgement in face-to-face or helpline settings (both traditional and virtual/video) can also inhibit help-seeking and intensify the emotional distress for gay and bisexual men (McDermott & Roen, 2016).

If this thesis had mobilised the lens of affordances in a more sustained way, it would have offered different perspectives on the research outcomes. For example, participants' preference for relationally oriented spaces may be related to platform features that prioritise *synchronous* rather than asynchronous communication, providing opportunities for helpful responses during crises in progress. Additionally, the theorised relief experienced by those who seek help via anonymous platforms (i.e., the reduction in imagined or actual judgement) may also relate to the affordances of text-based communication and requires further attention. Writing, as a method of inquiry, can be therapeutic for those who write to make sense of their experiences (Pachankis & Goldfried, 2010). Thus, the design of platforms and settings such as private 1-to-1 chat rooms and discussion forums may generally provide better mediums for lengthier and expressive conversations as opposed to shorter SMS-style messaging mediums that are common to other social media apps (e.g., Twitter, Snapchat, WhatsApp and niche SNSs). Other aspects of digital technology which may impacted an understanding of the data involves the devices gay and bisexual men use to access online support. Mobile devices such as smart phones, for example, offer more opportunities for private communication than say a work or household computer but may be more restrictive for service providers when trying to engage these men in a sustained conversation on niche SNSs (see Mowlabocus et al., 2016, for example). Smartphones are personal devices that are more or less always switched on and at hand and thus arguably can be used for online help seeking in new ways. However, smartphones are mainly app based and the interface is thus often limited in functionality compared to web-based services. Given more time, the study could explore such factors more in depth, via a mapping of the type of devices participants used for different types of help seeking, at different times of the day etc. Furthermore, the heavy featuring of commercial open access platforms such as Facebook or Twitter among small community-based organisations are common given their immense potential in terms of reach and scope for those operating within economic constraints (Ramanadhan et al., 2013). However, these platforms pose particular challenges for outreach workers and affective complications for gay and bisexual men given issues such as context collapse, community and commercial gatekeepers, and localised app profiles. A greater focus on platform-specificity in terms of their affordances and outreach work would have yielded richer insights. Community-based organisations cannot afford purpose-built platforms, and the use of commercial open access

platforms have many advantages, not least their ubiquity and familiarity. However, as Tanya Bucher (2018) notes, we should be clear about the fact that the algorithms of commercial social media platforms, such as Facebook, including their 'programmed sociality' are designed to create financial value, and given more time the study could have explored further the tensions this creates between the uses by not-for profit community organisations and the commercial interests of the social media corporations.

Second, as previously stated (see section 7.4.1), the voices and accounts of bisexual men are only partially heard in this thesis and there are several reasons for this. Although three men identified as bisexual according to collected demographic information, these participants primarily focused on their encounters and/or feelings for other MSM and help-seeking challenges experienced by sexual minority people more generally as part of interview data. There was thus little discussion around their bisexual-specific experiences and psychosocial stressors unique to their minority group in relation to help-seeking (see MacKay et al., 2017, for example). Also, given that I decided against identifying annotations at the end of interview extracts to provide more shelter for participants' identities (i.e., age, sexual orientation and/or gender identity (see Chapter 3, section 3.8.2), more attention was focused on understanding help-seeking of male sexual minorities as a whole more generally (e.g., heterosexism and homophobia) rather than specific sub-groups (i.e., monosexism and biphobia) Looking more closely at the data, there was some discussion around gender differences, monosexism and biphobia both within and outside the LGBTQ community. For instance, asking if he had any difficulties accessing support because of his identity as a bisexual man, one participant stated more generally that:

> Bisexuality… can be a difficult subject. I remember someone telling me that lesbians don't like bisexual men because if they go into a pub and there's a gay man there, they can talk to them okay, but if they talk to a bisexual man that man might fancy them. I don't know how true that is. There is some sort of feeling against bisexuals. I used to work in a swingers club… if you're a bisexual woman then you're loved in a swingers club. It's like a porn film. If you're a bisexual man its

> more difficult. There seems to be different feelings towards a bisexual man and a bisexual woman (pseudonym removed).

While the above extract doesn't specifically reference help-seeking, it does demonstrate how bisexual men and women can encounter multiple levels of biphobia and related microaggressions differently, and both from within and outside of the LGBTQ community. This alludes to the ways in which biphobia and monosexism might impact upon their help-seeking, including negative potential reactions from mainstream and/or LGBTQ-specific services. Focusing more on these bisexual-specific experiences during data collection and analysis would have yielded a richer account of bisexual men's help-seeking relations.

Third, my analysis and the research outcomes are also limited by mono-ethnicity, whiteness specifically (both my own as researcher and the research sample] (see Chapters 3 and 7, sections 3.5 and 7.4.1 respectively), and this limits the applicability of the findings and/or conclusions to gay and bisexual men from diverse racial/ethnic backgrounds. To use an example, the visuals presented in Figure 4 (see Chapter 4, section 4.1, p. 93) highlights how a homonormative queer male culture foregrounds and produces a set of norms around whiteness and its aesthetics, thereby excluding different racial and ethnic backgrounds from a full sense of belonging within the queer community and society more generally. While I briefly point to this in my analysis of the accompanying extract, I primarily examine the participant's discussion of exclusions around men and fitness in the gay community (i.e., the fit, perfected, idealised body in queer masculine culture as a measure of inclusion) as it relates to their central concern with the image; a discussion of whiteness by the participant is absent in their interview data. However, this absence requires further scrutiny, critical reflection (including self-reflection on my position as a white man), and explicit interrogation given the explicit and more subtle racial and ethnic exclusions that operate within wider society and the queer community. Had I achieved a more diverse demographic research sample, the following narratives would likely have come through in the analysis more strongly: the impact of racism from within/outside of the LGBTQ community on mental health and help-seeking both on- and offline (e.g., Couzens, Mahoney, & Wilkinson, 2017; Gosine, 2007); and, perhaps a bigger prominence of religious or spiritual support-seeking among diverse gay and bisexual

men (e.g., Meyer et al., 2015). Consequently, gay and bisexual men with differing ethnic and racial identities may face additional difficulties and exclusions in accessing online support.

Fourth, the applicability of the findings and conclusions may be limited to the age of the research sample represented here: gay and bisexual men with a mean age of 37; those who adopted many or most aspects of online technologies at some later point in their life i.e., digital immigrants (Prensky, 2001). This particular age group of men may see online spaces as natural settings for mental health help-seeking and easy forms of communication, whereas older gay and bisexual men, for example, may be less accustomed to the Internet and its functions (Ofcom, 2019; Pfeil, Arjan, & Zaphiris, 2009). Similarly, the dominant use of Facebook for outreach purposes may be less effective in reaching younger gay and bisexual men in light of the ageing demographics on the platform (Sweney, 2018). Indeed, as Jenzen (2017) cautions in relation to digital community outreach work and trans young people, the navigation of online digital and social media 'is complex and diverse, and possibly not purposeful in anticipated ways' (p. 1635). Being aware of generational differences in relation digital and social media outreach work can only enrich service provision.

The finding that gay and bisexual men turn to relationally oriented and text-based virtual spaces for help may relate to their early adoption and heavy use of online communities for social and sexual purposes, as well as ongoing community-based sexual health outreach work within these spaces. A review by Grov et al. (2014) summarises early research consideration of the ethics, feasibility and acceptability of using the Internet to conduct interventions with gay and bisexual men in the early 2000s with much of this work grounded in models of tailored disease prevention. Similarly, Mowlabocus et al. (2016) discusses community outreach initiatives by THT, the longest running charity dedicated to HIV promotion and transmission/harm reduction in the UK, as they operate across multiple digital and social media platforms to reach and actively engage with gay and bisexual men on their own 'turf' (e.g., offering advice via chatrooms, message boards, messaging services etc.). To that end, digital sexual health interventions can be read as leading the way in terms of social media outreach and interactive, multi-directional communication within these spaces. By comparison, mental health community-based organisations, such as

MindOut, appear take a more traditional and unidirectional approach, 'pushing' information about their services to social media audiences rather than encouraging participation and engagement across/within these spaces (Ramanadhan et al., 2013). One way to improve engagement is to provide support services across multiple platforms; however, this depends on the organisation's resources and will require strategic consideration around potential communication inequalities.

Another point to consider is the impacts of community-based sexual health outreach work on men of diverse ages with diverse relationships to the different phases of HIV/AIDS history, and what this might mean for online mental health initiatives. Stigma surrounding HIV/AIDS and the blame ascribed to gay, bisexual and other MSM for the disease has been well document since the beginning of the epidemic, when HIV/AIDS was initially labelled 'gay-related immune deficient' (Epstein, 1996), perhaps necessitating a need for anonymous forms of help-seeking and support in early digital interventions. However, the relationship between the virus and this subculture has altered over the last thirty years with recent initiatives prioritising increased confidentiality or privacy over affordances that preserve anonymity, given the sliding scale of anonymity provided by niche SNSs. It would be interesting to explore whether some of the learnings from HIV/AIDS communications tackling stigmatisation could be applicable to communicating about mental health, particularly for hard-to-reach parts of the community for whom mental health issues are still very stigmatising. An obvious example here are older gay or bisexual men who remember the pathologising histories of psychology and psychotherapy with regards to homo- and bisexuality.

Lastly, the analysis and treatment of the data resulted in two parts, the first involving the experiences of gay and bisexual men seeking help off- and online (see Chapters 4 and 5, respectively) and the second focused on the insights and practices of digital outreach workers (see Chapter 6). The interpretive or affect lens of this study was unequally weighted, dominating the first part and foregrounding the affective nature of gay and bisexual men's mental health help-seeking. Less attention was therefore paid to the affective demands of support giving on outreach workers. This is due a more restrictive focus in focus group data on the working protocols and practices of digital outreach workers as there are limited policies, standards, and procedures available to help guide online service provision with this group (for a similar critique, see Fantus et

al., 2017). An even application of the affect lens across both data sets would provide a fuller and more nuanced understanding of online help-seeking relations and warrants further exploration. To that end, individual interviews (rather than a focus group) with service providers may have been a more productive approach in this regard. The few interviews that had been conducted with this group allowed for some intimate discussions as service providers discussed their own help-seeking experiences; however, two outreach workers asking for this specific data to be removed. Outreach workers are keenly aware of the ethical issues associated with their work (such as maintaining client confidentiality and anonymity and managing personal and professional boundaries) and this may have impacted what they felt able to disclose during our interview discussions.

7.4.4 Becoming (in)visible: Researcher reflexivity and the help-seeking process

Over the past few years, I have been deeply enmeshed in literature and research on gay and bisexual men's mental health help-seeking and I would be remiss not to discuss or reflect on my personal experiences as it relates to the research topic. Indeed, researcher reflexivity is an essential part of qualitative analysis (Braun & Clarke, 2013), and refers a process of 'continual internal dialogue and critical self-evaluation of [the] researcher's positionality as well as [an] active acknowledgement and explicit recognition that this position may affect the research process and outcomes' (Berger, 2015, p. 220). Consequently, reflexivity is used as a vehicle for making the research process visible and challenging the views of knowledge as objective and independent of the researcher producing it. I include my reflexivity here at the end of this thesis not as an afterthought, but as a process and experience that I am still coming to terms with for reasons that will become apparent as this section progresses.

Before coming to Brighton to pursue my postgraduate studies, I worked and resided in Windhoek, Namibia: a country with a long and troubled history regarding its protection of LGBTQ people's human rights and civil liberties. Same-sex sexual relations between men remain illegal under common Roman-Dutch law in the country

although not actively enforced (Hubbard, 2015), and the Namibian constitution does not prohibit discrimination on the basis of sexual orientation and gender identity or expression (Home Office, 2018). In this period, I volunteered for a LGBTQ rights-based organisation, LGBTI Namibia, where I occupied several positions: first, as a social events organiser, then as trustee, and, later, even chairperson (albeit very briefly). I was initially approached by the organisation to assist with community organising, mobilising and networking efforts on account of my increasing visibility within the local LGBTQ community or 'gay scene': after the closure of the first and, to date, only openly gay venue in Windhoek, Donna Bella, I set out with a friend to establish spaces where LGBTQ people could meet one another – both on- and offline – for social support reasons; supports that I drew on as part of my coming out process. My involvement with the organisation extended my visibility beyond the local LGBTQ community where I spoke about the difficulties the community faced in meetings with other human right-based and non-profit organisations, and the Namibian media. While I was afforded certain privileges as a white, middle-class, and able-bodied gay man, my increasing visibility also brought its fair share of prejudice and stigma within heteronormative, puritanical and traditionally Afrocentric climate.

It was through the aid of University of Brighton scholarships that I was able to purse my postgraduate studies in relation to my interests in LGBTQ people, advocacy, and psychology. Living, studying and doing research in Brighton over the last few years opened my eyes to the possibility of an 'ordinary', as opposed to exceptional or transgressive, gay life. It is here where I first came to feel comfortable holding my partner's hand in public and less worried about coming across as 'straight-acting'. In many ways, Brighton provided me a space where I could simply *be.* At the same time, however, my social world became small compared to my large social network back home and I started feeling increasingly invisible to other people. Forming and maintaining new friendships in the city, both within and outside of the LGBTQ community, was and remains a challenge, exacerbated perhaps by my status as a foreigner as well as the often lonely and isolating experience of postgraduate studies (Ali & Kohun, 2006; Janta, Lugosi, & Brown, 2014). As time went on and data collection commenced, I started experiencing intense and debilitating anxiety which not only impacted my own mental health help-seeking, but my academic pursuits as well. At times, working on this study brought an unbearable sense of visibility and vulnerability

where I felt as if though I was putting a magnifying glass on my personal experiences and opening them up to critique from others. This severely impacted my thesis writing and academic help-seeking.

As mentioned previously (see Chapter Three), it was agreed with MindOut that I would be supported with a debriefing meeting during the data collection process, if the need arose. While I have no doubt that the organisation would have extended this support to me during the write-up of this thesis, I felt rather hard pressed and embarrassed to make use of their services given our professional relationship. Accessing private and voluntary mental healthcare was also a challenge during this period given the high costs associated with ongoing support. With the benefit of hindsight, if I were to start this project again, I would insist on regular and non-negotiable debriefing sessions with my community support worker or allocated funding to see a mental health professional at different stages throughout the research process. In doing so, opportunities for support would have been placed in my pathway and perhaps more accessible. I would therefore encourage future doctoral students or researchers in this topic area, particularly those who come from a similar background or who are in a similar position to my own, to put such protocols in place. Aside from therapeutic potentials, such occasions can also aid researcher reflexivity and provide opportunities to reflect on the research process.

On a positive note, I would argue that these positions impacted the research in several beneficial ways. First, my history with and interest in LGBTQ community-based organisations was perhaps an important impetus for my alternative mode of enquiry focused on their service users/providers in comparison to dominant approaches. Second, my sharing of participants experiences affected the process of data collection and analysis in that it allowed me to approach the study and certain topics with some knowledge (i.e., ‘cultural intuition’) and assisted in developing a rapport with participants. I would argue that such familiarity enabled a better in-depth understanding of participants’ perceptions and interpretations of their lived experiences in a way that may have been less possible in the absence of having shared such experiences. To that end, consultation with my supervisory team has been helpful in offering feedback on my analysis as a means of avoiding possible projections and ignoring relevant content.

To conclude this thesis, reflexive practice in research on issues of mental health help-seeking would be a welcome addition and resource for future research processes and outputs. One of my ambitions moving forward is to provide an autoethnographic account of my experience. Autoethnography is ‘a style of autobiographical writing and qualitative research that explores an individual’s unique life experiences in relationship to social and cultural institutions’ (Custer, 2014, p. 1), which tells ‘subjugated knowledges’ (i.e., experiences often hidden, not easily discovered, or missing in the existent literature) and has therapeutic potentials (Chang, 2016). Such a ‘telling’ will not only help others gain a new understanding about mental health help-seeking and the doctoral research process but also provide a means to better understand my own help-seeking difficulties and perhaps bring about some closure. As Doolin (2010) points out, ‘our words, experiences, time, and knowledge may be invaluable to those wondering how to deal with some of the same things’ (p. 101).

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help-seeking. *The American Psychologist*, *58*(1), 5–14.

Affleck, W., Carmichael, V., & Whitley, R. (2018). Men's mental health: Social determinants and implications for services. *The Canadian Journal of Psychiatry*, *63*(9), 581–589.

Aguinaldo, J. P. (2012). Qualitative analysis in gay men's health research: Comparing thematic, critical discourse, and conversation analysis. *Journal of Homosexuality*, *59*(6), 765–787.

Ahmed, S. (2015). *The cultural politics of emotion* (2nd ed.). New York: Routledge.

Albury, K., Burgess, J., Light, B., Race, K., & Wilken, R. (2017). Data cultures of mobile dating and hook-up apps: Emerging issues for critical social science research. *Big Data & Society*, *4*(2), 1–11.

Ali, A., & Kohun, F. (2006). Dealing with isolation feelings in IS doctoral programs. *International Journal of Doctoral Studies*, *1*, 21–33.

Allison, A. (2009). The cool brand, affective activism and Japanese youth. *Theory, Culture and Society*, *26*(2–3), 89–111.

Alonzo, A. (1984). An illness behaviour paradigm: a conceptual exploration of a situational-adaption perspective. *Social Science & Medicine*, *19*(5), 499–510.

Anderson, V. N. (2018). Cisgender men and trans prejudice: Relationships with sexual orientation and gender self-esteem. *Psychology of Men & Masculinity*, *19*(3), 373–384.

Armitage, C. J., & Connor, M. (2001). Efficacy of the theory of planned behaviour. *British Journal of Social Psychology*, *40*, 471–499.

Ash, M., & Mackereth, C. J. (2013). Assessing the mental health and wellbeing of the lesbian, gay, bisexual and transgender population. *Community Practitioner*, *86*(3), 24–27.

Austin, A., Craig, S. L., & Alessi, E. J. (2017). Affirmative cognitive behavior therapy with transgender and gender nonconforming adults. *Psychiatric Clinics of North America*, *40*(1), 141–156.

Azjen, I. (1991). The theory of planned behavior. *Organizational Behaviour and Human Processes*, *50*, 179–211.

Baams, L., Jonas, K. J., Utz, S., Bos, H. M. W., & van der Vuurst, L. (2011). Internet use and online social support among same sex attracted individuals of different ages. *Computers in Human Behavior*, *27*, 1820–1827.

Bachmann, C. L., & Gooch, B. (2017). *LGBT in Britain: Hate crime and discrimination*. London, UK.

Bailey, J. M., Gaulin, S., Agyei, Y., & Gladue, B. A. (1994). Effects of gender and sexual orientation on evolutionary relevant aspects of human mating psychology. *Journal of Personality and Social Psychology*, *66*, 1081–1094.

Balsam, K. F., Martell, C. R., & Safren, S. A. (2006). Affirmative cognitive-behavioural therapy with lesbian, gay, and bisexual people. In P. A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 223–243). Washington, DC: American Psychological Association Press.

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the lifespan: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology*, *73*(3), 477–487.

Barak, A., & Grohol, J. M. (2011). Current and future trends in Internet-supported mental health interventions. *Journal of Technology in Human Services*, *29*, 155–196.

Bariola, A., Lyons, A., & Leonard, W. (2016). Gender-specific health implications of minority stress among lesbians and gay men. *Australian and New Zealand Journal of Public Health*, *40*(6), 506–512.

Bates, E. A., McCann, J. J., Kaye, L. K., & Taylor, J. C. (2017). 'Beyond words': A researcher's guide to using photo elicitation in psychology. *Qualitative Research in Psychology*, *14*(4), 459–481.

Bauman, Z. (2003). *Liquid Love: on the Frailty of Human Bonds*. Cambridge: Polity.

Bennion, M. R., Hardy, G., Moore, R. K., & Millings, A. (2017). E-therapies in England for stress, anxiety or depression: What is being used in the NHS? A survey of mental health services. *BMJ Open*, *7*, e014844.

Berg, M. B., Mimiaga, M. J., & Safren, S. A. (2008). Mental health concerns of gay and bisexual men seeking mental health services. *Journal of Homosexuality*, *54*(3), 293–306.

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234.

Bersani, L., & Phillips, A. (2008). *Intimacies*. Chicago: Chicago University Press.

Bettinsoli, M. L., Suppes, A., & Napier, J. L. (2019). Predictors of attitudes toward gay men and lesbian women in 23 countries. *Social Psychological and Personality Science*, 1–12.

Biddle, L., Donovan, J., Sharp, D., & Gunnel, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behaviour. *Sociology of Health & Illness*, *29*(7), 983–1002.

Blackwell, C. W. (2015). Assessment and treatment of depression in gay and bisexual men in emergency settings. *Advanced Emergency Nursing Journal*, *37*, 116–124.

Blank, G. (2008). Online research methods and social theory. In N. Fielding, R. Lee, & G. Blank (Eds.), *The SAGE Handbook of Onlone Methods* (pp. 537–649). London: Sage.

Bolton, J. (2019). *Gay men, casual sex, and psychological well-being*. Alliant International University.

Borgogna, N. C., McDermott, R. C., Aita, S. L., & Kridel, M. M. (2018). Anxiety and depression across gender and sexual minorities: Implications for transgender, gender nonconforming, pansexual, demisexual, asexual, queer, and questioning individuals. *Psychology of Sexual Orientation and Gender Diversity*, 1–10. https://doi.org/10.1037/sgd0000306

Bourne, A., Reid, D., Hickson, F., Torres-Rueda, S., & Weatherburn, P. (2015). Illicit drug use in sexual settings ('chemsex') and HIV/STI transmission risk behaviour among gay men in South London: Findings from a qualitative study. *Sexually Transmitted Infections*, *91*(8), 564–568.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Bradford, J., Ryan, C., & Rothblum, E. D. (1994). National lesbian health care survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology*, *62*(2), 228–242.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative,*

qualitative, neuropsychological and biological (pp. 57–71). Washington, DC, US: American Psychological Association.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

Braun, V., & Clarke, V. (2016). (Mis)conceptualising themes, thematic analysis, and other problems with Fugard and Potts' (2015) sample-size tool for thematic analysis. *International Journal of Social Research Methodology*, *19*(6), 739–743.

Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health*, *27*(167–194).

Brighton & Hove City Council. (2014). *Brighton & Hove City Snapshot - Summary of Statistics 2014*. Brighton & Hove.

Brijnath, B., & Antoniades, J. (2016). 'I'm running my depression:' Self-management of depression in neoliberal Australia. *Social Science & Medicine*, *152*, 1–8.

British Medical Association. (2018). New BMA research unveils blindspot in mental healthcare. Retrieved 8 June 2018, from https://www.bma.org.uk/news/media-centre/press-releases/2018/february/new-bma-research-unveils-blindspot-in-mental-healthcare

British Psychological Society. (2014). *Code of Human Research Ethics (2nd edition)*. Leicester.

British Psychological Society. (2017). *Ethics Guidelines for Internet-mediated Research*. Leicester.

Brown, J. S. L., Sagar-Ouriaghli, I., & Sullivan, L. (2019). Help-seeking among men for mental health problems. In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health* (pp. 397–415). Cham, Switzerland: Palgrave Macmillan.

Brown, W. (2006). *Regulating Aversion: Tolerance in the Age of Identity and Empire*. Oxford: Princeton University Press.

Browne, K., & Bakshi, L. (2013). *Ordinary in Brighton?: LGBT, Activisms and the City*. Farnham, UK: Ashgate Publishing.

Browne, K., & Lim, J. (2008). *Mental Health. Count Me In Too Additional Findings Report May 2008*. Brighton.

Brownlie, J. (2018). Looking out for each other online: Digital outreach, emotional surveillance and safe(r) spaces. *Emotion, Space and Society*, *27*, 60–67.

Bruckman, A. (2002). Ethical guidelines for research online. Retrieved 24 June 2018,

from https://www.cc.gatech.edu/~asb/ethics/

Bucher, T., & Helmond, A. (2017). The Affordances of Social Media Platforms. In J. Burgess, T. Poell, & A. Marwick (Eds.), *The SAGE Handbook of Social Media* (pp. 233–253). London, UK: Sage.

Burchill, J., & Raven, D. (2007). *Made in Brighton*. London: Virgin Books.

Busby, M. (2019). Brighton Pride 2019: The annual LGBT parade - in pictures.

Butler, J. (1993). *Bodies that matter: On the discursive limits of 'sex'*. London: Routledge.

Butler, J. (2004). *Undoing gender*. London: Routledge.

Byron, P. (2019). 'Apps are cool but generally pretty pointless': LGBTIQ+ young people's mental health ambivalence. *Media International Australia*, *171*(1), 1–15.

Byron, P., Rasmussen, S., Wright Toussaint, D., Lobo, R., Robinson, K., & Paradise, B. (2016). *'You learn from each other': LGBTIQ young people's mental health help-seeking and the RAD Australia Online Directory*. Sydney, Australia.

Campkin, B., & Marshall, L. (2017). *LGBTQ+ cultural infrastructure in London: Night venues, 2006 - present*. London, UK.

Capurro, D., Cole, K., Echavarría, M., Joe, J., Neogi, T., & Turner, A. M. (2014). The use of social networking sites for public health practice and research: A systematic review. *Journal of Medical Internet Research*, *16*(3), e79.

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review*, *34*(4), 748–757.

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual issues in mental health help-seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*, 44–55.

Chakraborty, A., McManus, S., Brugha, T. S., Bebbington, P., & King, M. (2011). Mental health of the non-heterosexual population of England. *The British Journal of Psychiatry*, *198*, 143–148.

Chang, H. (2016). Autoethnography in Health Research: Growing Pains? *Qualitative Health Research*, *26*(4), 443–451.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of*

Psychiatry, *23*, 318–327.

Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology*, *12*(3), 297–298.

Clarke, V., Ellis, S. J., Peel, E., & Riggs, D. W. (2010). *Lesbian, gay, bisexual, trans & queer psychology: An introduction*. Cambridge: Cambridge University Press.

Clarke, V., & Peel, E. (2007). LGBT psychosocial theory and practice in the UK: a review of key contributions and current developments. *Journal of Gay & Lesbian Psychotherapy*, *11*(1/2), 7–25.

Cleary, A. (2012). Suicidal action, emotional expression, and the performances of masculinities. *Social Science & Medicine*, *74*, 498–505.

Clough, P. T. (2007). Introduction. In P. T. Clough & J. Halley (Eds.), *The Affective Turn: Theorizing the social*. Durham, NC: Duke University Press.

Cochran, S. D., & Mays, V. M. (2000a). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: Results from NHANES III. *American Journal of Public Health*, *90*(4), 573–578.

Cochran, S. D., & Mays, V. M. (2000b). Relation between psychiatric syndromes and behaviourally defined sexual orientation in a sample of the U.S. population. *American Journal of Epidemiology*, *151*, 516–523.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*(1), 53–61.

Cocks, H. (2002). ‘Sporty girls’ and “artistic” boys: Friendship, illicit sex and the British “companionship” advertisement, 1913-1928. *Journal of the History of Sexuality*, *11*, 457–482.

Collis, R. (2010). *New Encyclopedia of Brighton*. Brighton: Brighton and Hove Council.

Cooper, C., Spiers, N., Livingston, G., Jenkins, R., Meltzer, H., Brugha, T., … Bebbington, P. (2013). Ethnic inequalities in the use of health services for common mental disorders in England. *Social Psychiatry and Psychiatric Epidemiology*, *48*(5), 685–692.

Copp, H. L., & Koehler, W. J. (2017). Peer attitudes toward LGBT- identified university students as mediated by demographic factors. *Journal of Gay & Lesbian Mental Health*, *21*(4), 277–291.

https://doi.org/10.1080/19359705.2017.1320697

Corliss, H., Cochran, S., & Mays, V. (2009). Sampling approaches to studying mental health concerns in the lesbian, gay and bisexual community. In W. Meezan & J. Martin (Eds.), *Handbook of research with lesbian, gay, bisexual, and transgender populations* (pp. 131–158). London: Routledge.

Couzens, J., Mahoney, B., & Wilkinson, D. (2017). 'It's just more acceptable to be White or Mixed Race and gay than Black and gay': The perceptions and experiences of homophobia in St. Lucia. *Frontiers in Psychology*, *8*, 947.

Cover, R. (2012). *Queer youth suicide, culture and identity: Unliveable lives?* Surrey: Ashgate.

Cover, R. (2013). Conditions of living: Queer youth suicide, homonormative tolerance, and relative misery. *Journal of LGBT Youth*, *10*, 328–350. https://doi.org/10.1080/19361653.2013.824372

Custer, D. (2014). Autoethnography as a transformative research method. *The Qualitative Report*, *19*(37), 1–13.

D'haese, L., Dewaele, A., & Van Houtte, M. (2016). The relationship between childhood gender nonconformity and experiencing diverse types of homophobic violence. *Journal of Interpersonal Violence*, *31*, 1634–1660.

Davis, J. L., & Jurgenson, N. (2014). Context collapse: Theorizing context collusions and collisions. *Information, Communication & Society*, *17*, 476–485.

de Visser, R. O., & Smith, J. A. (2007). Alcohol consumption and masculine identity among young men. *Psychology & Health*, *22*, 595–614.

Dearing, R. L., & Twaragowski, C. (2010). The social psychology of help-seeking. In *Social Psychological Foundations of Clinical Psychology*. London, UK: Guilford Press.

Dhoest, A., & Szulc, L. (2016). Navigating online selves: Social, cultural, and material Contexts of social media use by diasporic gay men. *Social Media + Society*, 1–10.

Dickinson, P., & Adams, J. (2014). Resiliency and mental health and well-being among lesbian, gay and bisexual people. *International Journal of Mental Health Promotion*, *16*(2), 117–125.

Dodge, B., Herbenick, D., Friedman, M. R., Schick, V., Fu, T., Bostwick, W., … Sandfort, T. G. M. (2016). Attitudes toward bisexual men and women among a nationally representative probability sample of adults in the United States. *Plos*

One, *11*(10), e0164430. https://doi.org/10.1371/journal.pone.0164430

Doolin, E. M. (2010). Bridging the Gap for Lesbian Youth: Making Our Community Their Community. *Journal of Lesbian Studies*, *14*, 93–103. https://doi.org/10.1080/10894160903060457

Doré, B. P., Morris, R. B., Burr, D. A., Picard, R. W., & Ochsner, K. N. (2017). Helping others regulate emotion predicts increased regulation of one's own emotions and decreased symptoms of depression. *Personality and Social Psychology Bulletin*, *43*(5), 729–739.

Duggan, L. (2002). *The new homonormativity: The sexual politics of neoliberalism*. Durham: Duke University Press.

Duggan, L. (2003). *The twilight of equality: Neoliberalism, cultural politics and the attack on democracy*. New York: Beacon.

Durso, L. E., & Meyer, I. H. (2013). Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research and Social Policy*, *10*(1), 35–42.

Eady, A., Dobinson, C., & Ross, L. E. (2011). Bisexual people's experiences with mental health services: A qualitative investigation. *Community Mental Health Journal*, *47*, 378–389.

Eliason, M. (2015). Doing it for ourselves: Building communities for health education and support for older lesbian/bisexual women. *Journal of Gay & Lesbian Social Services*, *27*, 326–349.

Elison, S., Ward, J., Williams, C., Espie, C., Davies, G., Dugdale, S., … Smith, K. (2017). Feasibility of a UK community-based eTherapy mental health service in Greater Manchester: Repeated-measures and between-groups study of 'Living Life to the Full Interactive', 'Sleepio' and 'Breaking Free Online' at 'Self Help Services'. *BMJ Open*, *7*, e016392.

Elliot, M. N., Kanouse, D. E., Burkhart, Q., Abel, G. A., Lyratzopoulos, G., Beckett, M. K., … Roland, M. (2015). Sexual minorities in England have poorer health and worse health care experiences: A national survey. *Journal of General Internal Medicine*, *30*(1), 9–16.

Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people's experiences of mental health and gender identity services: A UK study. *Journal of Gay & Lesbian Mental Health*, *19*(1), 4–20.

Ellis, S. J., Riggs, D. W., & Peel, E. (2019). *Lesbian, Gay, Bisexual, Trans, Intersex,*

and Queer Psychology: An Introduction (2nd ed.). Cambridge, United Kingdom: Cambridge University Press.

Ellison, N. B., & Boyd, D. (2013). Sociality through social networks. In W. H. Dutton (Ed.), *The Oxford handbook of internet studies* (pp. 151–172). Oxford, UK: Oxford University Press.

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science & Medicine*, *62*(9), 2246–2257.

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2007). Exploring men's and women's experiences of depression and engagement with health professionals: More similarities than differences? A qualitative interview study. *BMC Family Practice*, *8*(1), 43.

Epstein, S. (1996). *Impure science: AIDS, activism, and the politics of knowledge*. Berkeley, CA: University of California Press.

Facebook. (2018). Facebook reports fourth quarter and full year 2017 results [press release]. https://doi.org/https://investor.fb.com/investor-news/press-release-details/2018/Facebook-Reports-Fourth-Quarter-and-Full-Year-2017-Results/default.aspx

Fantus, S., Souleymanov, R., Lachowsky, N. J., & Brennan, D. J. (2017). The emergence of ethical issues in the provision of online sexual health outreach for gay, bisexual, two-spirit and other men who have sex with men: Perspectives of online outreach workers. *BMC Medical Ethics*, *18*(1).

Ferlatte, O., Salway, T., Rice, S., Oliffe, J. L., Rich, A. J., Knight, R., … Ogrodniczuk, J. S. (2019). Perceived barriers to mental health services among Canadian sexual and gender minorities with depression and at risk of suicide. *Community Mental Health Journal*, *55*, 1–9.

Foucault, M. (1976). *The Will to Knowledge: The History of Sexuality: 1*. London: Penguin Books.

Foucault, M. (1977). *Discipline and Punishment*. London: Allen Lane.

Fraser, M. (1999). Classing queer. *Theory, Culture and Society*, *16*, 107–131.

Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., & Muraco, A. (2014). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist*, *54*(3), 488–500.

Frith, H., & Gleeson, K. (2012). Qualitative data collection: Asking the right questions. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester, West Sussex: John Wiley & Sons.

Frost, D. M. (2017). The benefits and challenges of health disparities and social stress frameworks for research on sexual and gender minority health. *Journal of Social Issues*, *73*(3), 462–476.

Frost, D. M., & Leblanc, A. J. (2014). Nonevent stress contributes to mental health disparities based on sexual orientation: Evidence from a personal projects analysis. *American Journal of Orthopsychiatry*, *84*(5), 557–566.

Frost, D. M., Meyer, I. H., & Schwartz, S. (2016). Social support networks among diverse sexual minority populations. *American Journal of Orthopsychiatry*, *86*, 91–102.

Fullagar, S. (2005). The paradox of promoting help-seeking: A critical analysis of risk, rurality and youth suicide. *International Journal of Critical Psychology*, *14*, 31–51.

Fullagar, S., Rich, E., & Francombe-Webb, J. (2017a). Digital ecologies of youth mental health: Apps, therapeutic publics and pedagogy as affective arrangement. *Social Sciences*, *6*(4), 135.

Fullagar, S., Rich, E., & Francombe-Webb, J. (2017b). New kinds of (ab)normal? Public pedagogies, affect, and youth mental health in the digital age. *Social Sciences*, *6*(3), 99.

Gardner, W., Hoge, S. K., Bennett, N., Roth, L. H., Lidz, C. W., Monahan, J., & Mulvey, E. P. (1993). Two scales for measuring patients' perceptions for coercion during mental hospital admission. *Behavioral Sciences & the Law*, *11*(3), 307–321.

Gibbs, J. J., & Rice, E. (2016). The social context of depression symptomology in sexual minority male youth: Determinants of depression in a sample of Grindr users. *Journal of Homosexuality*, *63*(2), 278–299.

Glaw, X., Inder, X., Kable, A., & Hazleton, M. (2017). Visual methodologies in qualitative research: Autophotography and photo elicitation applied to mental health research. *International Journal of Qualitative Methods*, *16*, 1–8.

Goedel, W. C., Brooks, F. A., & Duncan, D. T. (2016). Approaches to sampling gay, bisexual, and other men who have sex with men from geosocial-networking

smartphone applications: A methodological note. *Social Sciences*, *5*(51), 51.

Goedel, W. C., & Duncan, D. T. (2015). Geosocial-networking app usage patterns of gay, bisexual, and other men who have sex with men: Survey among users of Grindr, a mobile dating app. *JMIR Public Health and Surveillance*, *1*(1), e4.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster.

Goldblum, P., Pflum, S., Skinta, M., Evans, R. W., & Balsam, K. (2017). Psychotherapy with Lesbian, Gay, and Bisexual Clients: Theory and Practice. In A. J. Consoli, L. E. Beutler, & B. Bongar (Eds.), *Comprehensive Textbook of Psychotherapy: Theory and Practice* (2nd ed., pp. 330–345). New York: Oxford University Press.

Gonzales, G., Pzedworski, J., & Henning-Smith, C. (2016). Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States: Results from the national health interview survey. *JAMA Internal Medicine*, *176*(9), 1244–1351.

Gosine, A. (2007). Brown to blonde at Gay.com: Passing as white in queer cyberspace. In K. O'Riordan & D. Phillips (Eds.), *Queer Online: Media, Technology and Sexuality* (pp. 139–154). New York: Peter Lang Publishing.

Gough, B., & Flanders, G. (2009). Celebrating 'obese' bodies: Gay 'bears' talk about weight, body image and health. *International Journal of Men's Health*, *8*(3), 235–253.

Government Equalities Office. (2018a). *LGBT action plan: Improving the lives of lesbian, gay, bisexual and transgender people*. London, UK.

Government Equalities Office. (2018b). *National LGBT Survey*. London, UK.

Graham, K., Treharne, G. J., Ruzibiza, C., & Nicolson, M. (2015). The importance of health(ism): A focus group study of lesbian, gay, bisexual, pansexual, queer and transgender individuals' understandings of health. *Journal of Health Psychology*, *22*(2), 237–247.

Greco, M., & Stenner, P. H. (2013). *Emotions and social theory : a social science reader*. London: Routledge.

Grella, C. E., Cochran, S. D., Greenwell, L., & Mays, V. M. (2011). Effects of sexual orientation and gender on perceived need for treatment by persons with and without mental disorders. *Psychiatric Services*, *62*(4), 404–410.

Grella, C. E., Greenwell, L., Mays, V. M., & Cochran, S. D. (2009). Influence of

gender, sexual orientation, and need on treatment utilization for subtance use and mental disorders: Findings from a California quality of life survey. *BMC Psychiatry*, *9*, 52.

Grindr. (2017). Grindr fact sheet [press release]. Retrieved 23 March 2018, from https://www.grindr.com/press

Grov, C., Breslow, A. S., Newcomb, M. E., Rosenberger, J. G., & Bauermeister, J. A. (2014). Gay and bisexual Men's use of the Internet: Research from 1990s through 2013. *The Journal of Sex Research*, *51*(4), 390–409.

Grov, C., Ventuneac, A., Rendina, H. J., Jimenez, R. H., & Parsons, J. T. (2013). Perceived importance of five different health issues for gay and bisexual men: Implications for new directions in health education and prevention. *American Journal of Men's Health*, *7*(4), 274–284.

Guasp, A. (2013). *Gay and bisexual men's health survey*. London.

Gudelunas, D. (2012). There's an app for that: The uses and gratifications of online social networks for gay men. *Sexuality & Culture*, *16*, 347–365.

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: Sage.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1), 113–113.

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., … Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, *58*(1), 10–51.

Halberstam, J. (2011). *The queer art of failure*. London: Duke University Press.

Halkitis, P. N., & Parsons, J. T. (2003). Intentional unsafe sex (barebacking) among HIV-positive gay men who seek sexual partners on the Internet. *AIDS Care*, *15*, 367–378.

Hall, J. (2017). So, grindr has opened its doors to all - what does this mean? Retrieved 2 April 2018, from https://i-d.vice.com/en_uk/article/d3xp5k/grindr-hook-up-app-lgbtq

Halperin, D. M., & Traub, V. (2009). *Gay Shame*. London and Chicago: University of Chicago Press.

Hamilton, C. J., & Mahalik, J. R. (2009). Minority stress, masculinity, and social

norms predicting gay men's health risk behaviors. *Journal of Counseling Psychology*, *56*(1), 132–141.

Hardeman, W., Johnston, D. W., Bonetti, D., Wareham, N. J., & Kinmoth, A. L. (2002). Application of the theory of planned behavior in behavior change interventions: A systematic review. *Psychology & Health*, *17*, 123–158.

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies*, *17*(1), 13–26.

Harper, D., & Thompson, A. R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester, West Sussex: John Wiley & Sons.

Harper, G. W., Serrano, P. A., Bruce, D., & Bauermeister, J. A. (2016). The Internet's multiple roles in facilitating the sexual orientation identity development of gay and bisexual male adolescents. *American Journal of Men's Health*, *10*(5), 359–376.

Hatchel, T., Ingram, K. M., Mintz, S., Hartley, C., Valido, A., Espelage, D. L., & Wyman, P. (2019). Predictors of suicidal ideation and attempts among LGBTQ adolescents: The roles of help-seeking beliefs, peer victimisation, depression, and drug use. *Journal of Child and Family Studies*, *28*(9), 2443–2455.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin*, *135*(5), 707–730.

Hatzenbuehler, M. L. (2014). Structural stigma and the health of lesbian, gay, and bisexual populations. *Current Direction in Psychological Science*, *23*(2), 127–132.

Hatzenbuehler, M. L., McLaughlin, K. A., & Nolen-Hoeksema, S. (2008). Emotion regulation and internalizing symptoms in a longitudinal study of sexual minority and heterosexual adolescent. *Journal of Child Psychology and Psychiatry*, *49*(12), 1270–1278.

Hatzenbuehler, M. L., Nolen-Hoeksema, S., & Dovidio, J. (2009). How does stigma 'get under the skin'? The mediating role of emotion regulation. *Psychological Science*, *20*(10), 1282–1289.

Healey, D. (2000). Gay switchboards. In G. Haggerty (Ed.), *Encyclopedia of gay histories and cultures* (pp. 856–857). London: Routledge.

Hedman, E., El Alaoui, S., Lindefors, N., Andersson, E., Rück, C., Ghaderi, A., … Ljótsson, B. (2014). Clinical effectiveness and cost-effectiveness of Internet- vs.

group-based cognitive behavior therapy for social anxiety disorder: 4-year follow-up of a randomized trial. *Behaviour Research and Therapy*, *59*, 20–29.

Hegarty, P. (2018). *A Recent History of Lesbian and Gay Psychology: From Homophobia to LGBT*. Oxon, United Kingdom: Routledge.

Hennessy, R. (2000). *Profit and Pleasure: Sexual Identities in Late Capitalism*. London: Routledge.

Herek, G. M. (2000). Sexual prejudice and gender: Do heterosexuals' attitudes toward lesbians and gay men differ? *Journal of Social Issues*, *56*(2), 251–266.

Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annual Review of Clinical Psychology*, *3*, 353–375.

Herzog, K. (2017). Grindr is now open to everyone including women, trans people, and nonbinary folks. Retrieved 2 April 2018, from https://www.thestranger.com/slog/2017/11/27/25588606/grindr-is-now-open-to-everyone-including-women-trans-people-and-nonbinary-folks

Hickson, F., Davey, C., Reid, D., Weatherburn, P., & Bourne, A. (2016). Mental health inequalities among gay and bisexual men in England, Scotland and Wales: A large community-based cross-sectional survey. *Journal of Public Health*, *39*(2), 266–273.

Holley, J., Gillard, S., & Gibson, S. (2015). Peer worker roles and risk in mental health services: A qualitative comparative case study. *Community Mental Health Journal*, *15*(4), 477–490.

Hollis, C., Morriss, R., Martin, J., Amani, S., Cotton, R., Denis, M., & Lewis, S. (2016). Technological innovations in mental healthcare: Harnessing the digital revolution. *The British Journal of Psychiatry*, 263–265.

Holtz, A. (2017). Why is Brighton the LGBTQ Capital of the UK? Retrieved 13 June 2018, from https://theculturetrip.com/europe/united-kingdom/england/articles/why-is-brighton-the-gay-capital-of-the-uk/

Home Office. (2018). *Namibia: Sexual orientation and gender identity and expression*. London, UK.

Hooper, S., Rosser, B. R. S., Horvath, K., Oakes, J., & Danilenko, G. (2008). An online needs assessment of a virtual community: What men who use the Internet to seek sex with men want in Internet-based HIV prevention. *AIDS and Behavior*, *12*(6), 867–875.

Hsieh, N. (2014). Explaining the mental health disparity by sexual orientation: The

importance of social resources. *Society and Mental Health*, *4*(2), 129–146.

Hubbard, D. (2015). *Namibian Law on LGBT Issues*. Windhoek, Namibia.

Hudson-Sharp, N., & Metcalf, H. (2016). *Inequality among lesbian, gay bisexual and transgender groups in the UK: A review of evidence*. London, UK.

Hutchinson, E. (2015). Digital Methods and Perpetual Reinvention? Asynchronous Interviewing and Photo Elicitation. In H. Snee, C. Hine, Y. Morey, S. Roberts, & H. Watson (Eds.), *Digital Methods for Social Science: An Interdisciplinary Guide to Research Innovation* (pp. 143–156). Basingstoke, Hampshire: Palgrave Macmillan.

Israel, T., Gorcheva, R., Burnes, T. R., & Walther, W. A. (2008). Helpful and unhelpful therapy experiences of LGBT clients. *Psychotherapy Research*, *18*(3), 294–305.

Jackson, S., & Scott, S. (2010). *Theorizing Sexuality*. Berkshire: Open University Press, McGraw-Hill.

Janta, H., Lugosi, P., & Brown, L. (2014). Coping with loneliness: A netnographic study of doctoral students. *Journal of Further and Higher Education*, *38*(4), 553–571.

Jenzen, O. (2017). Trans youth and social media: Moving between counterpublics and the wider web. *Gender, Place & Culture*, *24*, 1626–1641.

Jenzen, O., & Karl, I. (2014). Make, share, care: Social media and LBTQ youth engagement. *Ada: A Journal of Gender, New Media, and Technology*, *5*.

Jerome, R. C., Woods, W. J., Moskowitz, J. T., & Carrico, A. W. (2016). The psychological context of sexual compulsivity among men who have sex with men. *AIDS and Behavior*, *20*(2), 273–280.

Joffe, H. (2012). Thematic analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209–223). Chichester: Wiley.

Johnson, K. (2007). Researching suicidal distress with LGBTQ communities in UK: Methodological and ethical reflections on a community-university knowledge exchange project. *The Australian Community Psychologist*, *19*(1), 112–123.

Johnson, K. (2011). Visualising mental health with an LGBT community group: Method, process, theory. In P. Reavey (Ed.), *Visual Methods in Psychology: Using and Interpreting Images in Qualitative Research*. London, UK: Routledge.

Johnson, K. (2015a). Affecting Sexuality. In *Sexuality: A Psychosocial Manifesto*.

Cambridge: Polity Press.

Johnson, K. (2015b). *Sexuality: A psychosocial manifesto*. Cambridge: Polity Press.

Johnson, K., Faulkner, P., Jones, H., & Welsh, E. (2007). *Understanding Suicide and Promoting Survival in LGBT Communities*. Brighton, UK.

Johnson, K., & Guzmán, A. M. (2013). Rethinking concepts in participatory action research and their potential for social transformation: Post-structuralist informed methodological reflections from LGBT and trans-collective projects. *Journal of Community & Applied Social Psychology*, *23*, 405–419.

Kalra, G., Ventriglio, A., & Bhugra, D. (2015). Sexuality and mental health: Issues and what next? *International Review of Psychiatry*, *27*(5), 463–469.

King, M., McKeown, E., Warner, J., Ramsay, A., Johnson, K., Cort, C., … Davidson, O. (2003). Mental health and quality of life of gay men and lesbians in England and Wales. *British Journal of Psychiatry*, *183*, 552–558.

King, M., Semleyn, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual & transgender people*. Lutterworth, Leicestershire.

King, M., Semleyn, J., See Tai, S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, *8*(1), 70–70.

Kingerlee, R., Precious, D., Sullivan, L., & Barry, J. (2014). Engaging in the emotional lives of men. *The Psychologist*, *27*(6), 418–421.

Kitzinger, C. (1987). *The Social Construction of Lesbianism*. London: Sage.

Kitzinger, C. (1997). Lesbian and gay psychology: A critical analysis. In D. Fox & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction* (pp. 202–216). London: Sage.

Kitzinger, C., & Perkins, R. (1993). *Changing our minds: Lesbian feminism and psychology*. New York: New York University Press.

Koh, A. S., & Ross, L. K. (2013). A comparison of lesbian, bisexual and heterosexual women. In J. Harcourt (Ed.), *Current Issues in lesbian, gay, bisexual, and transgender health* (pp. 33–58). New York: Haworth.

Kryzan, C., & Walsh, J. (1998). *The !OutProud! / Oasis Internet Survey of Queer and Questioning Youth, August to October 1997.* San Rafael, CA.

Kubicek, K., Carpineto, J., McDavitt, B., Weiss, G., & Kipke, M. (2011). Use and

perceptions of the Internet for sexual information and partners: A study of YMSM. *Archives of Sexual Behavior*, *40*, 803–816.

Lal, S., & Adair, C. E. (2014). E-mental health: A rapid review of the literature. *Psychiatric Services*, *65*(1), 24–32.

Lawrence, V., Banerjee, S., Bhugra, D., Sangha, K., Turner, S., & Murray, J. (2006). Coping with depression in later life: A qualitative study of help-seeking in three ethnic groups. *Psychological Medicine*, *36*(10), 1375–1383.

Lee, C., Oliffe, J. L., Kelly, M. T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care providers. *American Journal of Men's Health*, *11*(4), 910–919.

Lelutiu-Weinberger, C., Pachankis, J. E., Gamarel, K. E., Surace, A., Golub, S. A., & Parsons, J. T. (2015). Feasibility, acceptability, and preliminary efficacy of a live-chat social media intervention to reduce HIV risk among young men who have sex with men. *AIDS and Behavior*, *19*(7), 1214–1227.

Lester, D. (1997). The role of shame in suicide. *Suicide and Life-Threatening Behavior*, *27*(4), 352–361.

Levine, N. (2016, January 29). Austerity has killed London's leading LGBT mental health charity. *VICE*.

Liddon, L., Kingerlee, R., & Barry, J. A. (2018). Gender differences in preferences for psychological treatment, coping strategies, and triggers to help-seeking. *British Journal of Clinical Psychology*, *57*, 42–58.

Light, B. (2014). *Disconnecting with social networking sites*. Basingstoke, UK: Palgrave Macmillan.

Liu, W. (2017). Toward a queer psychology of affect: Restarting from shameful places. *Subjectivity*, *10*, 44–62. https://doi.org/10.1057/s41286-016-0014-6

Love, H. (2008). Compulsory happiness and queer existence. *New Formations*, *63*, 52–64.

Lupton, D. (2013). The digitally engaged patient: Self-monitoring and self-care in the digital health era. *Social Theory & Health*, *11*(3), 256–270.

Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: Exploring barriers and solutions. *Americal Journal of Men's Health*, *12*(1), 138–149. https://doi.org/10.1177/1557988315619469

Lyons, A., Pitts, M., & Grierson, J. (2013). Factors related to positive mental health in a stigmatized minority: An investigation of older gay men. *Journal of Aging and*

Health, *25*(7), 1159–1181.

Lyons, A., Pitts, M., & Grierson, J. (2014). Sense of coherence as a protective factor for psychological distress among gay men: A prospective cohort study. *Anxiety, Stress, & Coping*, *27*(6), 662–677.

Lyons, A., Rozbroj, T., Mitchell, A., & Christensen, H. (2015). *Improving e-therapy for mood disorders among lesbians and gay men: A practical toolkit for developing tailored web and mobile phone-based depression and anxiety interventions*. Melbourne, Australia.

Lytle, M. C., Silenzio, V. M. B., Homan, C. M., Schneider, P., & Caine, E. D. (2018). Suicidal and help-seeking behaviors among youth in an online lesbian, gay, bisexual, transgender, queer, and questioning social network. *Journal of Homosexuality*, *65*(13), 1916–1933.

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*, *3*(6), 434–442.

MacKay, J., Robinson, M., Pinder, S., & Ross, L. E. (2017). A grounded theory of bisexual individuals' experiences of help seeking. *American Journal Of Orthopsychiatry*, *87*(152–61).

Madill, A., Jordan, A., & Shirley, A. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1–20.

Magee, J. C., Bigelow, L., DeHaan, S., & Mustanski, B. S. (2012). Sexual health information seeking online: A mixed-methods study among lesbian, gay, bisexual and transgender young people. *Health Education & Behavior*, *39*(3), 276–289.

Mahalik, J. R., Burns, S. M., & Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science & Medicine*, *64*, 2201–2209.

Mahalik, J. R., Lagan, H. D., & Morrison, J. A. (2006). Health behaviours and masculinity in Kenyan and U.S. male college students. *Psychology of Men & Masculinity*, *7*, 191–202.

Mark, K. P., Garcia, J. R., & FIsher, H. E. (2015). Perceived emotional and sexual satisfaction across sexual relationship contexts: Gender and sexual orientation

differences and similarities. *Canadian Journal of Human Sexuality*, *24*(2), 120–130.

Markham, A., & Buchanan, E. (2012). Ethical Decision-Making and Internet Research: Recommendations from the AoIR Ethics Working Committee (Version 2.0). Retrieved from https://aoir.org/ethics/

Martin, J., & D'Augelli, A. R. (2009). Timed lives: Cohort and period effects in research on sexual orientation and gender identity. In W. Meezan & J. I. Martin (Eds.), *Handbook of research with lesbian, gay, bisexual, and transgender populations* (pp. 190–207). New York: Routledge.

Martos, A. J., Wilson, P. A., & Meyer, I. H. (2017). Lesbian, gay, bisexual, and transgender (LGBT) health services in the United States: Origins, evolution, and contemporary landscape. *PloS One*, *12*(7), e0180544.

Mays, V. M., & Cochran, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, *91*(11), 1869–1876.

McCann, E., & Sharek, D. (2014). Survey of lesbian, gay, bisexual, and transgender people's experiences of mental health service in Ireland. *International Journal of Mental Health Nursing*, *23*(2), 118–127.

McDermott, E. (2015). Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the 'failed' self. *Health*, *19*(6), 561–577.

McDermott, E., Hughes, E., & Rawlings, V. (2016). *Queer Futures: Understanding lesbian, gay, bisexual, and trans (LGBT) adolescents' suicide, self-harm and help-seeking behaviour*.

McDermott, E., Hughes, E., & Rawlings, V. (2017a). Norms and normalisation: Understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. *Culture, Health & Sexuality*. https://doi.org/10.1080/13691058.2017.1335435

McDermott, E., Hughes, E., & Rawlings, V. (2017b). The social determinants of lesbian, gay, bisexual and transgender youth suicidality in England: A mixed methods study. *Journal of Public Health*, *40*(3), e244–e251.

McDermott, E., & Roen, K. (2016). *Queer youth, suicide and self-harm: Troubled subjects, troubling norms*. London: Palgrave Macmillan.

McDermott, E., Roen, K., & Piela, A. (2013). Hard-to-reach youth online: Methodological advances in self-harm research. *Sexuality Research and Social*

Policy, *10*, 125–134.

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality*, *10*(8), 815–829.

McIntyre, J., Daley, A., Rutherford, K., & Ross, L. E. (2011). Systems-level barriers in accessing supportive mental health services for sexual and gender minorities: Insights from the provider's perspective. *Canadian Journal of Community Mental Health*, *30*(2), 173–186.

McKenna, K. Y. A., & Bargh, J. A. (1998). Coming out in the age of the Internet: Identity 'demarginalization' through virtual group participation. *Journal of Personality and Social Psychology*, *75*, 681–694.

McLaughlin, C., & Vitak, J. (2011). Norm evolution and violation on Facebook. *New Media & Society*, *14*(2), 1–17.

McNair, R. P., & Bush, R. (2016). Mental health help seeking patterns and associations among Australian same sex attracted women, trans and gender diverse people: a survey-based study. *BMC Psychiatry*, *16*, 209.

McNair, R. P., & Hegarty, K. (2010). Guidelines for the primary care of lesbian, gay, and bisexual people: A systematic review. *The Annals of Family Medicine*, *8*(6), 533–541.

McNair, R. P., Szalacha, L. A., & Hughes, T. L. (2011). Health status, health service use, and satisfaction according to sexual identity of young Australian women. *Womens Health Issues*, *21*(1), 40–477.

Mechanic, D. (1962). *Students Under Stress: A Study of the Social Psychology of Adaptation*. New York: Free Press.

Mechanic, D. (1982). The epidemiology of ilness behavior and its relationship to physical and psychological distress. In D. Mechanic (Ed.), *Symptoms, Illness Behavior, and Help-Seeking*. New Brunswick, NJ: Rutgers University Press.

Memorandum of Understanding. (2017). *Memorandum of Understanding on Conversion Therapy in the UK: Version 2*. London, UK.

Mental Health Taskforce. (2016). *The five year forward view for mental health*.

Mereish, E. H., & Poteat, V. P. (2015). A relational model of sexual minority mental and physical health: The negative effects of shame on relationships, loneliness, and health. *Journal of Counselling Psychology*, *62*(3), 425–437.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health*

and Social Behavior, *36*, 38–56.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697.

Meyer, I. H., & Frost, D. M. (2013). Minority stress and the health of sexual minorities. In C. J. Patterson & A. R. D'Augelli (Eds.), *Handbook of Psychology and Social Orientation* (pp. 252–266). New York: Oxford University Press.

Meyer, I. H., Ouellette, S. C., Haile, R., & McFarlane, T. A. (2011). "We'd be free": Narratives of life without homophobia, racism, or sexism. *Sexuality Research and Social Policy*, *8*(3), 2014–2214.

Meyer, I. H., Teylan, M., & Schwartz, S. (2015). The role of help-seeking in preventing suicide attempts among lesbians, gay men, and bisexuals. *Suicide and Life-Threatening Behavior*, *45*(1), 25–36.

Meyer, I. H., & Wilson, P. A. (2009). Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology*, *56*, 23–31.

Michaelsen, A. (2017). Feeling differently together: The It Gets Better Project as an unlikely intimate public of LGBT peers. *Emotion, Space and Society*, *25*, 144–149.

Miles, S. (2018). Still getting it on online: Thirty years of queer male spaces brokered through digital technologies. *Geography Compass*, e12407.

Miller, B. (2015). 'They're the modern-day gay bar': Exploring the uses and gratifications of social networks for men who have sex with men. *Computers in Human Behavior*, *51*, 476–482.

MindOut. (2017). *MindOut Annual Report 2016 - 2017*. Brighton & Hove.

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 148–155.

Morison, T., Gibson, A. F., Wigginton, B., & Crabb, S. (2015). Online research methods in psychology: Methodological opportunities for critical qualitative research. *Qualitative Research in Psychology*, *12*(3), 223–232.

Morley, K. C., Sitharthan, G., Haber, P. S., Tucker, P., & Sitharthan, T. (2014). The efficacy of an opportunistic cognitive behavioral intervention package (OCB) on sunstance use and comorbid suicide risk: A multisite randomized controlled trail. *Journal of Consulting and Clinical Psychology*, *82*(1), 130–140.

Mowlabocus, S. (2010). *Gaydar Culture: Gay Men, Technology and Embodiment in the Digital Age*. Farnham, UK: Ashgate.

Mowlabocus, S., Hargbottle, J., Tooke, B., Haslop, C., & Dasgupta, R. K. (2015). 'Because even the placement of a comma might be important': Expertise, filtered embodiment and social capital in online sexual health promotion. *Convergence: The International Journal of Research into New Media Technologies*, *21*(3), 375–387.

Mowlabocus, S., Haslop, C., & Dasgupta, R. K. (2016). From scene to screen: The challenges and opportunities of commercial digital platforms for HIV community outreach. *Social Media + Society*, *2*(4), 1–8.

Munt, S. (2000). Shame/pride dichotomies in queer as folk. *Textual Practice*, *14*(3), 531–546.

Munt, S. (2007). *Queer attachments: The cultural politics of shame*. Aldershot: Ashgate.

Mustanski, B., Lyons, T., & Garcia, S. C. (2011). Internet use and sexual health of young men who have sex with men: A mixed-methods study. *Archives of Sexual Behavior*, *40*, 289–300.

Nestpick. (2017). Best LGBTQ Cities 2017. Retrieved 1 October 2018, from https://www.nestpick.com/best-lgbt-cities/

Newman, R. S. (2008). Adaptive and nonadaptive help seeking with peer harassment: An integrative perspective of coping and self-regulation. *Educational Psychologist*, *43*(1), 1–15.

Nodin, N., Peel, E., Tyler, A., & Rivers, I. (2015). *The RaRE Research Report: LGBT Mental Health - Risk and Resilience Explored*. London, UK.

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rumination rethinking. *Psychological Science*, *3*(5), 400–424.

Norton, A. T., & Herek, G. M. (2013). Heterosexuals' attitudes toward transgender people: Findings from a national probability sample of U.S. adult. *Sex Roles*, *68*(11–12), 783–753.

O'Neil, J. M. (1981a). Male sex role conflicts, sexism, and masculinity: Psychological implications for men, women, and the counselling psychologist. *The Counselling Psychologist*, *9*(2), 61–80.

O'Neil, J. M. (1981b). Patterns of gender role conflict and strain: Sexism and fear of femininity in men's lives. *Personnel and Guidance Journal*, *60*, 203–210.

O'Neil, J. M. (1982). Gender role conflict and strain in men's lives: Implications for psychiatrists, psychologists, and other human service providers. In K. Solomon & N. B. Levy (Eds.), *Men in transition* (pp. 5–40). New York: Plenum Press.

O'Neil, J. M., Helms, B., Gable, R., David, L., & Wrightsman, L. (1986). Gender Role Conflict Scale: College men's fear of femininity. *Sex Roles*, *14*(5/6), 335–350.

Ofcom. (2019). *Adults: Media use and attitudes report 2019*. London.

Office for National Statistics. (2011). *2011 Census*. London, UK.

Office for National Statistics. (2019). *Civil partnerships in England and Wales: 2018*. Newport.

Oliffe, J. L., Ogrodniczuk, J. S., Bottorf, J., Johnson, J., & Hoyak, K. (2012). 'You feel like you can't live anymore': Suicide from the perspectives of Canadian men who experience depression. *Social Science & Medicine*, *74*(4), 506–514.

OSCI. (2017). *Equalities in Brighton & Hove: Data snapshot for equalities groups across the city*. Brighton, UK.

Pachankis, J. E. (2014). Uncovering clinical principles and techniques to address minority stress, mental health, and related health risks among gay and bisexual men. *Clinical Psychology: Science and Practice*, *21*(4), 313–330.

Pachankis, J. E., & Goldfried, M. R. (2010). Expressive writing for gay-related stress: Psychosocial benefits and mechanisms underlying improvement. *Journal of Consulting and Clinical Psychology*, *78*(1), 98–110.

Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology*, *83*(5), 875–886.

Pachankis, J. E., Lelutiu-Weinberger, C., Golub, S. A., & Parsons, J. T. (2013). Developing an online health intervention for young gay and bisexual men. *AIDS and Behavior*, *17*(2), 2986–2998.

Pain, H. (2012). A literature review to evaluate the choice and use of visual methods. *International Journal of Qualitative Methods*, *11*(4), 303–319.

Parent, M. C., & Bradstreet, T. C. (2017). Gay, bisexual and transgender masculinities. In R. F. Levant & Y. F. Wong (Eds.), *The Psychology of Men and Masculinities* (pp. 289–314). Washington, DC, US: American Psychological Association.

Parsons, J. T., Grov, C., & Gloub, S. A. (2012). Sexual compulsivity, co-occuring

psyhcosocial health problems, and HIV risk among gay and bisexual men: Further evidence of a syndemic. *American Journal of Public Health*, *102*, 156–162.

Peacock, M., Bissell, P., & Owen, J. (2014a). Dependency denied: Health inequalities in the neo-liberal era. *Social Science & Medicine*, *118*, 173–180.

Peacock, M., Bissell, P., & Owen, J. (2014b). Shaming encounters: Reflections on contemporary understandings of social inequality and health. *Sociology*, *48*(2), 387–402.

Pennant, M. E., Bayliss, S. E., & Meads, C. A. (2009). Improving lesbian, gay and bisexual healthcare: a systematic review of qualitative literature from the UK. *Diversity & Equality in Health and Care*, *9*(6), 193–203.

Pescosolido, B. (1991). Illness careers and network ties: A conceptual model of utilization and compliance. *Advances in Medical Sociology*, *2*, 161–184.

Pescosolido, B. (1992). Beyond rational choice: The social dynamics of how people seek help. *Americal Journal of Sociology*, *97*(4), 1096–1138.

Pescosolido, B. (2000). Rethinking models of health and illness behaviour. In M. W. Kelner (Ed.), *Complementary and Alternative Medicine* (pp. 175–184). Amsterdam, Netherlands: Harwood Academic.

Pescosolido, B., & Boyer, C. (1999). How do people come to use mental health services? Current knowledge and changing perspectives. In A. Horwitz & T. Scheid (Eds.), *A handbook for the study of mental health: Social context, theories and systems*. Cambridge, England: Cambridge University Press.

Pescosolido, B., Gardner, C. B., & Lubell, K. M. (1998). How people get into mental health services: Stories of choice, coercion, and “muddling through” from “first timers". *Social Science & Medicine*, *46*(275–286).

Pfeil, U., Arjan, R., & Zaphiris, P. (2009). Age differences in online social networking - A study of user profiles and the social capital divide among teenages and older users in MySpace. *Computers in Human Behavior*, *25*, 643–654.

Pingel, E., Bauermeister, J. A., Johns, M. M., Eisenberg, A., & Leslie-Santana, M. (2013). ‘A safe way to explore’: Reframing risk on the Internet amidst young gay men’s search for identity. *Journal of Adolescent Research*, *28*, 453–478.

PinkNews. (2013). London LGBT charity PACE launches new online mental health service. *PinkNews*.

Pitoňák, M. (2017). Mental health in non-heterosexuals: Minority stress theory and

related explanation frameworks review. *Mental Health & Prevention*, *5*, 63–67.

Platt, L. F., Wolf, J. K., & Scheitle, C. P. (2018). Patterns of mental health care utilization among sexual orientation minority groups. *Journal of Homosexuality*, *65*(2), 135–153.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. Levant & W. Pollack (Eds.), *A New Psychology of Men*. New York: Basic Books.

Plöderl, M., & Tremblay, P. (2015). Mental health of sexual minorities. A systematic review. *International Review of Psychiatry*, *27*(5), 367–385.

Pobuda, T., Crothers, L., Goldblum, P., Dilley, J. W., & Koopman, C. (2008). Effects of time-limited dynamic psychotherapy on distress among HIV-seropositive men who have sex with men. *AIDS Patient Care and STDs*, *22*(7), 561–567.

Powell, J. (2016). E-mental health special issue. *Digital Health*, *2*, 1–2.

Prensky, M. (2001). Digital natives, digital immigrants. *On the Horizon*, *9*(5), 1–6.

Probyn, E. (2000). Sporting bodies: Dynamics of shame and pride. *Body & Society*, *6*(1), 13–28.

Probyn, E. (2005). *Blush: Faces of shame*. Minneapolis: University of Minnesota Press.

Race, K. (2015). 'Party and play': Online hook-up devices and the emergence of PNP practices among gay men. *Sexualities*, *18*(3), 253–275.

Ramanadhan, S., Mendez, S. R., Rao, M., & Viswanath, K. (2013). Social media use by community-based organizations conducting health promotion: A content analysis. *BMC Public Health*, *13*(1), 1129.

Reisner, S. L., Gamarel, K. E., Dunham, E., Hopwood, R., & Hwahng, S. (2013). Female-to-make transmasculine adult health: A mixed-methods community-based needs assessment. *Journal of the American Psychiatric Nurses Association*, *19*, 293–303.

Richardson, D., & Hart, J. (1981). *The Theory and Practice of Homosexuality*. London: Routledge & Kegan Paul.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health*, *4*(3), 218–251.

Rickwood, D., Deane, F., & Wilson, C. (2007). When and how do young people seek professional help for mental health problems? *Medical Journal of Australia*, *187*(7), S35–S39.

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management*, *5*, 173–183.

Riggs, D. W., & Treharne, G. J. (2017). Queer theory. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology* (pp. 101–119). London: Palgrave.

Roberts, L. D. (2015). Ethical issues in conducting qualitative research in online communities. *Qualitative Research in Psychology*, *12*(3), 314–325.

Robertson, A. E. (1998). The mental health experiences of gay men: A research study exploring gay men's health needs. *Journal of Psychiatric and Mental Health Nursing*, *5*(1), 33–40.

Rodriguez, N. S., Huemmer, J., & Blummel, L. (2016). Mobile masculinities: An investigation of networked masculinities in gay dating apps. *Masculinities and Social Change*, *5*(3), 241–267.

Rose, N. S. (1989). *Governing the soul: The shaping of the private self*. London: Routledge.

Rozbroj, T., Lyons, A., Pitts, M., Mitchell, A., & Christensen, H. (2014). Assessing the applicability of e-therapies for depression, anxiety and other mood disorders among lesbians and gay men: Analysis of 24 web- and mobile phone-based self-help interventions. *Journal of Medical Internet Research*, *16*(7), e166.

Rozbroj, T., Lyons, A., Pitts, M., Mitchell, A., & Christensen, H. (2015). Improving self-help e-therapy for depression and anxiety among sexual minorities: An analysis of focus groups with lesbians and gay men. *Journal of Medical Internet Research*, *17*(3), e66.

Samson, A. C., & Gross, J. J. (2012). Humour as emotion regulation: The differential consequences of negative versus positive humour. *Cognition & Emotion*, *26*(2), 375–384.

Sánchez, F. J. (2016). Masculinity issues among gay, bisexual, and transgender men. In Y. J. Wong & S. R. Wester (Eds.), *APA Handbook of Men and Masculinities* (pp. 339–365).

Sánchez, F. J., Bocklandt, S., & Vilain, E. (2009). Gender role conflict, interest in casual sex, and relationship satisfaction among gay men. *Psychology of Men & Masculinity*, *10*, 237–243.

Sánchez, F. J., Bocklandt, S., & Vilain, E. (2013). The relationship between help-

seeking attitudes and masculine norms among monozygotic male twins discordant for sexual orientation. *Health Psychology*, *32*, 52–56.

Sánchez, J. P., Hailpern, S., Lowe, C., & Calderon, Y. (2007). Factors associated with emergency department utilization by urban lesbian, gay, and bisexual individuals. *Journal of Community Health*, *32*(2), 149–156.

Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., & Brown, J. S. L. (2016). Exploring professional help-seeking for mental disorders. *Qualitative Health Research*, *26*(12), 1662–1673.

Savin-Williams, R. (2005). *The new gay teenager*. Cambridge: Harvard University Press.

Scheff, T. J. (2000). Shame and the social bond: A sociological theory. *Sociological Theory*, *18*, 84–99.

Scheff, T. J. (2003). Shame in self and society. *Symbolic Interaction*, *26*(2), 239–262.

Schmidtt, D. (2006). Sexual strategies across sexual orientations: How personality traits and culture relate to sociosexuality among gays, lesbians, bisexuals and heterosexuals. *Journal of Psychology and Human Sexuality*, *18*, 183–214.

Schreiber, M. (2017). Showing/sharing: Analysing visual communication from a praxeological perspective. *Media and Communications*, *5*(4), 37–50.

Sedgwick, E. K. (2003). *Touching feeling: Affect, pedgagogy, performativity*. Durham: Duke University Press.

Sedgwick, E. K., & Frank, A. (1995). *Shame and its sisters: A Silvan Tomkins' reader*. Durham: Duke University Press.

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, *49*, 106–118.

Seidler, Z. E., Rice, S. M., Oliffe, J. L., Fogarty, A. S., & Dhillon, H. M. (2018). Men in and out of treatment for depression: Strategies for improved engagement. *Australian Psychologist*, *53*, 405–415.

Seidman, S. (1996). *Queer Theory/Sociology*. Oxford: Blackwell.

Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorder or low wellbeing: Combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, *16*, 67.

Semp, D., & Read, J. (2015). Queer conversations: Improving access to, and quality

of, mental health services for same-sex-attracted clients. *Psychology & Sexuality*, *6*(3), 217–228.

Shaw, R. L., Dyson, P. O., & Peel, E. (2008). Qualitative psychology at M level: a dialogue between learner and teacher. *Qualitative Research in Psychology*, *5*, 179–191.

Shepherd, A., Sanders, C., Doyle, M., & Shaw, J. (2015). Using social media for support and feedback by mental health service users: Thematic analysis of a twitter conversation. *BMC Psychiatry*, *15*(1), 29–29.

Simeonov, D., Steele, L. S., Anderson, S., & Ross, L. E. (2015). Perceived satisfaction with mental health services in the lesbian, gay, bisexual, transgender and transsexual communities in Ontario, Canada: An internet-based survey. *Journal of Community Mental Health*, *34*(1), 31–44.

Simonsen, G., Blazina, C., & Watkins, C. E. (2000). Gender role conflict and psychological well-being among gay men. *Journal of Counseling Psychology*, *47*, 85–89.

Sju, D., Irwin, J. A., Fisher, C., Ramos, A., Kelley, M., Mendoza, D. A. R., & Coleman, J. D. (2016). Mental health disparities within the LGBT population: A comparison between transgender and nontransgender individuals. *Transgender Health*, *1*(1), 12–20.

Smalley, K. B., Warren, J. C., & Barefoot, K. N. (2015). Barriers to care and psychological distress differences between bisexual and gay men and women. *Journal of Bisexuality*, *15*(2), 230–247.

Smalley, K. B., Warren, J. C., & Barefoot, K. N. (2016). Variations in psychological distress between gender and sexual minority groups. *Journal of Gay & Lesbian Mental Health*, *20*(2), 99–115.

Solobello, N., & Elliot, S. (2011). ‘We want them to be as heterosexual as possible’: Fathers talk about their teen children’s sexuality. *Gender & Society*, *25*, 293–315.

Somerville, C. (2015). *Unhealthy attitudes: The treatment of LGBT people within health and social care services*. London, UK.

Sorensen, L., & Roberts, S. J. (1997). Lesbian uses of and satisfaction with mental health services. *Journal of Homosexuality*, *33*(1), 35–49.

Spengler, E. S., & Ægisdóttir, S. (2015). Psychological help-seeking attitudes and intentions of lesbian, gay, and bisexual individuals: The role of sexual minority

identity and perceived coundelor sexual prejudice. *Psychology of Sexual Orientation and Gender Diversity*, *2*(4), 482–491.

Steele, L. S., Daley, A., Curling, D., Gibson, M. F., Green, D. C., WIlliams, C. C., & Ross, L. E. (2017). LGBT identity, untreated depression, and unmet need for mental health services by sexual minority women and trans-identified people. *Journal of Women's Health*, *26*(2), 116.

Storholm, E. D., Satre, D. D., Kapadia, F., & Halkitis, P. N. (2016). Depression, compulsive sexual behaviour, and sexual risk-taking among urban young gay and bisexual men: The P18 Cohort study. *Archives of Sexual Behavior*, *45*(6), 1431–1441.

Storholm, E. D., Siconolfi, D. E., Halkitis, P. N., Moeller, R. W., Eddy, J. A., & Bare, M. G. (2013). Sociodemographic factors contribute to mental health disparities and access to services among young men who have sex with men in New York City. *Journal of Gay & Lesbian Mental Health*, *17*(3), 294–313.

Sun, C. J., Stowers, J., Miller, C., Bachmann, L. H., & Rhodes, S. D. (2015). Acceptability and feasibility of using established geosocial and sexual networking mobile applications to promote HIV and STD testing among men who have sex with men. *AIDS and Behavior*, *19*(3), 543–552.

Sweney, M. (2018). Is Facebook for old people? Over-55s flock as the young leave. *The Guardian*.

Szulc, L., & Dhoest, A. (2013). The Internet and sexual identity formation: Comparing Internet use before and after coming out. *Communications: The European Journal of Communication Research*, *38*(4), 347–365.

The British Psychological Society. (2016). *Mental Health and LGBT People: Call for Evidence*. London, UK.

Tomkins, S. S. (1962). *Affect, Imagery, Consciousness: Vol. 1: The Positive Affect*. New York: Springer.

Tomkins, S. S. (1963). *Affect, Imagery, Consciousness: Vol 2: The Negative Affects*. New York: Springer.

Tonks, A., Lyons, A. C., & Goodwin, I. (2015). Researching online visual displays on social networking sites: Methodologies and meanings. *Qualitative Research in Psychology*, *12*(3), 326–339.

Turban, J. (2018). We need to talk about how Grindr is affecting gay men's mental health. Retrieved 25 April 2018, from https://www.vox.com/science-and-

health/2018/4/4/17177058/grindr-gay-men-mental-health-psychiatrist

Twitter. (2018). Twitter announces fourth quarter and fiscal year 2017 results [press release]. Retrieved 28 March 2018, from https://investor.twitterinc.com/results.cfm

Twomey, C., Baldwin, D. S., Hopfne, M., & Cieza, A. (2015). A systematic review of the predictors of health service utilisation by adults with mental disorders in the UK. *BMJ Open*, *5*, e007575.

Twomey, C., O'Reilly, G., & Byrne, M. (2014). Effectiveness of cognitive behavioral therapy for anxiety and depression in primary care: A meta-analysis. *Family Practice*, *32*(1), 3–15.

Wang, J., Häusermann, M., & Weiss, M. G. (2014). Mental health literacy and the experience of depression in a community sample of gay men. *Journal of Affective Disorders*, *155*, 200–207.

Warner, J., McKeown, E., Griffin, M., Johnson, K., & Ramsay, A. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: Results from a survey based in England and Wales. *British Journal of Psychiatry*, *185*, 479–485.

Warner, M. (2002). *Publics and counterpublics*. Cambridge, MA: Zone Books.

Waterloo, S. F., Baumgartner, S. E., Peter, J., & Valkenburg, P. M. (2018). Norms of online expressions of emotion: Comparing Facebook, Twitter, Instagram, and WhatsApp. *New Media & Society*, *20*(5), 1813–1831.

Webb, M., Burns, J., & Collin, P. (2008). Providing online support for young people with mental health difficulties: Challenges and opportunities explored. *Early Intervention in Psychiatry*, *2*, 108–113.

Weeks, J. (2016). *Coming Out: The Emergence of LGBT Identities in Britain from the 19th Century to the Present* (3rd ed.). London: Quartet Books Limited.

Weiner, T. (2011). The (un)managed self: Paradoxical forms of agency in self-management of bipolar disorder. *Culture, Medicine & Psychiatry*, *35*(4), 448–483.

Wenger, L. M. (2011). Beyond ballistics: Expanding our conceptualization men's health-related help seeking. *American Journal of Men's Health*, *5*(6), 488–499.

Wheldon, C. W., & Kirby, R. S. (2013). Are there differing patterns of health care access and utilisation among male sexual minorities in the United States? *Journal of Gay and Lesbian Social Services*, *25*(1), 24–46.

Willging, C. E., Salvador, M., & Kano, M. (2006). Pragmatic help seeking: How sexual and gender minority groups access mental health care in a rural state. *Psychiatric Services*, *57*(6), 871–874.

Wirback, T., Forsell, Y., Larsson, J., Engström, K., & Edhborg, M. (2018). Experiences of Depression and Help-Seeking Described by Young Swedish Men. *Psychology of Men & Masculinity*, *19*(3), 407–417.

Woodhead, C., Gazard, B., Hotopf, M., Rahman, Q., Rimes, K. A., & Hatch, S. L. (2016). Mental health among UK inner city non-heterosexuals: The role of risk factors, protective factors and place. *Epidemiology and Psychiatric Sciences*, *25*, 450–461.

Wu, S., & Ward, J. (2017). The mediation of gay men's lives: A review on gay dating apps. *Sociology Compass*, *12*, e12560.

Yeo, A., Legard, R., Keegan, J., Ward, K., McNaugton Nicholls, C., & Lewis, J. (2014). In-depth interviews. In J. Ritchie, J. Lewis, C. McNaughton Nicholls, & R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers* (2nd ed., pp. 177–210). London: Sage.

Yousaf, O., Popat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men & Masculinity*, *16*(2), 234–237.

Zaki, L., Gross, M., & Pachankis, J. E. (2017). Help-seeking for nonsuicidal self-injury in sexual minority adolescent and young adult females. *Journal of Gay & Lesbian Mental Health*, *21*(2), 171–187.

Zhao, S., Grasmuck, S., & Martin, J. (2008). Identity construction on Facebook: Digital empowerment in anchored relationships. *Computers in Human Behavior*, *24*, 1816–1836.

Appendices

Appendix 1: Scoping exercise of LGBTQ mental health-related services

Organisation	Description	Location	Digital and Social Media
Allsorts Youth Project	Support service for LGBTQ+ children and young people under the age of 26	Brighton & Hove	Website: www.allsortsyouth.org.uk Mainstream social media: • Facebook • Twitter
Brighton & Hove LGBTQ Switchboard	LGBTQ+ support helpline	Brighton & Hove	Website: www.switchboard.org.uk 1-to-1 chat intervention (operating schedule unavailable, no discernible timetable) Mainstream social media: • Facebook • Twitter • Instagram
London Friend	LGBTQ health and wellbeing service	London	Website: www.londonfriend.org.uk Mainstream social media: • Facebook • Twitter • YouTube
MindOut	LGBTQ+ mental health service run by and for LGBTQ people with experience of mental health difficulties	Brighton & Hove	Website: https://www.mindout.org.uk 1-to-1 chat intervention (after hours) Mainstream social media: • Facebook • Twitter • YouTube Niche social media: • Grindr • Scruff • Recon

			• Wapo / Wapa
PACE	LGBTQ+ mental health service	London	Website: www.pacehealth.org.uk Online wellbeing assessments Message boards Group chats 1-to-1 chat intervention Mainstream social media: • Facebook • Twitter
Switchboard	LGBTQ+ support helpline	London	Website: www.switchboard.lgbt 1-to-1 chat intervention (operating schedule unavailable, no discernible timetable) Mainstream social media: • Facebook • Twitter

Appendix 2: Letter to participate (PACE)

University of Brighton
School of Applied Social Science
Mayfield House, Room M229
Brighton
BN1 9PH

Friday, 14th August 2015

Margaret Unwin
Chief Executive
PACE
54 – 56 Euston Street
London
NW1 2ES

Dear Ms. Margaret Unwin,

INVITATION TO PARTICIPATE IN RESEARCH ON GAY AND BISEXUAL MEN'S ONLINE MENTAL HEALTH HELP-SEEKING BEHAVIOURS

I am a doctoral student funded by the Transforming Sexuality and Gender research cluster at the University of Brighton. My research is under the supervision of Dr Katherine Johnson (School of Applied Social Science, University of Brighton) and Dr Olu Jenzen (College of Arts and Humanities, University of Brighton).

Primarily, my study will consider how social media and other online mental health interventions are utilised in the help-seeking process by gay and bisexual men as well as mental health charities and services. The intention is that knowledge generated by this study will be of direct benefit to mental health charities and used to improve their online mental health service delivery. It will also aim to benefit gay and bisexual men's experience of using services and inform future directions for those who do not.

Your organisation has a long history of supporting LGBT people with their mental health and the expertise your charity has developed is important in informing research on gay men's mental health help-seeking. If you would be interested in exploring the opportunity to collaborate on this project, please contact me via the details below.

Yours Sincerely,

Willem Stander
Doctoral candidate
University of Brighton
Mobile: [redacted]
Email address: [redacted]

Appendix 3: Letter to participate (MindOut)

University of Brighton
School of Applied Social Science
Mayfield House, Room M229
Brighton
BN1 9PH

Friday, 14th August 2015

Helen Jones
Director
MindOut
Community Base
113 Queens Road
Brighton BN1 3XG

Dear Ms. Margaret Unwin,

INVITATION TO PARTICIPATE IN RESEARCH ON GAY AND BISEXUAL MEN'S ONLINE MENTAL HEALTH HELP-SEEKING BEHAVIOURS

I am a doctoral student funded by the Transforming Sexuality and Gender research cluster at the University of Brighton. My research is under the supervision of Dr Katherine Johnson (School of Applied Social Science, University of Brighton) and Dr Olu Jenzen (College of Arts and Humanities, University of Brighton).

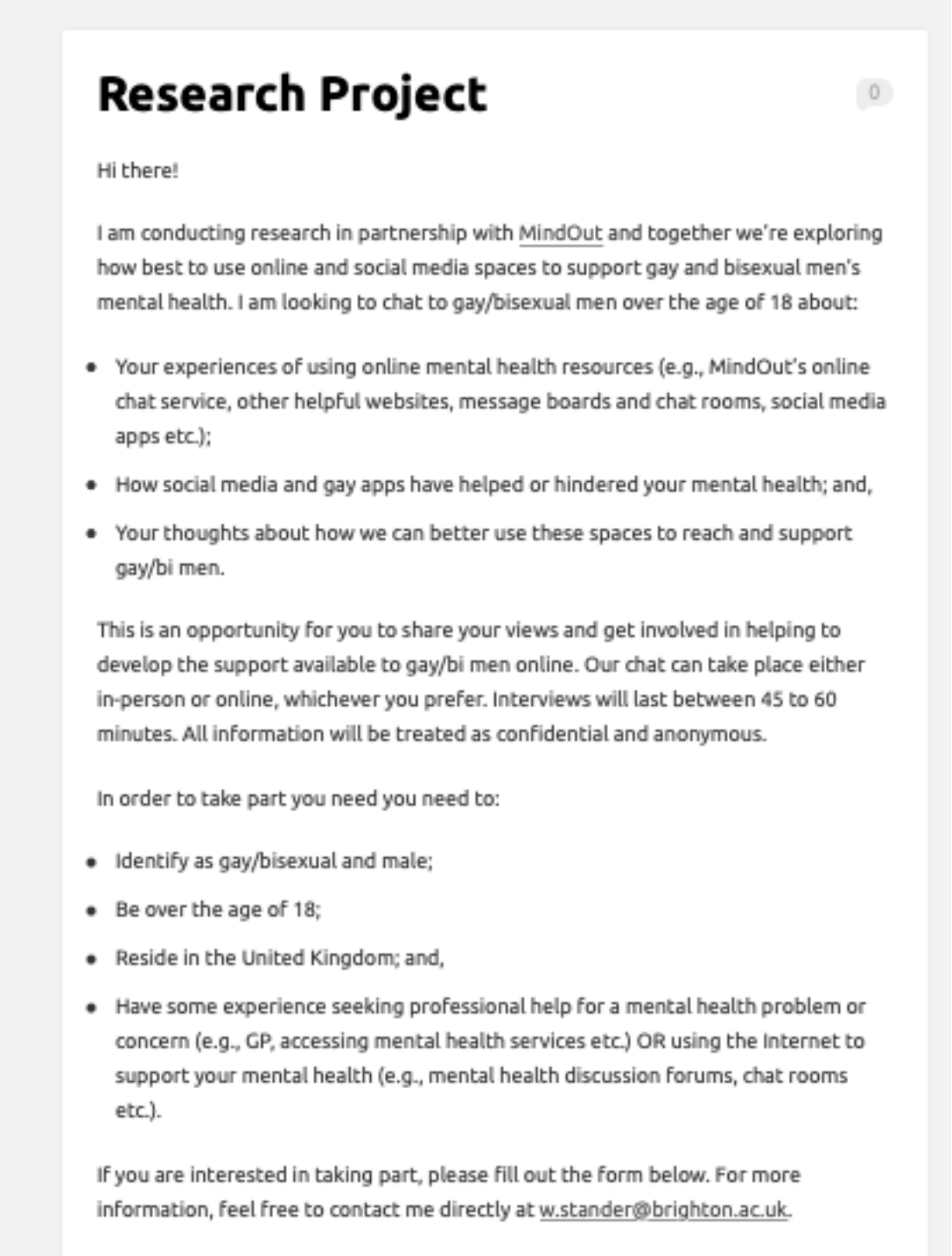
Primarily, my study will consider how social media and other online mental health interventions are utilised in the help-seeking process by gay and bisexual men as well as mental health charities and services. The intention is that knowledge generated by this study will be of direct benefit to mental health charities and used to improve their online mental health service delivery. It will also aim to benefit gay and bisexual men's experience of using services and inform future directions for those who do not.

Your organisation has a long history of supporting LGBT people with their mental health and the expertise your charity has developed is important in informing research on gay men's mental health help-seeking. If you would be interested in exploring the opportunity to collaborate on this project, please contact me via the details below.

Yours Sincerely,

Willem Stander
Doctoral candidate
University of Brighton
Mobile: [redacted]
Email address: [redacted]

Appendix 4: Edublog (screenshot of recruitment website/blog)



Research Project

0

Hi there!

I am conducting research in partnership with MindOut and together we're exploring how best to use online and social media spaces to support gay and bisexual men's mental health. I am looking to chat to gay/bisexual men over the age of 18 about:

- Your experiences of using online mental health resources (e.g., MindOut's online chat service, other helpful websites, message boards and chat rooms, social media apps etc.);
- How social media and gay apps have helped or hindered your mental health; and,
- Your thoughts about how we can better use these spaces to reach and support gay/bi men.

This is an opportunity for you to share your views and get involved in helping to develop the support available to gay/bi men online. Our chat can take place either in-person or online, whichever you prefer. Interviews will last between 45 to 60 minutes. All information will be treated as confidential and anonymous.

In order to take part you need you need to:

- Identify as gay/bisexual and male;
- Be over the age of 18;
- Reside in the United Kingdom; and,
- Have some experience seeking professional help for a mental health problem or concern (e.g., GP, accessing mental health services etc.) OR using the Internet to support your mental health (e.g., mental health discussion forums, chat rooms etc.).

If you are interested in taking part, please fill out the form below. For more information, feel free to contact me directly at w.stander@brighton.ac.uk.

Appendix 5: Focus group topic points

Do you think gay and bisexual men struggle to seek help for mental health-related concerns, and if so, why?

- Why might some they be reluctant to seek help (elsewhere)?
- What factors influence influences whether an individual decides to talk or to seek help?

What do you think distressed gay and bisexual men go online to seek help?

- Any examples from previous cases / Any feedback from previous chat users as to why they chose to seek support online specifically?
- How do they describe their experiences? How do they ask for help?
- What do they want help with? What do they want to get out of the online chat?
- Have you found differences in terms of age, gender, and sexuality? (anonymous space)

What have your experiences been like providing support to gay and bisexual men online?

- Why would people seek help from MindOut's online service specifically?
- What have you found works well in your practice?
- What challenges have you experienced?
- What is important in your practice when providing support online? How does the online chat enable/hinder that?

How can/does MindOut use digital and social media more widely to provide appropriate support measures (prevention interventions)?

- E.g., Websites, blogs, forums, Twitter, Tumblr, Facebook, Grindr etc.
- What are the possibilities and challenges related digital outreach work?
- Are some formats/mediums/platforms more appropriate than others? How so?

Appendix 6: Interview schedule (service providers)

INTRODUCTION

How did you come to work for *MindOut* / How long have you been with the organisation? / Please tell me about your role within *MindOut*…

- What work do you do?
- What does that involve?

What support services (both on- and offline) are currently on offer by *MindOut*?

- Do you find differences in terms of uptake by service users (e.g., age, gender, sexuality, new/existing service users etc.)? If so, what are those differences?
- Why do you think that is?
- What is your understanding of the work *MindOut* does online?

How important is the Internet and social media in your everyday life?

- What do you mostly use the Internet/social media for? Why these specific sites/apps?
- Would you say you're heavy Internet/social media user?
- What affects you positively and negatively within these online spaces?

Has the Internet or social media played a particular role in your own life in terms of your sexuality (i.e. coming out, meeting other LGBT people) and/or mental health?

- How so / In what way…
- What effect did that have?

DESIGN OF SERVICES

Is there a push by your funders to deliver mental health support online?

- How so?
- What are your views on this?
- In what way is this beneficial /challenging for *MindOut*?
- Do you think that the delivery of online support is particularly important to the LGBTQ community? How so?

Have you been involved in the design and planning of online services?

In your experience, what issues do LGBT people face in accessing broader, more mainstream services?

- How does MindOut overcome similar issues?

Can you tell me about the decisions that have gone into *MindOut's* online service delivery (i.e., online chat, website, social media)?

- In what ways have these restricted/encouraged inclusivity of different LGBT subgroups, age, gender, sexuality, race (i.e., a diversity of backgrounds and experiences)?

Do off- and online practices inform one another?

- How so / In what ways…

ONLINE CHAT

How often is the online chat available?

- Why specifically those times/days?

What kind of training is involved for volunteers who deliver support via the online chat?

- Is there a worry about different working styles? How do you overcome that?
- What kind of support do volunteers receive?
- What has the feedback been from volunteers providing support via the online chat?

What kind of impact has the online chat had for *MindOut*?

- E.g., in terms of reach; the uptake of use; new or existing service users; rural or urban etc.
- Why specifically a chatroom as opposed to a discussion forum (etc.)?
- How long are the sessions generally?
- How long has the service been available?
- How is it different from the work you do in-house?
- Do you find differences between the two?
- How do they inform one another?
- Does online engagement often extend into the access of offline services?

Have you personally done any online volunteering work via the chat?

- What were your experiences like?
- How do online service users articulate their distress?

- Did you find anything particularly challenging or beneficial?
- Can you step me a through a typical session?
- How do service users generally present themselves within such an anonymous space / How important do you think anonymity is within this context?
- How do service users articulate themselves and their distress within these spaces?
- Have you drawn on any personal experiences to inform your online work?
- Is there anything that surprised you? If so, what?
- What do people generally seek help for? How do you help them?
- In your discussions with service users, why do they come to seek help online? What challenges do they face in accessing support?
- Are those using the chat doing so in times of crises or just to have a chat more generally?
- In your conversations with service users online, do you get the sense that they carefully and rationally planned to use the service or is it more emotionally driven (i.e. distress, overwhelmed)?

SOCIAL MEDIA

What role do social media play in the delivery of *MindOut's* services?

- How do you discuss mental health issues on social media apps?
- How are these spaces used to support and engage with vulnerable LGBTQ people by *MindOut*?
- Why Facebook, Twitter, and YouTube specifically as opposed to other social media platforms? What have you found works, and what doesn't?
- In what ways is social networking apps like Scruff and Recon used within the context of *MindOut's* work? Why not other apps? How successful have these strategies been? Do you believe that these spaces are important to reach gay men?
- What possibilities and challenges have you encountered within these spaces and with your engagement with service users?
- Do you find that certain social media spaces are more popular among certain LGBT subgroups? If yes, why do you think that is? With regards to your

experience, do you think certain groups benefit from online support and social media outreach more than others?

- What kind of data/statistics do you collect via social media with regards to your audience?
- How do you address issues around confidentiality and privacy within these spaces?
- Have service users spoken about their use of the Internet and social media, in terms of either being detrimental or beneficial to their mental health?
- In what ways?

PERSONAL HELP-SEEKING

Have you every personally made use of *MindOut's* services (or other professional services) for mental health-related difficulties?

- When did you seek help?
- How did you seek help?
- Who did you seek help from?
- How did you experience this?
- What helped/prevented you from accessing support?
- Did you have any coping strategies that you found helpful during this time?
- Gay Men

Do you find that your interactions with gay men differ from other service users?

- If so, in what ways have they differed?
- Do you find that they have specific needs different from other service users?
- Do you think gay men face particular difficulties in reaching out in times of crises? How so?
- What do gay men seek help for?

In your experience, what are the main issues/challenges facing gay men seeking help for mental health problems or emotional distress?

- Societal pressure / norms / masculinity (gay men, as gay, as men, within LGBT community)

In what ways are your services tailored towards this group?

- Where/how do you interact with them in your online outreach work?

ROUNDING OFF QUESTIONS

Why did you choose to participate in this study?

Is there anything else you'd like to add/say about this study or the idea of giving/receiving mental health support over the Internet and social media?

Thank You.

Appendix 7: Interview schedule (service users)

INTRODUCTION/GENERAL

How important is the Internet and social media to you in your everyday life?

- What do you mostly use the Internet or social media for? Why these specific sites/apps?
- Would you say you're a heavy Internet or social media user?
- What affects you positively and negatively within these online spaces?

Has the Internet or social media played a particular role in your own life in terms of your sexuality and/or mental health?

- How so?
- What effect did that have?

Which mental health support services (both on- and offline) have you used to seek support?

- How did you come to use these services?
- Why those specific services?
- What were your experiences accessing these?
- What do you think helped/hindered you to look for support?

DIGITAL SPACES

Could you tell me more about the ways in which you use the Internet to support your mental health?

- Why did you come to look for support online as opposed to face-to-face?
- When do you look for support online?
- How do you look for support online? What spaces do you look to and why?
- What about this environment makes you feel supported (or adversely affect you)?
- Why these spaces specifically? (as opposed to e.g., message boards or forums etc.)

- What about these spaces make you feel like you can talk about your mental health problems?
- Are these general population or LGBTQ-specific spaces? In what ways are these helpful?
- How is anonymity/confidentiality important to you with regards this space and mental health help-seeking?
- What are your feelings around using these spaces? How do they make you feel? How do the help/hinder?

SOCIAL MEDIA

How have you used social media for mental health purposes?

- What spaces do you use? Why these spaces? How do you use these spaces?
- What about them makes you feel supported? In what ways to do they affect you negatively?
- What do you think about the availability of online (or offline) support for gay and bisexual men?

ELICITATION METHODS

Do you feel comfortable showing me some of these spaces on your phone or on an iPad?

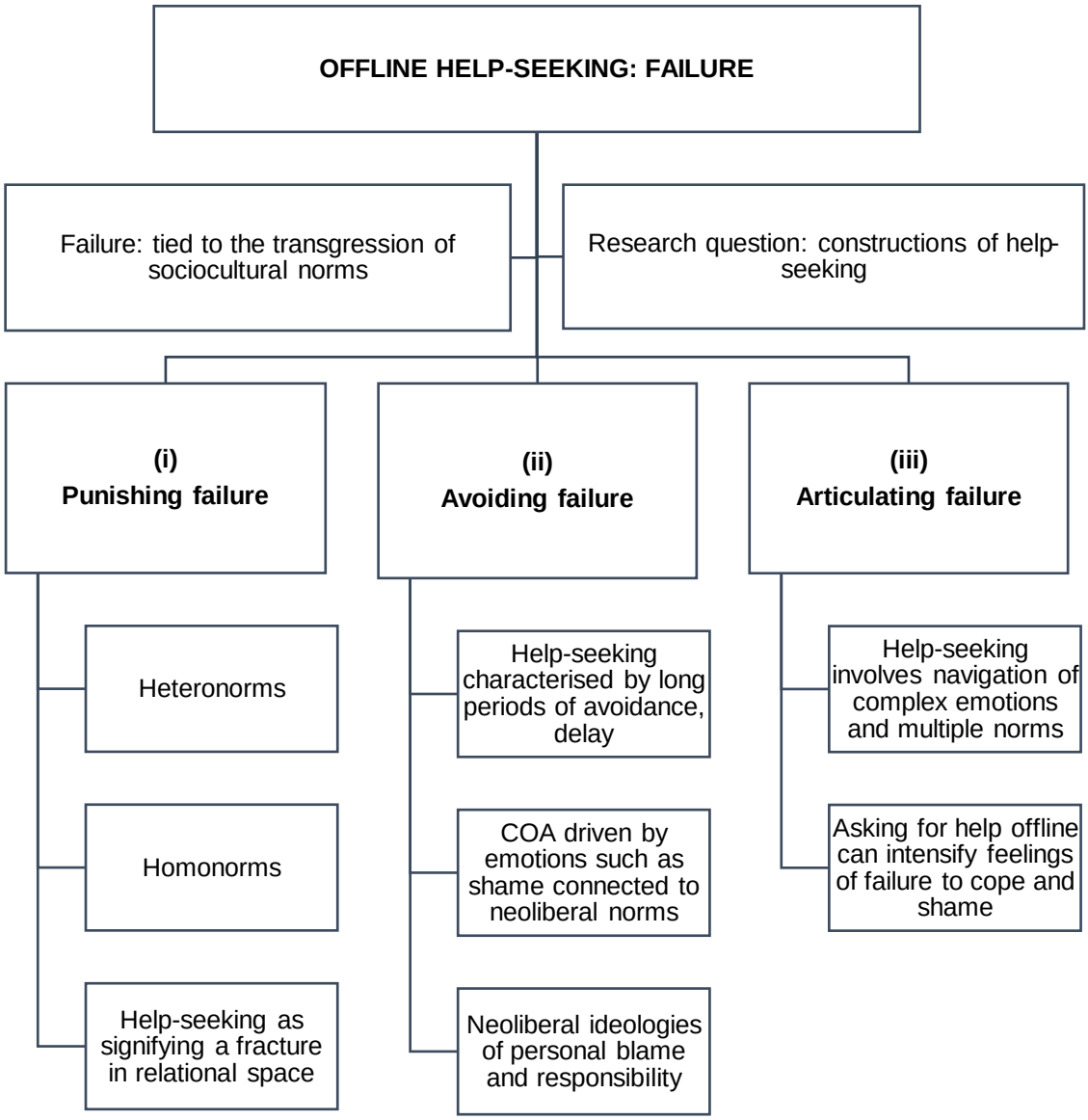
- Can you talk me through how you might use this space?
- What about it appeals to you?
- How does this space support your mental health or negatively affect it?

ROUNDING OFF QUESTIONS

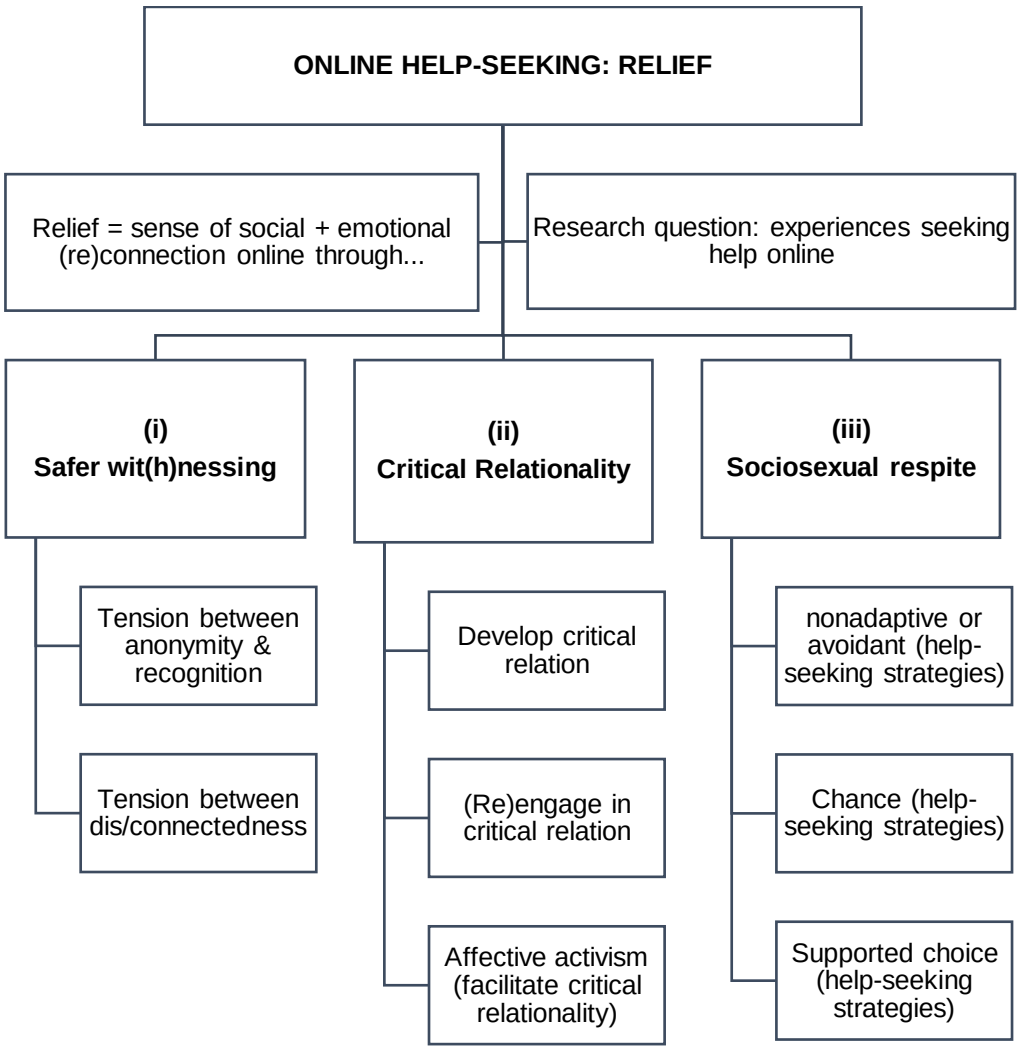
Why did you choose to participate in this study?
Is there anything else you'd like to add/say about this study or the idea of looking for mental health support over the Internet and social media?

Thank You.

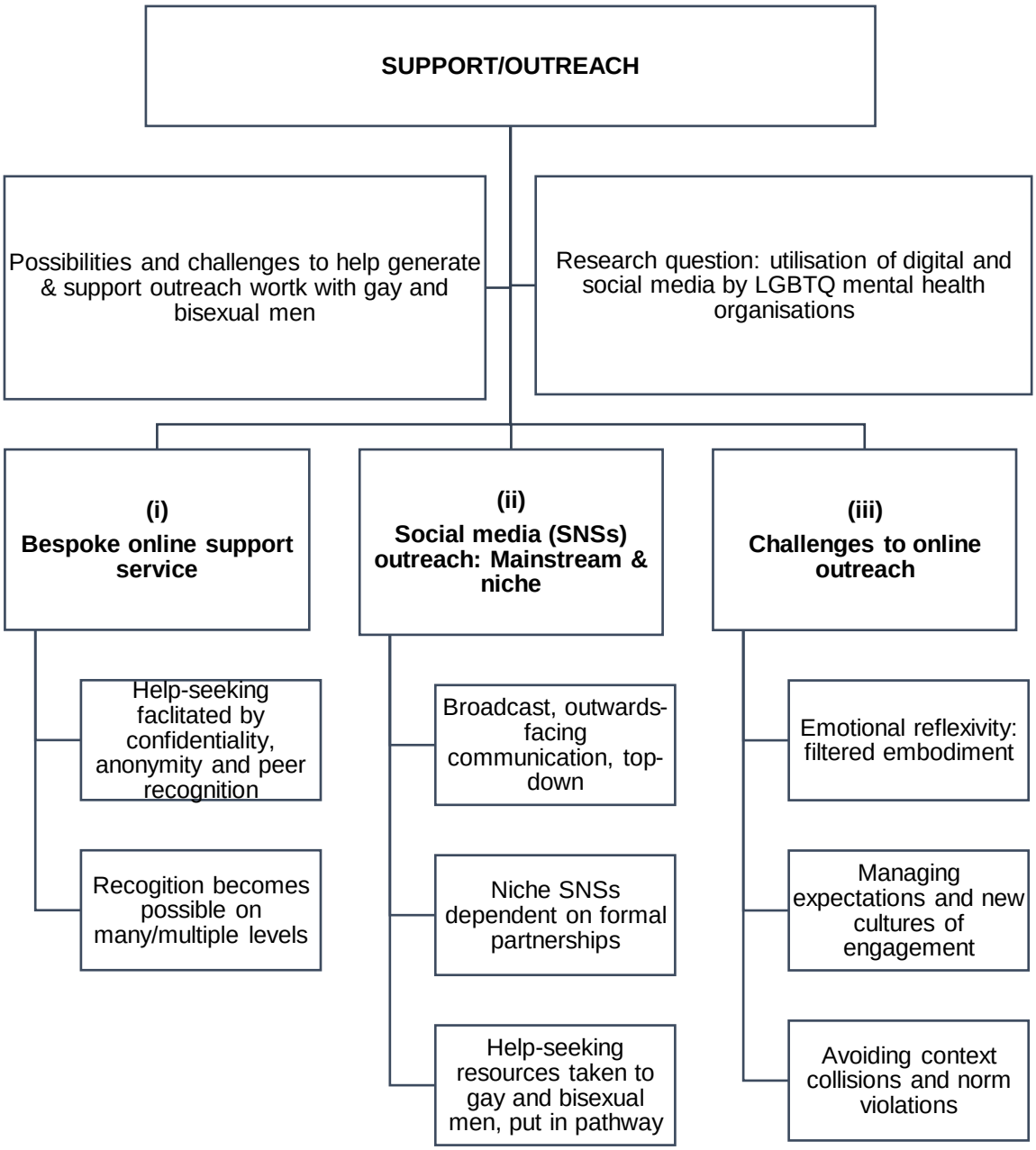
Appendix 8: Thematic map (failure)



Appendix 9: Thematic map (relief)



Appendix 10: Thematic map (support)



Appendix 11: Consent form (service providers)

Gay & Bisexual Men: Online Mental Health Help-Seeking Behaviours

	Please initial or tick box
I agree to take part in this research which explores how LGBTQ mental health charities utilise the Internet and social media to facilitate and provide support to gay men seeking help for mental health difficulties.	
The researcher has explained to my satisfaction the purpose, principles and procedures of the study and the possible risks involved.	
I have read the information sheet and I understand the principles, procedures and possible risks involved.	
I am aware that I will be required to take part in an interview or focus groups where I will discuss my experiences in planning, designing, developing, and delivery of online services to support LGBTQ people and their mental health.	
I agree to the researcher making an audio recording of the interview / focus group.	
I understand how the data collected will be used, and that any confidential information will normally be seen only by the researchers and will not be revealed to anyone else.	
I understand that I am free to withdraw from the study at any time without giving a reason and without incurring consequences from doing so.	
I agree that should I withdraw from the study, the data collected up to that point may be used by the researcher for the purposes described in the information sheet.	

Name (please print) ……...

Signed ……...

Date ……

Contact
If you have any questions or concerns, please contact me directly:

Willem Stander
Email: [redacted]
Phone: [redacted]
Mobile: [redacted]

University of Brighton
M229 Mayfield House, Falmer Campus
Village Way
BN1 9PH
Brighton BN1 9PH

Alternatively, should you wish to verify my identity or make a complaint, you can contact one of my supervisors:

Dr Katherine Johnson
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Mayfield House
Falmer
Brighton BN1 9PH

Dr Olu Jenzen
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Watts Building, Moulsecoomb
Lewes Road
Brighton BN2 9PH

Appendix 12: Consent form (service users)

Gay & Bisexual Men: Online Mental Health Help-Seeking Behaviours

	Please initial or tick box
I agree to take part in this research which investigates gay & bi men's experiences in seeking help for mental health-related concerns and explores how they use the Internet and social media to support their mental well-being.	
The researcher has explained to my satisfaction the purpose, principles and procedures of the study and the possible risks involved.	
I have read the information sheet and I understand the principles, procedures and possible risks involved.	
I am aware that I will be required to discuss my experiences of seeking support for mental health-related difficulties in either an on- or offline interview and that interviews will involve looking at and discussing social media & web-based material.	
I understand that photographs/screengrabs/screenshots will be taken by myself (or the researcher) of social media & web-based material used in our discussion. I am aware I will have final approval over the use & reproduction of these images.	
I understand how the data collected will be used, and that any confidential information will normally be seen only by the researchers and will not be revealed to anyone else.	
I understand that I am free to withdraw from the study at any time without giving a reason and without incurring consequences from doing so.	
I agree that should I withdraw from the study, the data collected up to that point may be used by the researcher for the purposes described in the information sheet.	

I agree to the researcher making an audio recording of our interview (if conducted face-to-face). ☐

Name (please print) ……...

Signed ……...

Date ……

Contact
If you have any questions or concerns, please contact me directly:

Willem Stander
Email: [redacted]
Phone: [redacted]
Mobile: [redacted]

University of Brighton
M229 Mayfield House, Falmer Campus
Village Way
BN1 9PH
Brighton BN1 9PH

Alternatively, should you wish to verify my identity or make a complaint, you can contact one of my supervisors:

Dr Katherine Johnson
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Mayfield House
Falmer
Brighton BN1 9PH

Dr Olu Jenzen
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Watts Building, Moulsecoomb
Lewes Road
Brighton BN2 9PH

Appendix 13: Participant information sheet (service providers)

Gay & Bisexual Men: Online Mental Health Help-Seeking Behaviours

I am a postgraduate research student in the School of Applied Social Science at the University of Brighton. As part of my PhD thesis, I am conducting research under the joint supervision of Dr Katherine Johnson and Dr Olu Jenzen, and I am inviting you to participate in my study. Before you decide, I would like you to understand why the research is being done and what it would involve. Please go through this information sheet and feel free to ask if there is anything that is not clear or if you have any additional questions.

What is the purpose of this research?

My research project investigates gay men's experiences in seeking help for mental health-related difficulties. Specifically, I would like to consider and explore the ways in which gay and bisexual men might use the Internet and social media to support their mental well-being, their engagement within these online spaces, and the factors that encourage them to seek assistance. Additionally, I'd like to consider how LGBTQ mental health charities/services currently utilise their online services and social media to engage with gay and bisexual men and provide support for mental health concerns. Knowledge generated by this project can be used to improve the provision and delivery of online mental health services and interventions to gay and bisexual men who might benefit from them.

Why have I been invited to participate?

This study seeks to recruit both employed staff and professional helpers/volunteers from LGBTQ mental health charities involved in the provision of, and running of, online support services.

Do I have to take part?

The decision to take part is completely up to you. Should you decide to take part, you will be given a copy of this information sheet to keep and you'll be asked to sign a

consent form. You are free to withdraw from this study, at any time, without giving a reason. A decision to withdraw will not affect you in anyway.

If the decision is made to withdraw before the data analysis has been completed and the dissertation submitted, then the data won't be used. Once data has been analysed and the dissertation submitted, the data will not be able to be removed from the dissertation. If a request has been made to remove the data at this particular stage, then the data will not be included in any subsequent publications.

What is expected from participants?

(a) Employed staff: you will be required to take part in a face-to-face interview. During the interview we will discuss drivers behind establishing online support and the organisational challenges faced in the planning, designing, developing and promotion of online mental health services. All interviews will be conducted at the premises of *MindOut* and will be audio recorded. Interviews are expected to last between 45 – 50 minutes.

(b) Professional helpers/volunteers: you will be required to take part in a focus group discussing your experiences of providing support online for mental health-related concerns. Focus groups will be held at *MindOut's* premises and all focus groups will be audio recorded. Focus groups are expected to average between 60 – 90 minutes.

What if I find being involved in the research upsetting/distressing?

It is possible that some of the topics during the interview may cause distress although every effort has been made to minimise the chances of this happening. If this should occur during the interview, I will offer you an opportunity to take a short break or to end the interview if you feel it's necessary. *MindOut* will assist internally with any support you might need. Additionally, I will also provide you with a list of local and national mental health services and helplines should you wish to engage with an alternate service.

Will people know who I am?

All participants are entitled to anonymity and confidentiality. However, there are a few factors that require your careful consideration. Firstly, given that *MindOut* might be

made in the outputs of this research and that interview extracts will be used to illustrate findings, there is a small chance that you might be recognised internally within *MindOut* by other staff and professional helpers/volunteers. Secondly, for those participating in the focus group(s), there is a chance that participants might reveal the identity of focus group members to others outside of the group. Every effort will be made to provide shelter for your identity. All identifying information will be anonymised where applicable and no identifying annotations will be included alongside interview extracts. Furthermore, participants of focus groups will be cautioned not to discuss the focus group or the identity of members with anyone else outside of the group.

How will what I say be stored?

All transcript and recordings will be stored securely on a password-protected University computer accessible only by the research team (myself and my supervisors). All data will be destroyed two years after completion of this research project.

What will happen to the results of the research study?

The results of this research will form part of my PhD thesis and will be shared with *MIndOut*. Additionally, findings from this study may be presented at academic conferences and published in academic journals or reports.

Who has reviewed this study?

This study has been reviewed and approved the School Research Ethics and Governance Committee of the University of Brighton.

Contact

If you have any questions or concerns, please contact me directly:

Willem Stander
Email: [redacted]
Phone: [redacted]
Mobile: [redacted]

University of Brighton

M229 Mayfield House, Falmer Campus
Village Way
BN1 9PH
Brighton BN1 9PH

Alternatively, should you wish to verify my identity or make a complaint, you can contact one of my supervisors:

Dr Katherine Johnson
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Mayfield House
Falmer
Brighton BN1 9PH

Dr Olu Jenzen
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Watts Building, Moulsecoomb
Lewes Road
Brighton BN2 9PH

Thank you for reading so far. If you are still interested in taking part in this study, please consider and complete the consent form.

Appendix 14: Participant information sheet (service users)

Gay & Bisexual Men: Online Mental Health Help-Seeking Behaviours

I am a postgraduate research student in the School of Applied Social Science at the University of Brighton. As part of my PhD thesis, I am conducting research under the joint supervision of Dr Katherine Johnson and Dr Olu Jenzen, and I am inviting you to participate in my study. Before you decide, I would like you to understand why the research is being done and what it would involve. Please go through this information sheet and feel free to ask if there is anything that is not clear or if you have any additional questions.

What is the purpose of this research?

My research project explores gay and bisexual men's experiences in using the Internet and social media to support their mental health and to seek help for mental health-related difficulties or emotional distress. I'd like to consider how LGBTQ mental health charities and services provide support online, as well as look at the possibilities/challenges in using social media to help generate and support outreach work with isolated, vulnerable, and marginalised individuals. Knowledge generated by this project can be used to improve the provision and delivery of online mental health services and interventions to those men who may benefit from them.

Why have I been invited to participate?

This study seeks to recruit gay and bisexual men (over the age of 18) who have some experience of seeking help online for mental health-related difficulties.

Do I have to take part?

The decision to take part is completely up to you. Should you decide to take part, you will be given a copy of this information sheet to keep and you'll be asked to sign a consent form. You are free to withdraw from this study, at any time, without giving a reason. A decision to withdraw will not affect you in anyway. If the decision is made to withdraw before the data analysis has been completed and the dissertation submitted, then the data won't be used. Once data has been analysed and the dissertation

submitted, the data will not be able to be removed from the dissertation. If a request has been made to remove the data at this particular stage, then the data will not be included in any subsequent publications.

What is expected from participants?

This study will require you to take part in an interview. You will be given the choice between either an in-person interview at the premises of *MindOut* (LGBTQ mental health service based in Brighton) OR an online interview via a secure chat format through the exchange of written messages. During the interview, I will ask you to tell me about your experiences in seeking support for mental health-related concerns. During the interview we will look at and discuss online spaces you may have used to seek assistance or the ways in which these spaces are used (or can be used) to support gay men's mental well-being. Additionally, you will also be asked to generate images of these websites, social media platforms, and/or apps by taking screenshots/screengrabs/photos and sharing them with me.

You will have final approval over all images generated by your participation. Thus, the final decision rests with you regarding which images are ultimately included in this study, and how these images will be reproduced in the outputs of this research project. All images will be transferred onto a password-protected hard drive and/or encrypted USB flash drive. All interviews will last between 60 - 90minutes, and in-person interviews will be audio recorded.

What if I find being involved in the research upsetting/distressing?

It is possible that some of the topics during the interview may cause distress although every effort has been made to minimise the chances of this happening. If this should occur during the interview, I will offer you an opportunity to take a short break or to end the interview if you feel it's necessary. *MindOut* will assist internally with any support you might need. Additionally, I will also provide you with a list of local and national mental health services and helplines should you wish to engage with an alternate service.

Will people know who I am?

All participants are entitled to anonymity and confidentiality. However, there are a few factors that require your careful consideration. Firstly, given the topic area of this study (mental health help-seeking), complete confidentiality cannot be guaranteed in cases where current plans to harm yourself or others are mentioned. Secondly, as I'm collaborating closely with *MindOut* on this project, there is a small risk that participant accounts might recognised internally by staff and professional helpers, specifically those who have made use, or continue to make active use, of *MindOut's* services. Thirdly, there are also concerns about the traceability of participant-generated online materials in that some images may contain information directly related to, or easily traced back to, your online profile and identity.

In order to address these concerns, the following measures have been implemented. In instances where current plans to harm oneself or others are mentioned, information of this nature will be shared with a *MindOut* community worker so that appropriate support or intervention can immediately be made available. With regards to anonymity, every effort will be made to provide shelter for your identity. All identifying information will be anonymised where applicable. No identifying annotations will be included alongside interview extracts, and identifying information in images will be digitally blurred. Moreover, participants will have final approval of all images used and reproduced in this study.

How will what I say be stored?

All transcript and recordings will be stored securely on a password-protected University computer accessible only by the research team (myself and my supervisors). All data will be destroyed two years after completion of this research project.

What will happen to the results of the research study?

The results of this research will form part of my PhD thesis and will be shared with *MindOut*. Additionally, findings from this study may be presented at academic conferences and published in academic journals or reports.

Who has reviewed this study?

This study has been reviewed and approved by the School Research Ethics and Governance Committee of the University of Brighton.

Contact for further information

If you have any questions or concerns, please contact me directly:

Willem Stander
Email: [redacted]
Phone: [redacted]
Mobile: [redacted]

University of Brighton
M229 Mayfield House, Falmer Campus
Village Way
BN1 9PH
Brighton BN1 9PH

Alternatively, should you wish to verify my identity or make a complaint, you can contact one of my supervisors:

Dr Katherine Johnson
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Mayfield House
Falmer
Brighton BN1 9PH

Dr Olu Jenzen
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Watts Building, Moulsecoomb
Lewes Road
Brighton BN2 9PH

Thank you for reading so far. If you are still interested in taking part in this study, please consider and complete the consent form.

Appendix 15: List of LGBTQ-specific mental health support services

MINDOUT

LGBTQ+ mental health service

Tel: 01273 243839

Email: info@mindout.org.uk

Website: www.mindout.org.uk (online support available)

BRIGHTON & HOVE LGBT SWITCHBOARD

LGBTQ+ helpline

Tel: 01273 204050

Email: info@switchboard.org.uk

Website: www.switchboard.org.uk (online support available)

SWITCHBOARD

LGBTQ+ helpline

Tel: 020 7837 7324

Email: chris@switchboard.lgbt

Website: www.llgs.org.uk (online support available)

LGBT FOUNDATION

LGBTQ+ helpline

Tel: 0345 3 30 30 30

Email: info@lgbt.foundation

Website: www.lgf.org.uk

BROKEN RAINBOW

LGBTQ+ domestic violence charity

Tel: 0300 999 5428

Email: help@brokenrainbow.org.uk

Website: www.brokenrainbow.org.uk (online support available)

Appendix 16: Letter of support (MindOut)

Community Base
113 Queens Road
Brighton
BN1 3XG

t: 01273 234839
e: info@mindout.org.uk

reg. company no. 7441667
Charity Number 1140098

22nd September 2015

To Whom It May Concern

Letter of Support

I would like to express my support for Willem Stander's research proposal on gay and bisexual men's online mental health help-seeking behaviours being submitted to the University of Brighton's Research Ethics and Governance Committee.

MindOut is delighted to collaborate on the project. We will assist with recruiting participants, provide support to all participants and to the researcher, both before and after research interviews are conducted. We will provide a MindOut worker to offer support as necessary.

We acknowledge and understand that the research is an independent project. MindOut's involvement as a named charity in any future publications, presentations, and/or reports that might arise from this project will be considered and discussed with Mr Stander. Furthermore, we are aware of the possibility that some participants might report negative experiences of our online support services. We acknowledge, however, that the generation of such knowledge might be of direct benefit to the design

and implementation of future strategies to facilitate online mental health service delivery to this population.

MindOut has a long history of supporting LGBTQ people with their mental health and our expertise as a charity will undoubtedly be important in informing this research project on gay men's mental health help-seeking. Moreover, our charity has a longstanding working relationship of 10 years with Mr Stander's supervisory team and, together, we have collaborated on numerous research projects involving vulnerable individuals and discussing sensitive topics.

I believe this research project is important, feasible, and very much consistent with the values of MindOut. I am hopeful that this proposal will be a success.

Yours faithfully,

Helen Jones
Director, MindOut

Appendix 17: Photo/image reproduction form

Gay & Bisexual Men: Online Mental Health Help-Seeking Behaviours

Willem Stander
School of Applied Social Science
University of Brighton

This form refers to photographs that you supplied, or photos that you allowed me, as the researcher to capture, as part of the Gay & Bisexual Men's Online Mental Health Help-Seeking research project. All photographs will be securely stored. As discussed, photographs may be shared with my supervisory team to help me in my analysis. I would like to use some of the photographs (in electronic or print form), in my thesis, reports, presentations, and publications that arise from this project. Please could you sign one of the sections below to indicate whether or not you are happy for me to do this. I have attached numbered prints of photographs to assist you, and for your records. I won't use any photographs outside the research team without your permission.

Please sign either section 1, 2, or 3 below:

SECTION 1. I give my consent for these photographs to be reproduced for educational and/or non-commercial purposes in a thesis, reports, presentations, publications, and websites connected to this research project. I understand that real names will NOT be used with the photographs and that all identifying information will be digitally blurred or removed.

Full Name (please print): _____

Signature: _____

Date: ___/___/___

OR

If you would like to give permission for us to publish some, but not all, of the photos please list the numbers of the photos you will allow us to use:

SECTION 2. I give my consent for the following photos (please provide photo numbers)

_____

to be reproduced (in electronic or print form), for educational and/or non-commercial purposes, in a thesis, reports, presentations, publications, and websites connected to this research project. I understand that real names will NOT be used with the photographs and that all identifying information will be digitally blurred or removed.

Full Name (please print): _____

Signature: _____

Date: ___/___/___

OR

SECTION 3. I do not wish any of these photographs to be reproduced in connection with the research project.

Full Name (please print): _____

Signature: _____

Date: ___/___/___

Contact

If you have any questions or concerns, please contact me directly:

Willem Stander

Email: [redacted]

Phone: [redacted]
Mobile: [redacted]

University of Brighton
M229 Mayfield House, Falmer Campus
Village Way
BN1 9PH
Brighton BN1 9PH

Alternatively, should you wish to verify my identity or make a complaint, you can contact one of my supervisors:

Dr Katherine Johnson
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Mayfield House
Falmer
Brighton BN1 9PH

Dr Olu Jenzen
E-mail: [redacted]
Phone: [redacted]

University of Brighton
Watts Building, Moulsecoomb
Lewes Road
Brighton BN2 9PH