Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm or Feel Suicidal

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ABSTRACT

Background: Mental health services in the National Health Service (NHS) exist in a context of heteronormativity, where there are assumptions made within services and wider society about the expected nature of sexual and gender identity, implicitly and explicitly. LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and any other sexual minority identity) adolescents and young adults are at a stage of life where they are forming their identities. This group of young people experience elevated risks of mental health needs, including self-harm and suicidality. Experiencing self-harm or suicidal feelings, and being LGBTQ+, are both associated with stigma and rejection, including within mental health services; this can have implications for help-seeking and being open about their identities.

Aims: This study aimed to explore the experience and impact of LGBTQ+ identity disclosure in NHS mental health services, for young people (aged 14-25) who experienced difficulties with self-harm or suicidality. The study aimed to provide space for young people's voices, and to promote changes within systems for improving care for this group of young people.

Method: Qualitative semi-structured interviews were used to gather information from five young people, recruited through social media. Transcripts were analysed using Reflexive Thematic Analysis.

Findings: Three primary themes were developed from the analysis: 'power and powerlessness', 'making sense of identity', and 'the importance of relationships'. The experience and impact of these concepts were explored, recognising the context of pervasive heteronormativity in NHS services, from a critical realist epistemological stance.

Conclusions: There is a need for change in individual clinical relationships, and at service and wider policy levels in the NHS, to prevent harmful experiences and longer-term consequences for LGBTQ+ young people. Changes are needed to reduce heteronormative bias and provide affirmative, transparent, supportive care to young people experiencing self-harm or suicidality, in their LGBTQ+ identity disclosures and subsequent interactions with clinicians.

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1.0 INTRODUCTION

1.1 Overview

This chapter explores current research and ideas related to young people who identify as LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning and any other sexual minority identity, including, for example, asexual, agender, pansexual and other language individuals may use; Stonewall, 2016). Specifically, it explores experiences related to LGBTQ+ identity disclosure, and experiences of self-harm and suicidality, for young people. It aims to situate the report in theory, literature, and socio-political context, and outlines the overarching framework for the study. Two literature searches provide additional focus on disclosure of LGBTQ+ identities in mental health services, and experiences of support for self-harm or suicidality, setting up the aims and research questions for the current study.

1.2 Approach to this Study

1.2.1 The Language of LGBTQ+

This study focuses on the experiences of young people who identify as LGBTQ+. This is the language used in this study for identities perceived as outside of hetero- and cis-normative expectations, whilst recognising that individuals may prefer different language and positioning in relation to these perceived norms. The acronym LGBTQ+ was chosen due to its wide use, within and outside of LGBTQ+ communities (Thelwall et al., 2022). Whilst versions of this acronym are used in different ways (e.g. LGBT, LGBTQIA+), the term ‘LGBTQ+’ was viewed to hold in mind many different ways of identifying, encapsulated via the + sign. This particular acronym also enables an element of choice in language preferences of individuals, keeping the terms open-ended and therefore broadly inclusive, to allow visibility of all identities that may or may not explicitly fit with the letters in the acronym, at the choice of the individual (for example, a person who is intersex may or may not view themselves as part of the LGBTQ+ community; Stonewall, 2023).

However, relegating many identities to the other side of a '+' can be othering, and thus it was important to hold in mind that this acronym is neither fully inclusive nor exhaustive as a means of conceptualising sexual and gender diversity. It also suggests there is a homogeneity in these identities. There is value in considering all non-heterosexual and non-cisgender identities together, in the context of the shared fight for rights for those who challenge societal norms related to identity, gender and sexuality (Monro, 2020). However, it is also important to recognise the distinctions within these identities, the associated differences in experiences, and the different levels of societal acceptance and legal protection (Monro et al., 2017b). Indeed, the language of LGBTQ+ may not resonate with all (Knauer, 2011). This terminology can be understood to emphasise *difference* to the expected societal norms, in the act of identities effectively being referenced in relation to their difference to hetero- and cis-normativity (Gonsiorek, 1993). The language chosen in this study aims to emphasise the role heteronormativity plays in our society and healthcare systems.

1.2.2 Heteronormativity

This study is framed from a perspective of the pervasiveness of heteronormativity in UK society, and more specifically in healthcare (particularly, mental healthcare). The term 'heteronormativity' is used here to refer to the lens through which Western Society views normative relationships, or sexual and romantic attraction; there is a perception that heterosexuality is expected as the norm, and the *ideal* sexual orientation (DiAngelo, 1997). Society is set up to privilege and reward heterosexual identities, effectively denigrating non-heterosexual identities and giving power to those who fit the heterosexual *ideal* (Rounds et al., 2013).

From a historical perspective, the grounding for such discrimination and abuse is well-entrenched in UK society; until 1967 homosexuality was a crime (Sexual Offences Act, 1967), followed by a pathology listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) explicitly until 1973, but remained in some form as diagnoses of distress associated with sexual identity until 2013 (American Psychiatric Association [APA], 2013), and the age of consent was only brought in line with heterosexual law in 1994 (Criminal Justice & Public Order Act, 1994). Indeed, arguably asexuality can still be pathologised via the DSM-V category of

‘*Hypoactive Sexual Desire Disorder’* (APA, 2013). Same-sex marriage was only recently legalised in the UK (Marriage Act, 2013), asexual people are still excluded from Equality Act (2010) protections (Harmless, 2022), and physical violence is still a widespread experience for many in the LGBTQ+ community (Bachmann & Gooch, 2017).

Similarly, cisnormativity refers to the expectation of a norm of persistence of gender-assigned-at-birth, leading to discrimination against transgender individuals (Boe et al., 2020). Transgender rights are still publicly debated, not yet established in law as basic human rights, often by individuals who are privileged by their heterosexual, cis-gender, white bias (John, 2021; Mermaids, 2019). These narratives emphasise a perspective that LGBTQ+ identities are undesirable, wrong, or need to be changed; being LGBTQ+ still constitutes risk and exclusion in UK society.

It is noted that the term ‘heteronormativity’ places focus on the perceived norm of opposite-gender sexual attraction, framing sexual identity in relation to attraction based on (binary) gender (Drescher, 2010). This framing can exclude a myriad of experiences of sexual and gender diversity; an asexual person may not feel attracted to a person of any gender, or an individual may be attracted to someone who does not identify along the gender binary. This term is used here to emphasise the prevalence and unhelpfulness of beliefs related to heteronormativity, to engage in a wider conversation around the ways these beliefs are used to the detriment of those who do not fit hetero- or cis-normative expectations (Lewin & Meyer, 2002; McIntyre & McDonald, 2012).

1.2.2.1 Theoretical Perspectives

The construct of heteronormativity can be understood to rely on the presence of identities that differ. From a Queer Theory perspective, without naming LGBTQ+ identities and their difference to heterosexuality, the dominant societal concept of heterosexual relationship standards would not exist (Warner, 1991; Yep, 2014). Heteronormativity silences LGBTQ+ individuals, by positioning heterosexuality as the expected and *ideal* norm, making it difficult for them to feel safe to disclose their identities for fear of consequences, hiding parts of themselves as a survival mechanism (Yep, 2014). Yet, the societal expectations that make it difficult for

LGBTQ+ individuals to be open about their sexual, gender, or romantic identities, rely on such disclosures to perpetuate the expected norms.

This leads to questions about how an environment that enables discrimination, violence, and abuse towards LGBTQ+ communities has been created and maintained. There are structural barriers to openness regarding LGBTQ+ identity prevalent in society, which may then be compounded by the resulting discriminatory acts of others and internalisation of these messages by some members of the LGBTQ+ community (Mongelli et al., 2019). These structural barriers exist in the form of expected norms, including legal expectations, for example the persistence of categories of gender-assigned at birth as legal markers of identity, and the only recent changes to the Marriage Act enabling same-sex marriage in the UK (Marriage Act, 2013).

Given the historical and current factors emphasising the pervasiveness of heteronormative ideals in UK society, it is important to consider the subsequent impact. Living in a society that positions an individual as ‘other’, and where this ‘other’ identity has at times led to active discrimination and harm, may increase a person’s likelihood of experiencing emotional distress. Minority Stress Theory (MST; Meyer, 2003) posits that the build-up of difficult life experiences for people who belong to minoritised groups, such as LGBTQ+ communities, contributes to emotional distress, including increased risk of responding to this distress through self-harm and suicidality. Internalised stigma and shame, and indeed the internalisation of heterosexual expectations, contribute to the increased risk of self-harm and suicidality for LGBTQ+ individuals (Hatzenbuehler,2009).

The discrimination faced due to being perceived as belonging to a group that differs to the socially expected norms or majority increases day-to-day stressors experienced by the LGBTQ+ community (Meyer, 2003); LGBTQ+ individuals may be faced with homo/bi/ace/trans-phobic responses of others in their lives, including discrimination and violence (Bachmann & Gooch, 2017). Such stressors, external to the individual, are referred to as *distal* stressors in the context of MST (Meyer, 2003). This may also impact the ways that individuals interact with the world around them, including their experience of disclosing aspects of their lives; discriminating attitudes of others may become internalised, contributing in some cases to individuals choosing not to disclose their sexual orientation to others, which can then add further distress (Binion & Gray, 2020; Cole et al., 1996). Jackson and colleagues (2017) found that LGBTQ+ men referenced the proximal stressors (internal stressors, as consequences of the difficult environment; Meyer, 2003) related to their sexual minority identities as creating barriers to disclosure of sexual assault, as well as internalised homophobia stemming from messages propagated by society around them. Thus, there are real-world consequences to the build-up of stressors stemming from societal attitudes towards minority groups, such as LGBTQ+ individuals.

The presence of these stressors could be understood as stemming from a heteronormative environment which enables, and even encourages, such discriminatory and stigmatising attitudes and behaviours towards those perceived as ‘other’ (Rounds et al., 2013). The construct of heteronormativity, privileging heterosexual relationships and behaviours, and denigrating those who do not identify in this way, creates an environment where the LGBTQ+ population experience frequent and compounding stress from their social environment (Meyer, 2003). The term *heteronormativity* highlights the context and direction of the prejudice and discrimination, occurring by positioning heterosexuality as the expectation and ideal; thus, it reinforces the distal stressors experienced by LGBTQ+ individuals.

However, the assumption within MST that internalised homophobia develops as a result of the ‘othering’ attitudes and actions of members of society around LGBTQ+ individuals, can be understood as holding blaming connotations. By focusing on the proximal and distal stressors faced by LGBTQ+ individuals, focus is detracted from the wider context that perpetuates and reinforces these stressors. Therefore, it is important to hold in mind the context of the system that enables internalisation of ‘othering’ to occur: the heteronormative expectations of UK society.

Given that LGBTQ+ individuals likely experience increased life stressors compared to their heterosexual or cisgender peers, due to existing in a world that views their identities as ‘other’, this leads to questions about their experiences within healthcare. Indeed, the build-up of life stressors can contribute to increased propensity for mental health difficulties, or utilising methods of distress management that can be harmful, such as self-harm, and fear of discrimination may increase difficulties in accessing services (Meyer, 2003).

1.2.2.2 Heteronormativity in Healthcare

It is widely reported that there are prevalent hetero- and cis-normative assumptions within Western healthcare settings (Bauer et al., 2009; Bjorkman & Malterud, 2009; Law et al., 2015; Morris et al., 2022; Neville & Henrickson, 2009; Rich, 2003; Rees et al., 2021). Users of healthcare services report discriminatory and prejudicial assumptions being made about their gender, sexual orientation, and sexual promiscuity, as well as heteronormative language, and the negative impact this can have on their experience of care (Law et al., 2015; Morris et al., 2022). In Morris and colleague's (2022) recent study, participants shared not only the assumptions made about their gender and sexual orientation, but the pathologisation that can occur as a result; "*it's constantly brought up as some sort of like mental illness within itself*" (participant 24, pp234, Morris et al., 2022). Thus, emphasis is placed on the perceived heterosexual ideal, and identities that differ to this are viewed as needing to be *fixed.* Indeed, harmful practices intending to change a person's sexual or gender identity (*conversion practices*) are known to occur within the context of healthcare (Crockett et al., 2022).

Whilst the potential for improved health outcomes has been recognised following disclosure of sexual or gender identity (Kamen et al., 2015), LGBTQ+ individuals also find themselves excluded from elements of healthcare due to heteronormative assumptions and practices. This may take the form of active refusal of healthcare and support based on sexual or gender identity (Lambda Legal, 2010), or failure to include those who are important to the individual in their care; for LGBTQ+ individuals, networks of support may look different to their heterosexual counterparts, and there is a need for healthcare services to consider the inclusion of same-sex partners and chosen-families (Grossman et al., 2000; Kamen et al., 2015).

1.2.2.3 Intersectional Perspectives

Heteronormativity does not exist in isolation; young people are also devalued in healthcare systems and wider society, given limited power and autonomy in decision making (Westberg et al., 2022). Likewise, difficulties associated with mental health often lead to stigma, discrimination, and disempowerment, both in healthcare settings and outside (LeFrançois, 2013). For young people who inhabit these identities and experiences, there may be increased risk of unhelpful and invalidating experiences when accessing support from healthcare organisations; this may be further exacerbated for those who inhabit other minority identities. For example, healthcare in the UK is set up to privilege the experiences of white service-users, to the detriment of racialised groups (Purdie-Vaughns, & Eibach, 2008). Indeed, institutional racism within healthcare may interact with hetero- and cis-normativity; racialised transgender people report discrimination and judgemental assumptions based on both their gender identity and ethnicity (Howard et al., 2019). In a patriarchal society, these experiences also interact with inherent sexism in organisations, leading to increased powerlessness (Adelman & Woods, 2006).

1.2.3 Identity Development

Adolescence and young adulthood are periods of key importance for identity formation (Erikson, 1968), where individuals develop and test out emerging facets of their adult identities, and take steps towards independence from their existing context (for example, people, views, cultures; Casey et al., 2008). For the purposes of this study, and the focus on NHS settings, young adulthood is considered to be up to age 25, in line with the conceptualisation in the NHS long-term plan (NHS England, 2019).

Development of sexual identity often occurs during adolescence (Erikson, 1968; Marcia et al., 1993). For LGBTQ+ adolescents and young adults, additional challenges to identity development present when they are exposed to constant narratives that their identities are not valid, accepted, or wanted by the world they live in (Boe et al., 2020). It is therefore important to consider what it might be like for an adolescent to begin to develop and recognise their non-heterosexual, non-cisgender identity in a world that vilifies difference.

Not feeling able to disclose or express one's LGBTQ+ identity has been associated with increased risk of emotional distress (Grafsky et al., 2018). Indeed, from an MST perspective (Meyer, 2003; Mongelli et al., 2019), internalised stigma or fear of discrimination can both contribute to increased distress, and given the context of a world that privileges heterosexual and cisgender identities, there is likely to be a level of fear about the potential consequences of disclosing a minoritised identity. Young people may live in fear of exposure and hide a part of themselves, from friends, family, school, employers and others (D'Augelli et al., 2010). Parental involvement in healthcare may impact young people's abilities to explore and integrate their LGBTQ+ identities, due to the fear of being exposed by a healthcare provider to their parent or guardian, or by their parent or guardian actively preventing them from accessing affirmative support (Zullo et al., 2021). This may impact access to appropriate sex education, affirmative therapies, or access to gender transition support, as well as reducing their power and autonomy in their own lives.

Given that young people are at an age where identity, including sexual identity, is developing (Erikson, 1968), and given the increased propensity for emotional distress as a result of proximal and distal stressors (external and internalised discrimination and stigma; Meyer, 2003), in a world that expects heterosexuality, it is important to consider their experiences of seeking support for emotional distress. However, limited existing research focuses on this context and population.

1.3 LGBTQ+ Young People and Mental Health

1.3.1 Prevalence of Mental Health Concerns

A plethora of literature has identified a high prevalence of mental health difficulties among LGBTQ+ adolescents and young adults, spanning a range of symptoms and diagnoses (Amos et al., 2020; Plöderl & Tremblay, 2015; Wilson & Cariola, 2020). Indeed, Amos and colleagues (2020) showed from a large sample of young people in the UK (N = 11,884) 54% of LGBTQ+ young people had experienced self-harm, in comparison to 14% of their heterosexual peers. However, often young people choose not to access services (McDermott, 2015), or prefer to access LGBTQ+ specific services rather than mainstream mental health provisions (Golding, 1997); Higgins and colleagues (2021) showed, from a sample of 1,064 LGBTQ+ young people (aged 14-25) that 81% identified as experiencing barriers when accessing mental healthcare. Some young people may present to services for the first time when in crisis, having avoided or experienced barriers to accessing mental health provisions prior to this time (McDermott, 2015; McDermott et al., 2016). This leads to questions about what is missing from mainstream provisions, and how services and clinical responses can be improved to provide better provision for their LGBTQ+ service-users.

1.3.2 Self-Harm and Suicidality

Self-harm is not one homogenous action, and can take many forms, including deprivation or impulsivity, and may be interpreted differently by each individual (Hetrick et al., 2020). For some, this may be a short-term experience, whereas for others these difficulties may persist longer-term (Storey et al., 2005). Such experiences may not always be understood within a framework of diagnosable mental health difficulties (Hawton et al., 2013). Likewise, suicidal ideation is often considered a broad category ranging from passive thoughts of ending one's life, to active actions towards this end; NHS mental health services notoriously aim to categorise people's risks of harm to themselves along a continuum from no risk to severe risk, negating the dynamic nature of suicidality and the difficulties associated with static categorisations (Wyder et al., 2021). This study uses terms such as 'mental health difficulties' and 'experiences of distress' to refer to experiences that may occur alongside self-harm, in the context of young people who specifically access mental health services for support.

Significantly higher rates of self-harm and suicidality are reported amongst LGBTQ+ young people, in comparison to their heterosexual and cisgender counterparts (Amos et al., 2020; Consolacion et al., 2004; DiGiacomo et al., 2018; Irish et al., 2019; McDermott et al., 2016; Semlyen et al., 2016). Experiences such as rejection linked to identity disclosure within families have been shown to contribute to increased suicidal actions (Ryan et al., 2009). Self-harm can be associated with stigmatised clinical diagnoses such as 'personality disorder', and research is beginning to consider the potential overapplication of this label to LGBTQ+ individuals (Rodriguez-Seijas et al., 2021), leading to questions about the potential pathologisation of difference or non-conformity, and the harmful consequences of such categorisation.

Disclosing experiences of self-harm and suicidality to healthcare professionals can be difficult, with a fear of consequences such as hospitalisation (McDermott et al., 2018; Mughal et al., 2021) or rejection (Beale, 2022). Within a heteronormative value system, there is potential for risk associated with double disclosure; young people may need to disclose both their LGBTQ+ identity and their experiences of self-harm and suicidality in order to receive support they find meaningful, which holds risk, particularly of rejection (Gilmour et al., 2019). Thus, there may be additional risks of discrimination and stigma faced by young people who are both LGBTQ+ and experience self-harm or suicidality, increasing the external stressors faced in accessing mental healthcare, and perhaps increasing fear and distress (Meyer, 2003; Mongelli et al., 2019).

1.3.3. Contextualizing Risk

Within a heteronormative and cisnormative world, young people who identify as LGBTQ+ face judgement, discrimination and even violence in daily life (Bachmann & Gooch, 2017; Bradlow, et al., 2017; Kosciw et al., 2014); there can be a constant sense of threat from others, and for some a need to hide their identity to protect their safety. Experiences of bullying, homo/bi/ace/trans-phobia remain prevalent (Chakraborti and Hardy, 2015), and social isolation can result (Habib & Ward, 2019). Young people may feel they do not fit in with their family or peers, and may struggle to find a sense of their own identity (Gamarel et al., 2014).

The build-up of microaggressions, discrimination, and difficulty finding space within a hetero- and cis-normative world, can be understood in relation to MST (Meyer, 1995) to contribute to experiences of emotional distress for LGBTQ+ young people (Kuper et al., 2014; Meyer et al., 2021). Young people who are LGBTQ+ are effectively living in a society that is not set up to value and accept them, which can understandably lead to distress, and a need for code-switching, changing their presentation of self to fit with the heteronormative culture (Anders et al., 2023; Davies, 1998).

Thus, given the context in which LGBTQ+ young people live, there are a wide range of risk factors which may increase the likelihood of responding to distress with self-harming actions, or a feeling of hopelessness that contributes to suicidal tendencies

(Rutherford et al., 2012). However, there is also an impact to conceptualising LGBTQ+ young people as ‘at risk’ or more vulnerable than their peers, which may serve to increase stigma by increasing comparison of *difference* to groups perceived to represent the ‘norm’ (Braveman, 2006). Indeed, whilst MST (Meyer, 1995; Meyer, 2003) can frame the current study in terms of the impact of such additional life-stressors faced by LGBTQ+ young people who self-harm or experience suicidality, additionally considering the pervasiveness of heteronormativity emphasises the systemic, rather than individual, nature of discrimination and difficulty experienced by LGBTQ+ young people.

1.3.4 Access to Mental Health Services

Despite this level of prevalence and need, LGBTQ+ young people face many barriers to accessing support through mental health services (Dunbar et al., 2017; Higgins et al., 2021; McDermott et al., 2018; Roberts et al., 2018; Williams & Chapman, 2011). Barriers include fears of discrimination and negative attitudes within healthcare (Crockett et al., 2022; Fortune et al., 2008; Hunt, 2020), fear of having to disclose identity and associated confidentiality concerns (McDermott et al., 2018; Williams & Chapman, 2011), worries about being misunderstood or pathologized (Hunt, 2020; Zullo et al., 2021), and fears about exposure to conversion practices (Crockett et al., 2022).

There is additional stigma in the interaction between LGBTQ+ identity and mental health (Bettergarcia et al., 2022). Service providers can perpetuate stigma, including promoting an idea that individuals are to blame for their distress, negating the impact of systemic discrimination (Gulliver et al., 2010; Kingdon et al., 2004; Rettenbacher et al., 2004). Young people have also identified self-stigma and stigma of those around them as barriers in seeking help; some may prefer independent ways of managing, and many utilise informal and peer support (Idenfors et al., 2015; Wadman et al., 2018).

Some individuals do not interpret their difficulties as significant mental health needs, reducing their likelihood of seeking help from professional services (Hassett & Isbister, 2017); all 8 male participants in Hassett and Ibisters’ (2017) study noted they only recognised their own mental health needs when acknowledged first by others. There are also worries about being judged as an ‘attention seeker’ (Fortune et al., 2008). Indeed, many young people only access support for self-harm or suicidality when it is recognised by an adult in their lives (Storey et al., 2005).

Given the already negative, stigmatising, and harmful attitudes of mental health services towards those who experience distress in these ways, the combination of this with the pathologisation and invalidation of LGBTQ+ identities has potential to make mental health services a particularly unsafe space for young people. For those already struggling to access hetero- and cis-normative services that reject their identities in many ways, both overt and subtle, there may then be additional barriers for those who experience self-harm or suicidality.

1.3.5 Service and Clinician Responses

Within mental health services, and other services young people access due to experiences of self-harm or suicidality (for example, local accident and emergency services [A&E]), staff report experiences of fear, negativity, and hopelessness (Saunders et al., 2012). It is understandably difficult for clinicians to manage the anxiety and uncertainty that arises from attempting to support a young person to stay safe and alive (Palmer et al., 2006), however this can lead to overtly derogatory attitudes and discriminatory practice (O’Keeffe et al., 2021).

Occasions where staff responded to young people who experienced self-harm or suicidality in a compassionate manner were linked to more positive and helpful experiences of care, emphasising the importance of relationships (O’Keeffe et al., 2021). Clinicians working with young people who experience difficulties with harming themselves often request further training or support to manage their own emotional experience, and to manage the treatment plan effectively for the young person (McDermott et al., 2018).

Similarly, there is often fear, uncertainty, and lack of knowledge amongst professionals in relation to working with LGBTQ+ young people (McDermott et al., 2018). As a result, often no conversation about sexual or gender identity is held (McDermott et al., 2018; Rossman et al., 2017). Young people report being rejected from services in response to their LGBTQ+ identity (Grant et al., 2011), and some staff report that being LGBTQ+ is against their personal beliefs, associated with factors such as religion, gender, and personal knowledge (Balik et al., 2020; Stewart & O'Reilly, 2017), leading to identity erasure and discriminatory practices. For some, this can again lead to overt discrimination, assumptions of mental illness related to LGBTQ+ identity, and conversion practices (Crockett et al., 2022; Somerville, 2015; Stewart & O'Reilly, 2017).

However, many clinicians are knowledgeable and understanding of LGBTQ+ struggles, or are keen to learn more and build their confidence working with this population of young people (Acosta et al., 2019). Indeed, McDermott and colleagues (2018) found NHS clinicians' confidence increased in their skills for working with young people who were LGBTQ+ and experiencing difficulties related to self-harm, following attendance at training related to both topics.

Despite the desire for additional learning and improving self-confidence in this work, and the existence of good practice (McDermott et al., 2018), the pervasive stigma and heteronormative value system within mental health settings suggests further work is needed to support LGBTQ+ young people who experience self-harm or suicidality.

1.4 Identity Disclosure

1.4.1 The Concept of Identity Disclosure

The concept of 'coming out', or identity disclosure for LGBTQ+ people, sits within the heteronormative context (Cass, 1979; Gonsiorek & Rudolph, 1991; Rosario et al., 2001); the need to disclose one's LGBTQ+ identity exists because of the assumption that the expected identity status is to be cisgender and heterosexual. Whilst early coming out models considered it to be a linear process, a move towards an end point of identity integration, there is increasing evidence to show this may be an unhelpful conceptualisation that does not account for the potential fluidity of both identity and disclosure (Kitzinger & Wilkinson, 1995; Liddle, 2007).

Coming out does not always involve an explicit conversation or statement, it can be a more subtle and ongoing process. Individuals may initially approach this process by increasing their involvement in LGBTQ+ activities and wider community, essentially showing to themselves and others that they are part of this community (Rosario et al., 2001).

There is an emotional toll and potentially harmful consequences associated with decisions to come out (or not); each time a person discloses their LGBTQ+ identity, they do so risking rejection and harm (Herek & Garnets, 2007). Due to the expectation of heterosexuality and cis-genderism in Western society, individuals may need to disclose their identity multiple times in their lives, to different people and in different settings, continually building this emotional impact. Indeed, there has been a higher incidence of suicidality noted for young people who experience rejection following identity disclosure (D'Augelli & Hershberger, 1993).

Despite LGBTQ+ identities being grouped together in many settings, including this research, there is not one homogenous experience of coming out, and the process is often ongoing and varied, depending on individual identities, social, and cultural contexts (Cox & Gallois, 1996; Martos et al., 2015). Intersectional experiences and additional marginalisation can also impact the process and experience of identity disclosure (Purdie-Vaughns, & Eibach, 2008); young people who experience self-harm or suicidal feelings may experience a coming out on multiple levels, their sexual/gender identity alongside mental health difficulties, and their context in terms of ethnicity, class, disability, and other aspects of identity. Indeed, racialised and disabled LGBTQ+ individuals have experienced difficulties feeling understood in their interactions with mental health services (Bachman & Gooch, 2018).

1.4.2 Identity Disclosure in Healthcare

Health disparities arise for LGBTQ+ young people, in comparison to their peers, considering the intersections of their developmental stage, navigating heteronormative society, and the associated risks to physical and mental health (Strutz et al., 2015). Given the hetero- and cis-normative context of Western healthcare, it is important to consider experiences of LGBTQ+ identity disclosure in these settings, as this may influence individuals' experiences of themselves and of the care they receive, health outcomes, and future care (Brotman et al., 2002; Johnson & Nemeth, 2014).

Whilst some research advocates for services specific to the needs of LGBTQ+ individuals (Matsuzaka et al., 2021), and such services do exist, others argue this could further fuel the heteronormative context of healthcare, further minoritising a heterogenous group of individuals, and viewing LGBTQ+ healthcare as a specialist area, rather than integrating good practice into wider services (Semp, 2011). For purposes of this study, mainstream mental health services are focused on, given the NHS context where young people experiencing self-harm and suicidality are likely to access services in the first instance, regardless of other identity factors (Evans et al., 2019).

Given the elevated prevalence of mental health needs within the young LGBTQ+ population, it is important to consider the process of coming out in mental health services. However, limited literature was found directly exploring the disclosure experiences of young people in mental health settings specifically. Therefore, wider research in general healthcare settings is also reported.

1.4.2.1 General Healthcare

LGBTQ+ identity disclosure has been linked to increased comfort in healthcare interactions (Gioia et al., 2021), and improved health outcomes (Kamen et al., 2015). Some research has focused on the value of disclosure for accessing appropriate care (for example, for sexual health screenings; Petroll & Mosack, 2011), which can hold different meanings and importance from the perspectives of providers and service-users.

Other literature has focused on the impact of clinician responses. Rossman and colleagues (2017) found that young people disclosing LGBTQ+ identities in physical healthcare settings received varied responses, from prejudice to affirmation. Indeed, some clinicians may hold a view that during adolescence and young adulthood, the development and exploration of identity invalidates LGBTQ+ experiences; effectively, they may hold a view that it is ‘just a phase’ (McCann & Sharek, 2014). Instead, compassion has been noted as key to affirmative care, alongside active acknowledgement of the heteronormativity present in healthcare, and inclusive language (Law et al., 2015). This emphasises the importance of improving not just access to care, but the experiences of healthcare for these young people.

1.4.2.2 Mental Healthcare

The pervasive heteronormativity in youth mental health settings has been acknowledged; a study in an inpatient child and adolescent mental health service (CAMHS) in the UK (LeFrançois, 2013) explored how physical acts of support between young women were conflated with sexual orientation, and then viewed as undesirable and effectively as *bad behaviour:* "*…they said it is inappropriate … because it was two girls holding hands or something … They said it wasn't a very nice thing to do in front of boys…"* (LeFrançois*,* 2013, para. 9*).* This response also highlights the sexism present in paternalistic NHS services, with young women vilified by men in positions of power, and emphasising the privileging of male perspectives (LeFrançois, 2013).

LGBTQ+ adults have described a fear that arises prior to a new disclosure in mental health settings; "*when you're in one-to-one counselling, before you actually mentioned your sexuality, you feel fear of rejection, and it's after … say, your girlfriend or whatever and … they're positive, that you feel more comfortable to talk*" (Lesbian 001, pp.5, McCann & Sharek, 2014). This highlights the assumption that a disclosure of non-heterosexual identity may be perceived as against the clinician's expectations, and therefore holds a level of risk, with uncertainty of the clinical response. For those who experience difficulties related to suicidality and self-harm, there is risk of these difficulties being exacerbated by experiences of rejection related to identity disclosure (Ryan et al., 2009), or keeping sexual/gender identity hidden (Mayock et al., 2009).

Often mental health clinicians do not initiate conversation around sexual and gender identity; some may hold an assumption that these identity facets would be self-evident (Semp & Read, 2015). Thus, the onus to disclose may be left to the young person, leading to a process in deciding about the safety of coming out. Zullo and colleagues (2021) found that young people who experienced suicidality reported being unsure whether it would be safe to disclose their LGBTQ+ identities, and noted that overt signals of allyship (such as rainbow flags) were viewed as signs towards safety.

Increased comfort in disclosure has been associated with perceived identity status of the clinician; some young people have noted that they feel more able to disclose their LGBTQ+ identity, and subsequently be open about other matters relating to their healthcare, if they perceive the clinician to share these aspects of identity (Hunt, 2020; Zullo et al., 2021). Whilst there is undeniably value in feeling understood based on similarities, and likewise difficulties being understood by those who do not hold the same experiences, this leads to questions about what is missing in healthcare practice; if LGBTQ+ service-users feel most comfortable when a clinician is perceived to share this identity, how can cisgender and heterosexual clinicians better understand and respond to these communities?

Thinking about young people specifically, there is a powerlessness not only linked to their age but to their experience of emotional distress or being labelled with a mental health difficulty (LeFrançois, 2013). Disclosing LGBTQ+ identities may therefore hold additional risks, and come with additional difficulty, with the uncertainty of how this will be responded to and the subsequent impact on their experience of themselves and their mental healthcare.

1.5 Literature Review

A scoping review was conducted using systematic searches of existing literature. Having identified in the narrative summary above that young people are at a particular stage in life where identity formation is paramount, the scoping review focused on this population. As no studies were found that specifically focused on experiences of LGBTQ+ identity disclosure for young people who experienced self-harm or suicidality, in their interactions with mental health services, as the primary topic, two separate searches were conducted. The first looked for literature related to young people's disclosures of LGBTQ+ identities in mental health services.

The second search focused on the experiences of young people accessing mental health provisions for difficulties associated with self-harm or suicidality. For young people who already fear discrimination based on their gender or sexual diversity, the added burden of stigma and potential for rejection related to their experiences of suicidality or self-harm may further increase their propensity for negative experiences in mental health services.

In both searches, qualitative studies were focused on, given the NHS priority on hearing the views of service-users in their own words (Department of Health, 2010), emphasising the importance of focusing on the increased voice and depth available in qualitative compared to quantitative findings on this topic.

1.5.1 Review 1: Identity Disclosure in Mental Health Services

A systematic scoping search of four databases (APA PsycInfo, CINAHL Complete, Academic Search Ultimate, and Scopus) was conducted to find studies that looked specifically at young people's experiences of disclosing their LGBTQ+ identities in mental health services. Appendix A shows search terms, and a flow-chart of the search process can be viewed in Appendix B.

Initial screenings of titles and abstracts to identify potentially relevant studies identified forty-three articles, and a full-text screening of these was conducted. References from these studies were also screened, alongside a google scholar search, to identify any further relevant studies.

Inclusion criteria for articles at this point was:

1) Focused on young people aged 25 or under
2) Primarily focused on LGBTQ+ identity disclosure experiences
3) Primarily focused on services providing mental health assessment and intervention
4) Qualitative methodology (centring the voices of young people in their own words)
5) English language available
6) From 2003 onwards. This allowed for selection of articles from within the last 20 years, for focus, and this specific timeframe was chosen as 2003 was when Section 28 (Local Government Act, 1988; legislation preventing discussion of LGBTQ+ identities in education settings) was overturned, and thus within the UK began a change in the narrative towards identity disclosure.

Studies were excluded if they included adult populations, with participants over the age of 25.

Limited articles focused directly on the process of identity disclosure in mental health settings. Therefore, articles were included that looked at factors in facilitating disclosure, the experience of disclosure, and the longer-term impact of disclosure. Five studies met the above inclusion criteria (see Appendix C for a table of study details).

Interestingly, all five studies had been conducted in very recent years, since 2019, suggesting the topic of identity disclosure in mental health services for young people is becoming an increasing concern. The studies occurred in four countries, with two occurring in the UK/England (NHS services). Studies have been grouped below for further exploration, in relation to key themes identified. Sample sizes varied, from 8 to 41 participants. Whilst only one study (Hunt, 2020) focused on disclosure of LGBTQ+ identity explicitly as the primary content, the topic of disclosure arose as a prominent theme in all studies.

1.5.1.1 Decision to Disclose

Several studies noted the importance of the decision to disclose, and factors that influenced this decision, both helpfully and unhelpfully. Crockett and colleagues' (2022) study of LGBTQ+ university students accessing mental health support reported ways identity disclosure could arise, with some participants emphasising the importance of this aspect of identity in their wider life. Trusting relationships with the clinician were recognised as enabling disclosure, whereas complexity around the moment of disclosure was a barrier (for example, if disclosure did not arise on the young person's terms). Some participants chose not to disclose at all, for a range of reasons, including fear of the consequences. This study focused on experiences of young people who had primarily accessed private mental health services, and included those who had accessed specialised LGBTQ+ services, and therefore the findings may not generalise reliably to other settings, such as NHS services where there is less service-user choice in the clinicians accessed. Indeed, the need for LGBTQ+ identity disclosure in clinical sessions is negated in specialised LGBTQ+ services, as effectively disclosure occurs in the decision to access such services. This leads to questions about the impact of clinical relationships on identity disclosure in services such as the NHS where individuals have less choice in who is allocated as their clinician.

Zullo and colleagues (2021) explored experiences of young people accessing mental healthcare in the USA, specifically for LGBTQ+ young people who experienced suicidality, using interviews and focus groups. Whilst again this is likely to reflect experiences of private healthcare, and participants were particularly recruited from services known to be LGBTQ+ affirmative, the study discusses the process of identity disclosure; however, this process is likely to be different for individuals accessing services already known to be affirmative, limiting the generalisability of these findings. Private therapy offers an element of choice, and participants reflected on the characteristics they looked for in a clinician with whom they might feel safe enough to disclose their identity; preferences included younger clinicians, those who were LGBTQ+ or held another marginalised identity, or who displayed visual signs of acceptance such as rainbow flags. These were considered as signs clinicians might be able to understand their experiences of being LGBTQ+. Confidentiality emerged as a fear, especially in the context of the intersection of suicidal feelings and LGBTQ+ identity, with participants feeling unsure who would be told this information. There appeared a dance that occurred in the act of disclosure, with participants wanting clinicians to bring this topic up, yet not always being ready or feeling safe enough to respond if that was to occur.

Disclosure for transgender young people can take different forms to disclosure of sexual orientation, often being more overtly obvious (i.e., if using pronouns that differ from gender assigned at birth, which is often initially listed on medical documentation). Indeed, Acosta and colleagues (2019) explored the experiences of nine transgender young people in an inpatient unit in the USA, and eighteen professionals, using qualitative interviews, and noted that young people arriving at the unit often found themselves being misgendered due to the name listed on their admission documentation, which was distressing. The process of disclosure was discussed, with some choosing to disclose immediately on arrival at the unit, and others waiting until they felt a level of comfort. The study did not focus explicitly on the act of disclosure, instead more on the wider experience of being transgender in an inpatient mental health setting. There is also limited generalisability to other services, given the specific nature of inpatient treatment in the USA, with an insurance-based healthcare model which can limit access to services (Cohen et al., 2015).

1.5.1.2 Consequences of Disclosure

Consequences following disclosure arose in Crockett and colleagues' (2022) study with LGBTQ+ students. Whilst some participants reported experiences of feeling respected and understood following disclosure of their LGBTQ+ identity, others had more unhelpful or harmful experiences in mental health services, with discriminatory attitudes, and disclosure of their identity without consent to others. Identity erasure also occurred, with participants reporting experiences of clinicians actively denying or dismissing their sexual or gender identity in favour of their own assumptions and heteronormative expectations. However, this study focused on university students, whose experiences of accessing mental health services and sharing their LGBTQ+ identity with others may differ from those who are younger or still live with their families, and may be able to access university based services which differ from mainstream provisions.

Hunt's (2020) study specifically looked at the experience of disclosure and the subsequent impact for young people accessing therapy. Interpretive Phenomenological Analysis (IPA) explored the importance of disclosure in moving towards self-acceptance, and associated difficulties. Participants reflected on the wider influence of heteronormativity in therapy, for example with therapists making assumptions about the experience of being LGBTQ+ from a heterosexual perspective, or engaging in personal opinion biases about acceptability of certain sexual behaviours. Participants emphasised the importance of clinical relationships; some experienced difficulties feeling understood by therapists they assumed did not identify as LGBTQ+ themselves, and others experienced fear of rejection based on their prior disclosure experiences. Therapists were recognised to hold power to help repair the effects of harm from the heteronormative world, or to exacerbate these effects, in their response to disclosure. However, there was limited homogeneity within this study, limiting the generalisability, as the eight participants experienced a wide range of mental health needs, and accessed therapy services across multiple different countries. Therefore, findings may represent a variety of different systems for accessing therapy, types of therapy available, and influences of societal heteronormativity.

Carlile (2021) investigated the experiences of 13 families (parents, and transgender and non-binary young people), accessing NHS services. Although the focus was not explicitly on the coming out process in mental health services specifically, the young participants referred to difficulties that occurred following disclosure, such as back-and-forth processes between professionals delaying referrals for specialist support, and the lack of specialist gender identity knowledge by clinicians in CAMHS, leading to denial of identity. In some instances, clinicians were reported to conflate sexual orientation with gender identity, which caused distress. Interestingly, some participants found private therapy more gender-affirming, although given that the NHS is free to access, use of private therapy may be less common, and limited to those for whom this is affordable.

Acosta and colleagues (2019) reported that at times participants felt they had to educate professionals regarding the needs and experiences of transgender young people, but this was often understood by them to be a sign of willingness to learn. However, the authors acknowledged the study occurred in a more liberal area of the USA, where they recognised there to be a level of understanding of transgender rights already present.

1.5.1.3 Summary and Relevance

These studies highlight that the fears young people might have that provide barriers both to identity disclosure, and accessing services, are valid, in the context of real experiences occurring. There is emphasis on fear experienced in a heteronormative setting, around decisions to disclose to clinicians who cannot immediately be trusted to respond in an affirmative manner. The process of deciding to disclose is understandably difficult, with potential for damaging consequences, despite recognition of the value of openness. This suggests the need for further research exploring what it may be like for young people who do make the decision to disclose their LGBTQ+ identity, despite the barriers.

This review highlighted that there is a dearth of research specifically looking at young people’s LGBTQ+ disclosure experiences in mental health settings, as the primary aim. Whilst this was the case in Hunt's (2020) study, the non-NHS focus of this study limits the applicability to a UK context, where the processes and structures of mental health services differ greatly from systems available in other countries; for example, therapy is only one clinical encounter young people may have in NHS services. Indeed, the variety of locations and services explored within these studies also limited the generalisability of the findings, often focusing on private or LGBTQ+ affirmative services, rather than mainstream public provisions such as NHS mental health services. The other UK centred study (Carlile, 2021) explored the journey of transgender young people accessing specialist gender identity services. This may not be a pathway all experience, and thus does not provide a clear insight into experiences transgender young people might face when accessing general mental health support, which may be separate to their needs regarding gender identity. Thus, there is a particular need for further research exploring disclosure experiences in NHS settings, where young people will often have less choice over the service and clinicians accessed, perhaps further impacting their internal assessment of safety for disclosure.

1.5.2 Review 2: Mental Health Support for Self-Harm and Suicidality

Seeking help for difficulties related to suicidality or self-harm also requires a disclosure; self-stigma and stigma in wider society often form barriers to disclosure, and the proportions of individuals who choose to disclose these difficulties within mental health services is somewhat unclear (Barnes et al., 2010; Fulginiti et al., 2016, Husky et al., 2016).

Therefore, a second systematic scoping search of existing literature was conducted to identify young people's experiences when accessing mental health service provisions for self-harm or suicidality. An initial search identified only one study (Zullo et al., 2021) which met the criteria of being about experiences of mental health service care for self-harm or suicidality, specifically for young people who were LGBTQ+, and is therefore covered in both searches. Other studies tended to focus on experiences related to LGBTQ+ identity, rather than disclosure of self-harm or suicidality. Therefore, an expanded search was conducted, beyond the LGBTQ+ community, to consider the ways support for self-harm or suicidality can be experienced more generally. These two areas are then brought together for the current study.

To maintain consistency with the previous search, the same databases were used. The search terms around mental health services were kept the same, and new terms were included to look specifically at experiences of self-harm and suicidality (see Appendix D). The search structure in shown in Appendix E. Following screening of titles and abstracts, references screening of the relevant studies, and a google scholar search, thirteen studies were selected for inclusion in this review (see Appendix F for study details, including sample sizes which ranged from 3 to 74).

Inclusion criteria were:

1) Focused on young people aged 25 or under
2) Primarily focused on experiences of accessing support from mental health services directly related to self-harm or suicidality. Articles focused on A&E or General Practitioners (GPs) were included if these were explicitly located within a wider context of mental health service support and reported on experiences directly in mental health services.
3) Qualitative methodology
4) English language available
5) From 2003 onwards (for consistency with first literature search).

Gilmour and colleagues (2019) conducted a similar literature search to the one reported here, whilst using a meta-ethnography approach, noting from the four studies explored that there was a repeated sense of young people not feeling heard, and that clinicians often avoided explicit conversations around suicidality. The current literature search builds on Gilmour and colleagues' (2019) study, including terms around stigma and discrimination, based on the experiences outlined earlier in this thesis of self-stigma and discrimination in services for young people experiencing mental health difficulties alongside marginalised identities.

1.5.2.1 Difficulties Accessing Services

Themes were acknowledged around the difficulties young people faced accessing care related to their self-harm or suicidality. Participants in Idenfors and colleagues' study (2018) identified a need for rapid support following self-harm, and the difficulties facing long waits for treatment; although this study took place in Sweden, there are similarities to NHS services, where long waiting times are common (Frith, 2016). Mitten and colleagues (2016) reported young people's experiences of barriers to accessing appropriate care, from A&E, with participants describing difficulties in sufficiently demonstrating the severity of their distress, and subsequent rejections from specialist services.

Similarly, Hassett and Ibister (2017) reported the experiences specifically of eight young men, using IPA, noting their difficulties recognising their own needs and initiating help-seeking, often linked to self-stigma regarding emotional difficulties. Wadman and colleagues (2018) utilised an IPA approach to exploring experiences related to self-harm and associated help-seeking for fourteen care-experienced young women, where participants noted difficulties asking for help, in part due to fear of consequences (including negative attitudes and confidentiality breaches). As care-experienced young people often lack a sense of relational security in their lives (Tarren-Sweeny, 2008), such difficulties may be exacerbated for this group. Similarly, McAndrew and Warne (2014) interviewed seven young people about their narratives of self-harm reported feelings of shame, and difficulties in young people initiating service access themselves. However, this study solely explored experiences of white British young women, and therefore does not address the potential additional barriers others might experience based on intersecting aspects of identity.

Jordan and colleagues (2012), whilst not explicitly providing details on the age range of the thirty-six young men interviewed, also reported experiences of barriers related to referral criteria. Storey and colleagues (2005) found young people expressed difficulties accessing therapeutic services, rather than medication-focused support. However, this study focused on young people accessing A&E for self-harm, meaning the sample likely represented those for whom emotional distress was more long-term, perhaps increasing the likelihood of negative service contacts.

Mughal and colleagues (2021) explored experiences of thirteen young people following GP support for self-harm, in the wider context of GPs as gatekeepers to many mental health services, and thus experiences of this process were considered relevant to the current study. Participants emphasised the difficulties accessing therapeutic or specialist mental health input following disclosure of self-harm; one participant was told *“we can do eight sessions of CBT but we don't think it's going to achieve anything and you're still hurting yourself and it's against our policy to do that*" (Divya, pp747, Mughal et al., 2021). This provides an example of the often limited nature of support available, which can be inaccessible based on exclusionary criteria that can discriminate against those who experience difficulties services perceive as more *complex*. The sample in this study was largely female; gender differences have been noted in experience of self-harm support, limiting applicability of these findings to other genders (Jordan et al., 2012).

1.5.2.2 Service Responses

The importance of the relationship between the young person and clinician was highlighted in many cases, even when these connections were only brief. Non-patronising care was valued, as the young people valued being treated like adults (Hassett & Isbister, 2017; Jordan et al., 2012; Mitten et al., 2016; Wadman, et al., 2018). Murray and Wright’s (2006) study looked at the experiences of a specialist, in-depth family risk assessment process. Whilst only 3 young people took part, and retrospectively (at least a year had passed since their assessment), qualitative interviews highlighted the central value of the clinical relationship in young people’s experiences of care; compassionate clinical responses, and clinicians who listened well to the young person were valued, promoting a sense of hope.

Jordan and colleagues (2012) reported from a sample of young men, who had considered suicide in the past, that value was placed on clinicians actively listening to them, demonstrating they cared. Similarly, Clamp (2021) interviewed ten young people from Improving Access to Psychological Therapy (IAPT) services, taking a thematic analysis approach. Participants shared that a non-critical stance by clinicians was helpful, where promoting a feeling of safety in the sessions. However, with the researcher being a member of the wider service, participants may have found it more difficult to express concerns regarding their experiences of care.

Consistency in care was an important factor in beneficial experiences for young people, with several studies noting that changes to clinicians occurred frequently and with negative impact on the quality and outcome of care (Balcombe et al., 2011; Idenfors, 2015; Storey et., 2005). Some preferred particular characteristics of clinicians, for example, their gender (Hassett & Ibister, 2017; Balcombe et al., 2011). In some instances, very small samples were utilised; Balcombe and colleagues (2011), in their exploration of mental health support after hospital presentation for self-harm, only interviewed 3 young people, limiting the generalisability of the findings. However, any experience of poor care or difficulty accessing services is important to highlight, as all young people should be provided care that is compassionate and free from harm.

Young people also reported stigmatising and unhelpful responses from clinicians when disclosing self-harm or suicidality, leading to fears of rejection from support and feelings of shame (Mitten et al., 2016; Mughal et al., 2021; Wadman et al., 2018). Some young people experienced they were not effectively listened to by clinicians, labelled as ‘attention seeking’, or not believed because of their mental health difficulties (Storey et al., 2005; Wadman et al., 2018).

Mitten and colleagues (2016) explicitly explored the impact of stigma in mental health services, for twelve young people recently discharged from inpatient care. Participants acknowledged the presence of stigma in many forms, including from clinicians, who left them feeling belittled, invalidated in their emotional experiences, and who made unhelpful assumptions about their lives. However, stigma can be conceptualised differently by individuals, and this study did not explicitly consider the interplay of other aspects of identity on the experience of stigma in inpatient settings, which may exacerbate the difficulties experienced. Indeed, Zullo and colleagues (2021) considered the specific accounts of forty-one LGBTQ+ young people, and acknowledged ways suicidality and sexual identity can be conflated by clinicians in mental health services; participants reported that it was important to be understood that their suicidal feelings were not a consequence of their LGBTQ+ identity.

1.5.2.3 Summary and Relevance

This review adds to the previously explored concepts of stigma and barriers to care for young people who experience difficulties related to self-harm and suicidality. Whilst helpful and compassionate experiences of care are reported, often based on characteristics and styles of individual clinicians, the continued existence of stigmatising, patronising, and harmful care warrants further exploration; no young person should be discriminated against due to their identity or mental health presentation, or have their experiences invalidated. Such experiences, and barriers to effective care, likely further impact young people's sense of powerlessness in mental health services, with many noting they did not feel heard by professionals.

These studies reviewed here focused on young people who had openly accessed support for self-harm or suicidal feelings, limiting the focus on wider factors which may impact both difficulties with self-harm or suicidality, and seeking help for these difficulties. Similarly, whilst gender differences were noted within these studies, and one focused on a subsection of young people who were care-experienced, other intersectional experiences were not the focus of these studies; the stigma associated with self-harm, and noted difficulties accessing helpful care, may be compounded for those minoritised in other ways, highlighting a gap in the literature for LGBTQ+ individuals.

1.6 Rationale

In a society that expects and privileges heterosexual and cisgender identities, discrimination and stigma can occur for LGBTQ+ individuals, increasing their risks of experiencing emotional distress (Meyer, 2003). LGBTQ+ young people are at a stage in life where they are developing and integrating their sexual identity, and thus beginning to experience the associated consequences and 'othering' by the world around them (Erikson, 1968; Boe et al., 2020). Indeed, the high prevalence of mental health difficulties, particularly self-harm and suicidality, amongst this population warrants further exploration regarding their experiences of accessing support, considering the potential difficulties faced (e.g., fear of further discrimination or rejection; D'Augelli et al., 2010; McDermott et al., 2018; Mughal et al., 2021). Limited existing research has explored young people's voices on this topic, despite the importance of adolescence and early adulthood in developing and integrating sexual identity (Erikson, 1968; Marcia et al., 1993).

There is a clear trend of continued stigmatisation and presence of unhelpful experiences from young people’s perspectives when accessing mental health services for difficulties associated with self-harm and suicidality, as well as when disclosing LGBTQ+ identities. Given the heteronormative lens of the NHS mental health system, the prevalence of self-harm and suicidality amongst LGBTQ+ adolescents and young adults (Amos et al., 2020), and the known positive impacts on general life experiences, wellbeing, and mental health outcomes for those who choose to be open about their LGBTQ+ identities (Ryan et al., 2010), there is clear importance to consideration of disclosure in mental health settings. Indeed, many people choose to hide their LGBTQ+ identity in healthcare settings (Mayock et al., 2009), yet hiding a part of oneself has been linked to negative impacts on wellbeing (Grafsky et al., 2018). A focus on improving support available on the NHS for young people who experience self-harm or suicidality, and for those who are LGBTQ+, has been identified at a government level (Department of Health, 2012).

Thus, there is a need to explore experiences of LGBTQ+ people, who are often exposed to stigma and discrimination, who are also marginalised due to their age and manifestations of emotional distress (self-harm or suicidality), in mental health services that exist within a heteronormative value system. Whilst there are examples of good practice and positive experiences, the continued existence of the more negative experiences and the risk of re-traumatisation and harm from accessing services emphasises that this is still a topic in need of further research. This leads to a question about what happens for young people for whom these aspects of their lives combine; what are the experiences of those who access support for self-harm or suicidality, and who also make the decision to disclose their LGBTQ+ identity?

This study aims to provide a space for young people’s voices and views to be heard regarding these experiences and the subsequent impact, to support mental health providers in delivering services that are best suited to the needs of these young people, to enable supportive and affirmative care. Indeed, recognising the heteronormative ideals perpetuated within healthcare settings, and the associated powerlessness, hearing the voices of young people on this topic is paramount (Neville & Henrickson, 2009).

1.6.1 Gaps in Research

This study aimed to draw together previous research highlighting the potential barriers faced by young people in disclosing their LGBTQ+ identity and accessing mental health support for difficulties associated with self-harm and suicidality. Whilst some research has investigated experiences of disclosure of LGBTQ+ identity for young people in mental health services, most studies have simply included thoughts about disclosure experiences amongst other primary topics. From the available research, no study was found that explicitly explored the experiences of young people with difficulties associated with self-harm or suicidality, specifically regarding the moment of LGBTQ+ identity disclosure, in NHS mental health services.

Mental health services within the NHS are a relatively unique setup, being free to access; service-users are often referred initially by a GP, and endure long waiting lists, access short-term treatment, and have relatively little choice in the clinician or modality (Department of Health, 2015; Worrall-Davies, 2008). In CAMHS, families are often encouraged to be involved in appointments. In both CAMHS and adult services, a range of clinicians may be involved, including support workers, mental health nurses and social workers, doctors, and psychologists, amongst others. Therefore, a particular focus on young people’s NHS experiences is taken in this current study, to consider the unique perspectives associated with these models of care.

Whilst for some young people difficulties with self-harm or suicidality may be short-lived, others may continue to experience a need for input from mental health services over the longer-term (Storey et al., 2005); therefore, the longer-term impact of LGBTQ+ identity disclosure, and potential for multiple experiences of disclosure, in a specific NHS setting, formed part of the scope of this current study. Both self-harm and suicidality are considered together in the present study; whilst different experiences, these often co-occur (Storey et al., 2005), and are both subjected to stigma within mental health settings (Beale, 2022).

1.6.2 Clinical Psychology Relevance

Young people accessing NHS mental healthcare may come into contact with clinical psychologists, who therefore may receive young people’s disclosures of LGBTQ+

identity. Clinical psychologists have a responsibility to provide and promote non-discriminatory care (British Psychological Society [BPS], 2019).

Issues of power arise in relation to clinical psychologists' work with young people; in the NHS, young people under the age of 16 still require parental consent for healthcare, and many young people's families are involved in their mental healthcare, resulting in limited confidentiality and personal autonomy (Westberg et al., 2022). Clinicians inherently hold power in the professional role, with their ability to make decisions around interventions and support, including discharge from services (Treichler et al., 2021; Westberg et al., 2022). From a clinical psychology perspective, it is therefore important to reflect on the impact of this power imbalance in the context of additional marginalised identities; there is risk in disclosure of both self-harm or suicidality, and LGBTQ+ identities, including risk of rejection or further loss of autonomy (being 'outed' to others, or being subjected to coercive and restrictive care; Crockett et al. 2022; Mughal et al., 2021).

Therefore, it is paramount for clinical psychologists, as clinicians and leaders in NHS services, to actively attend to the voices of LGBTQ+ young people regarding their experiences of disclosure in the services these professionals work within, to enable dialogue that can promote affirmative, compassionate, and meaningful care.

1.7 Research Questions

The current study aimed to hear the voices of young people, in their own words, regarding their experiences of services. In hearing about their experiences and the impact of identity disclosure in services for this group of young people, the hope is to build a narrative to promote better services in future that are more able to meet their specific needs.

The specific research questions to be addressed are:

For young people who identify as LGBTQ+, who have engaged in suicidal thinking and/or self-harm, and have used NHS mental health services:

1. What is their experience of disclosing their LGBTQ+ identity to mental health service clinicians?

2. What was the impact of their disclosure?

2.0 METHODS

2.1 Overview

This chapter addresses the study's epistemological position, the processes involved in designing and conducting the study, ethical considerations, and approach to analysis, alongside researcher reflexivity.

2.2 Epistemology

Considering the epistemological stance taken in research is important to understand the lens through which the study is designed and interpreted (Willig, 2013); this reflects thinking about how knowledge can be gained (Crotty, 1998), whilst the ontological stance considers what is possible for us to know and understand about the world (Snape & Spencer, 2003).

A critical realist stance to thinking about LGBTQ+ identity disclosure was used by the researcher in this study. This approach can be seen as ontologically realist, as it understands there to be realities in lived-experiences which can be drawn from data, whilst also being epistemologically more relativist, recognising that these realities are not always clearly observable and need to be understood within the influences of their wider social and cultural context (Harper, 2011; Maxwell, 2012; Wikgren, 2005). Social realities are viewed as stemming from underlying structures, separate to our linguistic constructions, (Bhaskar, 1989), and critical realist approaches emphasise understanding and explaining these realities, in their wider context (Elster, 1998).

For purposes of this study, a realist perspective is taken, with the view there is a lived-reality to the experience of LGBTQ+ identity disclosure in mental health services; in explicit narratives in UK society, LGBTQ+ identities are conceptualised as 'different' to the expected heterosexual norm (Gonsiorek, 1993), and therefore there are risks involved in disclosing this identity, including very real consequences such as physical harm (Bachman & Gooch, 2017). Consequences exist within healthcare (Rossman et al., 2017), such as rejection and loss of support (Lambda Legal, 2010), discrimination and abuse (Institute of Medicine, 2011). However, it is accepted that an objective reality cannot be understood without integration with broader contextual elements, as individuals will have differing perspectives and ways of making sense of their lived-experiences of this reality, influenced by their context in the world.

A critical realist approach locates these lived-realities within their social context; individual experiences of heteronormativity exist in the context of a society which has constructed this to be a perceived norm (Warner, 1991). Social structures exist which perpetuate this construction, such as the prevalence of a category of binary gender assigned at birth on many legal documents (Government Equalities Office, 2020; Newman & Peel, 2022). The structure of heteronormativity in the UK, and indeed in NHS services, enables these to exist as places where disclosure of identities outside of this perceived norm brings risk and consequence.

Thus, the critical realist stance here appreciates the voices of each participant as providing an insight into a lived-reality, whilst recognising that this interacts with the researcher’s own views and experiences, and with the context of the world we live in and beliefs of wider society (Braun & Clarke, 2006). Whilst the findings can be interpreted to provide an understanding of a reality of experience, there is importance to framing this within the heteronormative context, and to recognising this as a deliberately chosen frame. This is in contrast to a social-constructionist framework, which would posit that sexual and gender identity exist solely in the (ever-changing) social and political context, and that no clear reality can be discerned; thus, this approach could negate the complexity of the practical and lived-realities of LGBTQ+ young people, for example being excluded from healthcare, by reducing focus on causal interpretations (Reed, 2001).

2.3 Design

The study was developed using a qualitative interview-based design, aiming to address the research questions by gathering detailed accounts of experiences of young people, with experiences of suicidality or self-harm, in disclosing LGBTQ+ identities in NHS mental health services.

A qualitative approach enabled gathering of rich, person-centred insights into individuals' experiences, offering opportunities to explore avenues that may not have been possible through quantitative methods, and allowing for young people's voices to be heard in their own words (Braun & Clarke, 2006). Specifically, an interview approach was chosen to enable depth in individual responses (Knodel, 1993). From a critical realist perspective, an understanding of phenomena can be gained from interpreting data from qualitative interviews, and identifying resulting actions needed for change, whilst recognising that each presents just one account of reality; this is held within a particular social, cultural, and political context, necessitating interpretation and integration with further evidence (Fletcher, 2017; Hammersley, 2009; Willig, 2013).

Whilst other qualitative approaches, such as focus groups, are useful for working with young people, as shared experiences can promote openness and increase data depth (Peterson-Sweeney, 2005), individual interviews were considered most suitable due to the sensitive nature of discussions around identity disclosure.

2.4 Participants

2.4.1 Recruitment

Two strands of recruitment were initially considered: recruitment via third sector organisations relevant to LGBTQ+ young people (see Appendix G for example contact email), and directly via NHS services. This was to enhance the likelihood of recruiting young people with varied experiences and backgrounds. Contact was made with several LGBTQ+ related organisations, and four agreed to share the study advert amongst their cohorts. Due to lack of participation requests, this approach was later expanded to include recruitment via social media and the researcher's personal network. In all instances, the study was advertised by a flyer containing key information (Appendix H).

Social media recruitment utilised Twitter and Facebook accounts specifically set up for the study. The study advert was posted in a relevant Facebook group, following acceptance of a request to join by the group admin. On Twitter, several ‘tweets’ were created with the advert attached. Relevant hashtags were added to promote increased readership, and relevant organisations and individuals who the researcher hoped would be willing to share the advert were ‘tagged’.

Links were made with an NHS CAMHS for potential recruitment, however due to numerous delays in acquiring Health Research Authority (HRA) and local ethical approvals, this arm of the study was abandoned as it was not feasible within the study timeframes. Recruitment instead occurred outside of NHS services.

Initially the study aimed to recruit young people aged 14-20. However, to support further recruitment, due to difficulties in accessing potential participants, the age range was later expanded to age 25. Indeed, the NHS Long Term Plan (NHS England, 2019), promotes consideration of young people’s developmental trajectory over a longer period, advocating for services that work with young people up to age 25.

There was an aim for 10-12 participants, to support gathering sufficient data for content saturation (Guest et al., 2006). However, within Reflexive Thematic Analysis (RTA) the concept of saturation has limited utility, given the focus on researcher interpretation of the content, rather than assuming the data itself provides objective thematic clarity (Braun & Clarke, 2021).

As an expression of gratitude for their participation, participants were each offered a £10 Amazon voucher. There are ethical implications to such payments, (for example, individuals in financial difficulty may feel a need to participate to gain renumeration, compromising fully informed consent). However, due to the personal nature of identity disclosure required in the study, renumeration was considered important to demonstrate respect for participants’ sharing of experiences (Goodman et al., 2004).

2.4.2 Criteria

2.4.2.1 Inclusion Criteria

To address the study aims, participants were required to meet certain eligibility criteria:

a) Identify as LGBTQ+ (or use other language to describe sexual or gender minority identity) and have disclosed this identity to a mental health clinician in UK NHS services at least once. Disclosure was defined as sharing one's LGBTQ+ identity with a clinician, recognising this could take a variety of forms.

b) Be aged 14-25 years old. Following initial email contact by participants expressing interest, the researcher asked them to confirm their age, before sending the age-relevant participant information sheets (PIS), and to identify whether parental consent was required.

c) Have experienced self-harm or suicidality. Considering the complexities of defining self-harm and suicidality (Hetrick et al., 2020), this study chose not to explicitly define these terms, to enable participation based on whether each participant identified with these experiences, rather than on clinical categorisation.

2.4.2.2 Exclusion Criteria

Participants were not eligible if they identified as currently experiencing a mental health crisis, due to the potential for additional distress if they were to speak about their experiences whilst acutely unwell.

2.5 Procedure

2.5.1 Initial meetings

A study advert (poster) was developed outlining the study rationale and inclusion criteria, signposting potential participants to the researcher's email address for further information.

Potential participants expressed interest via email. They were requested to confirm their age, and sent a copy of the age-appropriate PIS (and parent/guardian versions if required). As participants were later informed their date of birth would be required to claim the voucher, disclosures of age were assumed to be legitimate. If any concerns had arisen regarding potential misreporting of age, this would have been discussed with the research supervisor. Those who remained interested after reading the PIS were invited to an initial meeting via Microsoft Teams to go through the PIS and any questions together with the researcher, and for the researcher to assess eligibility.

Recognising the imbalance of power inherent in the researcher-participant relationship, I chose to share my own relationship to LGBTQ+ identity disclosure during the pre-interview meetings; this aimed to promote a sense of safety, to reassure that experiences of heteronormativity could be openly spoken about, understood, and accepted (Dardick & Grady, 1980). Given that LGBTQ+ people may tailor their responses to a heteronormative ‘expectation’, to feel safe, this approach aimed to encourage openness (Rounds et al., 2013; Rossman et al., 2017). The clear focus on exploring heteronormativity, named within the title to emphasise this frame, aimed to position the study as a space where experiences related to LGBTQ+ identities were welcomed. However, recognising the term ‘heteronormativity’ may not be familiar to all, the study aims were explained in initial meetings.

Participants who were eligible and expressed ongoing interest were then invited to an interview at a later date, and provided with consent (or assent) and demographics forms, to complete prior to interview.

The demographics form was developed to gather background information for further context; this asked participants to self-identify in free-text format their gender identity, sexual orientation, ethnicity, and age (Appendix I). This format aimed to move away from researcher-led categorisations and encourage participants to express their identities using their own language. Questions were included about the inclusion criteria, allowing participants to confirm they met these criteria and were not currently experiencing a mental health crisis, recognising this may have changed since the initial meeting.

2.5.2 Interview Procedure

Semi-structured interviews were used, which aimed to last between approximately 30-60 minutes, via Microsoft Teams; this approach was adopted to enable sufficient focus to address the research aims, alongside opportunities for participants to explain their experiences in their own ways and language, without leading too much along any particular route.

An interview schedule (Appendix J) was designed to explore benefits and difficulties associated with LGBTQ+ identity disclosure in mental health services, and resulting longer term impacts, in line with the research questions. The questions were designed to be relatively open, to promote participants' voices being expressed in ways that were meaningful to them. The interviews were not piloted due to the short study timeframes and the relatively small pool of potentially eligible participants, so as not to limit those who may have wanted to participate in the main study.

A young person who had previously disclosed their LGBTQ+ identity whilst accessing CAMHS was approached as a service-user consultant, from the researcher's personal network. This young person helped refine the interview questions, by providing feedback on the topics and prompts, which were then further refined in discussion with the research supervisor. The service-user consultant also provided suggestions for the interview setting-up process, to promote participant comfort (such as the researcher introducing themselves with pronouns, to demonstrate relevant understanding of expressions of identity).

Given the sensitive nature of LGBTQ+ identity disclosure, and experiences of self-harm or suicidality, participants were advised they could choose how much they wanted to say during interviews, and could decline any questions they did not want, or feel comfortable, to answer. However, the inherent power imbalance remained, with potential for this to inhibit responses (Keltner et al., 2003); as a clinician, I may have represented an authority figure and perhaps part of the *problem*, for those whose experiences in NHS services had been poor, perhaps making it difficult for some participants to speak openly. Thus, I aimed to be empathetic and encouraging in my responses, to encourage comfort and openness (Mauthner et al., 2002), whilst recognising the interaction between my clinician and researcher role; interview encounters in research may become semi-therapeutic in nature, given the exploration of a sensitive topic, held within the researcher-participant relationship (Kvale, 2006). Consideration of power was important, ensuring participants were aware of potential dissemination plans so they were aware how their words might be used, and had the chance to check their transcripts to confirm they remained in agreement with the public use of their words.

2.5.3 Recruitment challenges

Following the advertisement on Twitter, a large number of participation requests (over 100) were received in quick succession, often with very short and almost identical content. During introductory meetings, it became apparent these participants did not legitimately meet the criteria (for example, providing contradictory information, such as changing their age). Two progressed to interview, however it was clear then they did not meet the study criteria and provided clearly false details. Thus, it was agreed with the research supervisor not to include these in the analysis.

A screening procedure was introduced as an attempt to identify legitimate participants; any who were immediately considered to follow typical pattern of non-legitimate participants (for example, one-word emails) were not responded to, and any who were considered potentially legitimate were invited for the initial meeting, where the researcher explored whether they met the criteria. An email explained the meeting provided an opportunity for the researcher to confirm their eligibility, and for the prospective participant to ask questions about the study. Whilst this approach may have missed legitimate participants, anecdotally the researcher noted there was a qualitative difference in the style and quality of emails from participants who appeared to legitimately meet the criteria.

2.6 Ethics

Ethical approval was sought from the University of East London Research Ethics Panel (Appendix K). This was granted with no changes required (Appendix L), although changes in recruitment criteria and strategies necessitated later amendments (Appendix M) and changes to the title (Appendix N), all of which were approved. NHS HRA ethical approval was initially sought, and later abandoned, thus no participants were recruited directly from NHS services. Professional guidelines regarding ethics in research were adhered to throughout the study (BPS, 2021).

2.6.1 Informed Consent

Informed consent was required for participation. The PIS provided potential participants with information on the purpose of the study, the processes involved, plans for dissemination, and their rights as participants. Separate PIS were provided for young people under the age of 16, their parents/guardians, and those aged 16 and over (Appendix O). These were initially shared with participants via email, and in introductory meetings were discussed together with the researcher, to ensure the content was understood, and to clarify any questions.

Participants who subsequently agreed to proceed were requested to sign the consent form, or for those under 16, an assent form, along with a parent/guardian consent form (Appendix P). Due to the requirement for parent/guardian consent for those under the age of 16, any young people of this age who had not disclosed their LGBTQ+ identity, or experiences of self-harm or suicidality, to their parent/guardian, were unfortunately unable to participate. Whilst acknowledging the loss of these young people’s voices in this study, it was important to ensure fully informed parent/guardian consent was gained, to promote safety in participation.

2.6.2 Confidentiality and Anonymity

A UEL Data Management plan was written and approved, and updated when changes were made to the project (Appendix Q), outlining a structured plan for data storage, including location (UEL OneDrive for Business), and timeframes (3 years post-completion). This information was reflected in the PIS for participants’ awareness. Participants were informed that consent forms which contained their names were stored in a separate folder to their other data, which was pseudo-anonymised with participant numbers. Additionally, to protect confidentiality, pseudonyms were used for any quotes in write-ups, to provide assurance of anonymity, where participants would not be identifiable.

Participants were given an opportunity to check their transcripts, partly to confirm they were happy with the level of anonymity in their words. Any names or identifiable places were redacted to protect anonymity.

2.6.3 Safety

The interview content was personal in nature, which may have been distressing for some young people. Participants were advised they could ask to skip questions they did not want to answer, could request to end the interview at any point, and could withdraw prior to their data being included in the analysis.

Participants were informed in initial meetings that whilst the study criteria included experience of self-harm or suicidality, the interview would not explicitly ask about these experiences, as the research focused on experiences of LGBTQ+ identity disclosure for this population. Potential participants currently experiencing a mental health crisis were advised they were unfortunately unable to participate, and thanked for their interest. They were advised they could reach out again when their mental health was more stable, if they remained interested and participation was still available.

The PIS covered procedures that would be adhered to if any risks of harm or safeguarding concerns were identified. Participants were advised if a severe risk was identified, emergency services may be contacted; all participants agreed to this as part of the consent process.

Participants were encouraged to inform the interviewer if they became distressed during the interview, and the debrief conversation reminded of support structures available to them: friends, family, local NHS services, helplines. This was reiterated in the debrief sheet (Appendix R), provided via email following interview.

2.7 Approach to Analysis

2.7.1 Rationale

RTA (Braun & Clarke, 2021) was chosen as the method of analysis, utilising a combined deductive/inductive approach (Fereday & Muir-Cochrane, 2006), to centre the words of participants, whilst also recognising the lens of pervasive heteronormativity, and the subsequent impacts of this through MST (Meyer, 2003). The researcher in the present study aimed to consider both the impact of the heteronormative world, and the systemic factors that maintain heteronormativity. RTA enabled the data to be analysed through this lens; the researcher held in mind the ways UK society and healthcare services are set up to privilege and expect heterosexual and cisgender identities. This included thinking about the increased stressors LGBTQ+ young people may face in their lives that lead them to access mental health services, as well as stressors faced within mental health services.

RTA encourages this flexibility, alongside a focus on the researchers' own reflective processes, and active consideration of their own identity and positioning, interactions of power, and potential biases (Braun & Clarke, 2021); research cannot be conducted completely separate to the identity of the researcher, as our identities provide the frames through which we view the world.

Whilst other approaches such as IPA are often utilised to explore experiential accounts, this research chose RTA, in adherence to the epistemological position; RTA lends itself to a critical realist perspective, with a focus on building an understanding of salient, complex phenomena and developing suggestions for change (Braun & Clarke, 2021; Fletcher, 2017; Harper, 2011). Whilst IPA could have provided a focus on participants' ways of making sense of participants' lived-experiences of disclosure, RTA enabled a focus on diversity of experience, rather than homogeneity (Braun & Clarke, 2020; 2021). RTA also promoted development of practical recommendations arising from identified themes, which fit with this study's focus on encouraging conversations around service improvement (Braun & Clarke, 2021).

2.7.2 Analytic Process

The recommended six stages of RTA outlined by Braun and Clarke (2006; 2021) were used to develop the analysis.

Familiarisation: The initial process of familiarisation and content immersion (Braun & Clarke, 2006) began with transcription, and further re-readings of these transcripts. Interviews were transcribed verbatim by the researcher from the Microsoft Teams recordings, to maintain the young people's words, whilst acknowledging transcription errors inevitably occur (MacLean et al., 2004). Mergenthaler and Stinson (1992) outlined key principles to adhere to in transcription, emphasising simplicity, which guided the current study; to account for non-speech related markers of conversation, notations were included to reflect pauses, interruptions, and laughter. In choosing not to interpret further than the explicit content at this stage, the focus remained on the language used by participants.

Participants were given an opportunity to review their transcript. Whilst this approach may enable bias in the included data (Hagens et al., 2009), this checking element aimed to promote an increased sense of safety, validation of content, and empowerment for participants, by inclusion in decisions about ways their voices were used (Page et al., 2000; Saldana, 1998). However, no participants requested any changes.

Coding: Initial codes were identified by the researcher when reading the transcripts, attributing a word or phrase that represented the key content in each section (see Appendix S for codes and coded transcript extract), recorded using NVivo (12) software.

Generating Initial Themes: Codes were grouped by perceived similarity or shared meaning, and developed into prospective themes, representing an interpretation by the researcher of the data across all the interviews (Braun & Clarke, 2006; Braun & Clarke, 2021); this including thinking with a lens that recognised the pervasive heteronormativity in NHS services and the researcher's relationship to the topic. An initial Thematic Map is available in Appendix T.

Reviewing Themes: Initial candidate themes were further refined and developed by the researcher, following reviews of the data and codes, to ensure they contained the resonant narratives. This involved re-checking the themes against the codes and the raw data, as a fluid process; in line with the inductive element of analysis, continued re-checking of themes against the data was important to ensure themes reflected young people’s words. Several iterations of visual maps were created to depict the theme development process, and were used to refine the themes and provide a coherent and comprehensive representation of the data.

Refining and Defining Themes: Once consistent themes were developed to encapsulate an interpretation of the data across the interviews, concise names were derived for each theme to provide a topic summary (Braun & Clarke, 2021).

The Final Report: The interpretations, alongside reflections on the process, were drawn together into this final report, to provide a representation of the findings, supported by quotes from young people’s transcripts which emphasised the themes.

2.7.3 Reflexivity

It was important to consider my own position, and how this may interact with, and impact, participants’ accounts, throughout study development, analysis, and interpretation (Hesse-Biber, 2007). RTA provided a way to integrate these perspectives (Braun & Clarke, 2021); a reflexive process was engaged with throughout the study.

I write from a position of being a cisgender woman, and have my own relationship to LGBTQ+ identity disclosure in mental health services. I have experienced a heteronormative approach to understanding and working with individuals and their networks in the NHS, as well as in the wider design and development of services. As a clinician I have also been a member of this system that perpetuates these heteronormative expectations and assumptions, and as an adult I have often been the decision maker and the person holding power in contrast to adolescents and younger adults. Whilst I identified an ‘insider’ in some ways, I also held a position of power and authority, as my experiences as a cisgender woman, adult, and clinician brought difference into the interactions as well (Hesse-Biber, 2007).

I aimed to hold a stance which enabled curiosity and openness to different perspectives that might arise in the interviews, whilst being aware of how my own lens, and power, might impact my thinking and my interactions with participants (Braun & Clarke, 2021).

3.0 ANALYSIS

3.1 Overview

This chapter outlines the RTA conducted for exploration of the interview content to address the research questions. Given the limited pool of potential participants due to the specific study criteria, five eligible participants took part. A thematic map outlines the themes developed, and these themes are then explored in further detail, alongside researcher interpretations, which present one way of understanding the data. Quotes are used to support the interpretations, taken verbatim from the interview transcripts to preserve the participants' language. However, for readability, punctuation is added, and at times ellipses are used to represent words that have been removed.

3.2 Length of Interviews

The interview length varied, with the shortest being 11 minutes and 59 seconds, and the longest being 40 minutes and 32 seconds. Whilst one interview was therefore relatively short, I was aware of the power imbalance as researcher/clinician in relation to the participants; I prompted but did not pressure, and the participant provided sufficient information to be included in analysis. I accepted that some young people may prefer to share their experiences via a shorter narrative, and left the interviews relatively open for participants to choose how much or how little to say, in an attempt to restore some level of power and autonomy to the participant (Milligan, 2016). As researcher, I held a view that all experiences were important to include, regardless of how briefly they were shared, in line with the research aims of hearing young people's voices.

3.3 Participants

A total of five participants (Table I) were recruited who met criteria for the study, all via social media. One additional participant was interviewed, but it was later agreed in supervision to remove this data, due to a researcher error.

No concerns were raised by participants during the study, and no participants expressed distress or requested any follow-up by the researcher. Two participants took the opportunity to review their transcript, and no changes were requested.

To protect participant anonymity, pseudonyms were used. Participant numbers were considered to be dehumanising in comparison to names, which was a particularly important issue to consider when writing a chapter that aimed to give a voice to the participants. Whilst pseudonyms can neglect to account for participants' cultural backgrounds, and participant choice, it was decided for purposes of this study to use randomly generated names (Heaton, 2022). This option was chosen to negate researcher bias in the choice of names, and to protect anonymity which can be reduced when participants choose names themselves, as these names may be identifiable to others in their lives.

3.3.1 Demographic Information

Whilst there was some variety in the age range of young people who took part (Range: 17 – 25, M = 21.2), no participants were aged 16 or younger. All participants were female, or used she/her pronouns, and the majority of participants were of white ethnicity. No participant explicitly identified as transgender, although some spoke about experiences of gender fluidity during the interviews. All participants were verbally asked their pronouns in the initial meeting.

Participants identified as lesbian or bisexual, although other orientations and questioning of sexual identity were mentioned during the interviews, demonstrating the potential for fluidity and the ways categorical language around orientation may not fit everyone's sense of identity.

Table I

Participant Demographics

Name (pseudonym)	Age	Gender Identity	Sexual Orientation	Ethnicity	Length of time in Mental Health services
Isobelle	>21	Female	Lesbian	White	Over 1 year
Pippa	>21	Cisgender Female	Lesbian	White other	Over 1 year
Verity	>21	She/her	Bisexual	Asian British	Over 1 year
Alice	≤21	Cisgender Female	Bisexual	White Scottish	Over 1 year
Zoe	≤21	Female	Lesbian	White British	Over 1 year

Note I: language used is that of the young people; the researcher did not provide categories except regarding length of time in NHS mental health services.

Note II: To protect confidentiality, age ranges are given rather than specific ages. Age ranges are written in relation to the average.

3.3.2 Use of Mental Health Services

All participants had accessed mental health services over a long-term period, specifically more than one year. All participants met the criteria of having experienced self-harm or suicidality, and further mental health and neurodevelopmental diagnoses and symptoms were mentioned during interviews (including eating disorders and Autism, and other diagnoses not specified). Participants had experiences of disclosing their LGBTQ+ identities to a range of professionals across CAMHS and adult mental health services, including specialist, inpatient and community settings. Therapy and counselling in non-NHS settings was also mentioned by some participants, in addition to NHS experiences. Professionals who participants had disclosed to included psychological therapists, support workers, nurses, psychiatrists, and unspecified CAMHS clinicians.

All participants spoke of multiple (at least two) separate instances of LGBTQ+ identity disclosure in mental health services, with a range of responses experienced (both in terms of their own internal response and the clinician’s response).

Whilst some participants spoke of experiences spanning a long period of time, starting around a decade ago, and acknowledged this, these experiences were not necessarily timebound; the unhelpful, judgemental, and actively damaging experiences were not simply those from a decade ago, but those from more recent times as well, demonstrating the pervasiveness of heteronormativity, ongoing.

3.4 Thematic Analysis

3.4.1 Thematic Map

The final thematic map encompassed three primary themes, with a range of subthemes, as shown in Figure 1.

Whilst a specific theme related to power and powerlessness was developed to hold these particular experiences, all the themes could be interpreted through this lens, which for purposes of this study centres the power and impact of pervasive heteronormativity, as outlined earlier in this report. However, due to the prevalence of specific instances of clinician power and participant powerlessness noted by participants, particularly in the context of being silenced, invalidated, and rejected, it was decided for this to be a separate theme as well. Thus, there was some overlap, marking connections and relationships between the separate themes.

Whilst it is recognised that other interpretations of the interviews could have led to a different focus, the context of power (and indeed the power of heteronormativity) was considered pertinent, as naming the ways this power is enacted within NHS mental health services provides a step towards being able to change this imbalance (Salter et al., 2021). Thus, the more deductive element of analysis enabled the lens of heteronormativity to be used to interpret the data, accepting this was one of many ways the data could be understood. As such, the researcher held in mind throughout the analysis the frame that LGBTQ+ young people are living, and accessing mental health services, in a world that expects and privileges heterosexual and cisgender identities, enabling thinking about the potential impact of internal and external stressors (Meyer, 2003) faced by minoritised young people in this context.

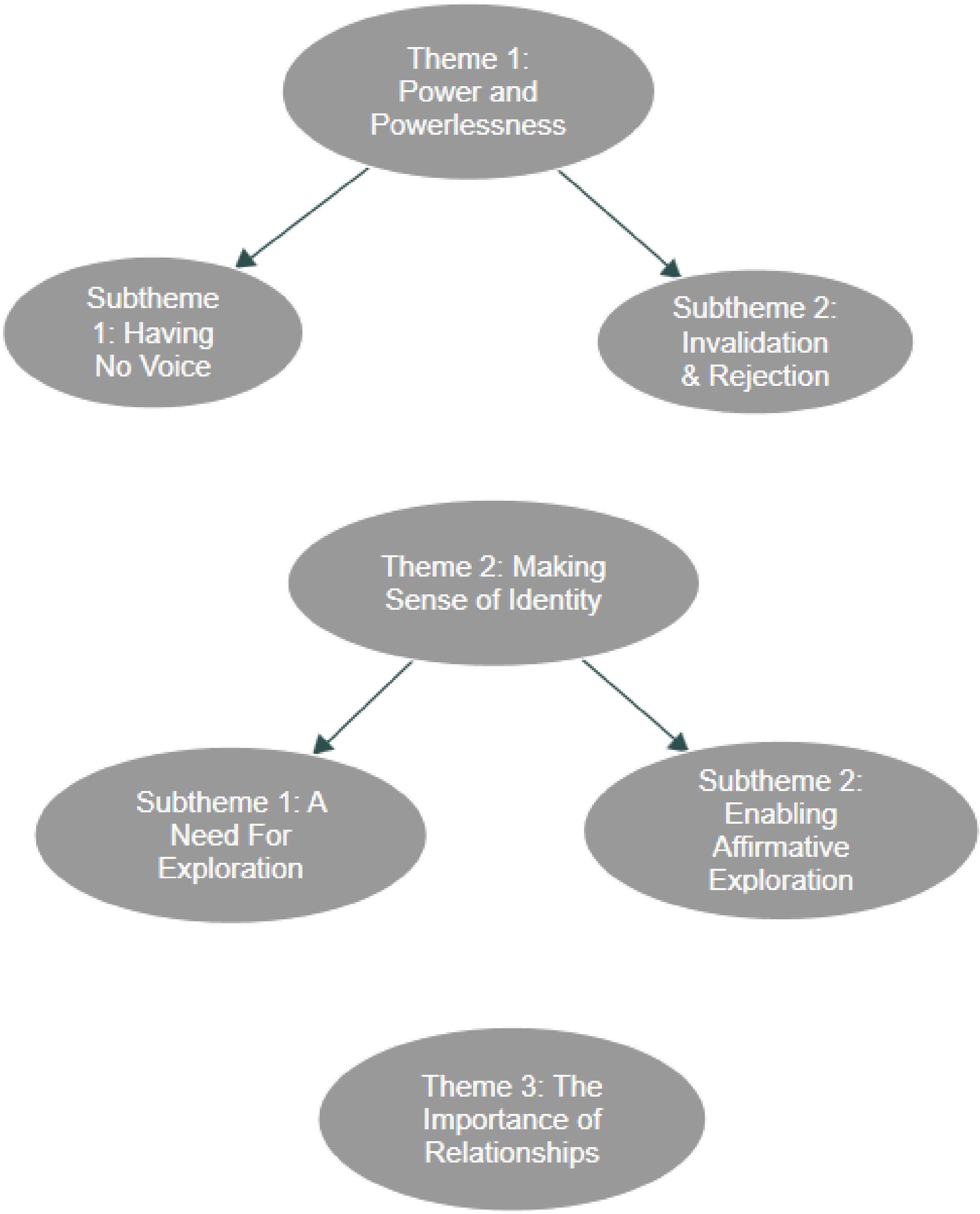

Figure 1

Final Thematic Map

3.4.2 Theme 1: Power and Powerlessness

This theme highlights participants' experience of powerlessness, in contrast to the clinician's holding of power, in their disclosure interactions. This can be understood via the two subthemes, the first of which looks at participants' experiences of their voices not being heard, and their choices not being respected, and the subsequent impact of this. The second subtheme looks at the power clinicians hold to invalidate and reject young people's experiences. Considering the pervasiveness of heteronormativity in UK society, and the impacts of subsequent discrimination and stigma faced, as outlined in MST (Meyer, 2003), lack of power may be particularly silencing for LGBTQ+ young people who self-harm or experience suicidality, perhaps acting as a further stressor contributing to increased distress.

3.4.2.1 Subtheme 1: Having No Voice

The experience of (non-)disclosure of LGBTQ+ identity was described by participants as contributing to an experience of their voices not being listened to, being silenced, or taken away, by clinicians. Indeed, the power imbalance had potential to prevent participants from feeling able to, or feeling supported to, disclose their LGBTQ+ identity, even when they might have wanted to, silencing their voices; *"it would have been nice to get that off my chest, and I never had the opportunity with that CAMHS worker to do that"* (Zoe).

This left some feeling powerless and even unable to express themselves, or their identity: *"…then I couldn't even talk about that bombshell* [a breakup] *that I'd had dropped on me because I didn't feel like I could because I didn't feel like I was being listened to"* (Isobelle).

Participants age, and the powerlessness associated with youth, appeared to be a factor in reducing opportunity for participants' voices to be heard. Isobelle's experience of one clinician's response to her LGBTQ+ identity disclosure shows how age can interact with clinician power, silencing of young people's voices:

> *I was quite taken a back and I was like absolutely not, I can't believe you just said that to me, in my head [laughs], I didn't say this to him, 'cause, umm I was a little shy 15 year old that just wanted to go home. Ummm yeah, I don't think we talked about it again, umm, after that I didn't feel like I could really… bring it up.* (Isobelle).

Clinicians held power in the relationship, and therefore their voices and agendas were privileged. Participants referred to difficulties initiating topics of conversation, such as LGBTQ+ identity disclosure, or directing the conversation towards a meaningful topic, as clinicians instead appeared to hold this power, silencing their voices: *"it felt good telling her, but she didn't really, she kind of just moved on straight away, she was just like "ok" and then carried on, so, and I don't think it'll ever come up again"* (Zoe).

There was a hope for clinicians to use their power to initiate conversations about LGBTQ+ identity, in a way that benefitted the young person. Thus, the timing of conversations was important, for example being at a point where the young person was not too distressed, and was able to think about how they wanted to express themselves or explore their sense of identity: "*Maybe when I was a bit calmer, they'd like, maybe, and maybe more able to take in information, maybe if they'd kind of brought it up again*" (Pippa).

Indeed, participants reflected a hope that clinicians provide multiple opportunities for disclosure, even for those who for various reasons had initially identified themselves as being heterosexual:

> *… she asked me the question that once and then never brought it up, 'cause I probably had her for about 6 months and like then got a new one. So in that 6 months she could have asked me again if she wanted to, when I was alone, but she didn't*. (Zoe).

Thus, enabling the young person to hold some of the power in the relationship and direction of the conversation was valued as an important experience following identity disclosure, for example to decide where the conversation went next:

"*I had the opportunity to kind of switch the conversation and I was quite happy to talk to her about it because I felt comfortable with her*" (Zoe).

The language clinicians used was also important, and contributed to their power to direct conversations in a manner that suited them, silencing young people's own voices:

> *I think on the whole it's wrong how so many people just assume everyone's straight, like especially in this day and age, like even if she didn't want to ask me straight away, she could have just been like "oh, do you have a partner" and umm kind of used more gender-neutral terms rather than just assuming my sexuality.* (Zoe).

Language holds power, in the context of pervasive heteronormativity in mental health services, and thus could be exclusionary, and further reinforce an idea that being LGBTQ+ is understood as *different* to clinician's expectations.

The power of others in the clinical space, whether clinicians or family members, had the ability to take away choice and autonomy from the young person. Participants reported experiences of LGBTQ+ identity disclosure that were not initiated by them, where they were powerless to come out on their own terms. This could be unexpected, reducing choice about when and how to come out to a particular person, such as a clinician:

> *I think my mum at one point just kind of blurted out, ohh yeah and this girl at school is no help, you know she's like broken up with her. And I was just there like, oh, right, we're umm coming out, here, umm, now.* (Isobelle).

Clinicians, in their professional roles, also had the power to take away choice of who was given information about the young person, which could be anxiety provoking; *"I remember being kind of quite anxious about what happened with that information"* (Pippa). Thus, consent and confidentiality were important considerations at the time of disclosure, with some participants being fearful and concerned about parental involvement. This led to missed opportunities for sharing their identity with clinicians when asked in the presence of their parents:

"I think at the time I was in year 9 and I was not out to my parents, so I just went "err, straight", because I didn't want to, like, tell my parents" (Zoe).

There appeared to be a lack of conversation or process for gaining consent or agreement from the young person regarding topics that might be disclosed to their parents. Indeed, there was a desire for more choice and for clinicians to hear their own views, before sharing information with their parents. There was awareness from participants of procedures around confidentiality regarding safeguarding concerns or risk of self-harm or suicidality, and understanding of the reasons for this, yet there appeared less clarity around information sharing about other experiences, which became barriers to disclosure and trust:

> *… in all my CAMHS appointments, I get that they have to tell my parents like safety issues, but it felt like absolutely everything I would speak to my CAMHS worker about she'd be straight in, like on the phone to my mum … wasn't a safeguarding issue, it was like friendship fallouts and stuff like that and I was just, there's no need … so why would I like disclose my sexuality with you when I can't even trust you with like, information about my friends which I've just said don't tell my parents.* (Zoe)

This exemplifies the internal process that often occurs for LGBTQ+ individuals in attempts to ascertain whether a person and space is safe enough for disclosure; taking away the young person's choice in what information is shared with others meant their voice and sense of agency was lost, and thus could prevent them from feeling able to speak about their LGBTQ+ identity.

Fears and uncertainty around the passing of information to others extended beyond what family members would find out, to what other professionals involved in their current and future care might find out. Participants identified a lack of control over where information, and indeed their LGBTQ+ identity, was shared: *"I wouldn't maybe have wanted it brought to the MDT meeting maybe, although I don't know, I think you kind of have to document everything and every conversation"* (Pippa). This could impact future disclosures as well: *"I was very off put telling all future CAMHS people because I know she would just tell people"* (Zoe).

Again, there appeared to be a lack of transparency experienced by participants regarding what happens to information about their LGBTQ+ identity disclosure. One participant described a concern that clinicians might themselves be privileged in being safe and comfortable in their own identities, which might then prevent them from realising the young person might not want this information shared with others:

> *I just didn't know whether… like sexuality and, and gender identity and stuff, is, is sensitive information that maybe people shouldn't pass on… I guess for someone for whom being able to be you is very, very normal, and stuff, they might not even think twice about not realising that person might not want to be out to their, umm, seemingly like, you know, educated parent…* (Pippa).

Thus, it was hard for participants to trust where information about their sexual or gender identity might go, thereby reducing their power and autonomy in clinical spaces. Indeed, there was a preference for being asked about LGBTQ+ identity confidentially, without the presence of others, which could promote a sense of control and enable openness: *"not asking me in front of my parents, 'cause then I would have probably like gave them a more accurate answer"* (Zoe). Similarly, open and honest conversations about confidentiality that included the young person, and clarified what would happen to information about LGBTQ+ identity, were valued:

> *I think maybe just letting people know about what the limits of confidentiality are… just let people know 'if you know, I feel like you're at risk of harm in some way, then, that would go somewhere, but actually if you just want to talk about the stuff and any frustrations you're having, we can talk about that and I'll be here for you to say whatever you want to about this topic'* (Pippa).

3.4.2.2 Subtheme 2: Invalidation and Rejection

Powerlessness was also experienced in the form of invalidation and rejection of LGBTQ+ identities, including via pathologising and dismissive assumptions.

In the context of a heteronormative mental health system, dismissive and invalidating responses occurred due to the preconceived ideas about straightness (as the expected norm) held by the clinicians, such as that a relationship between two people of the same gender was not based on sexual or romantic attraction. One participant shared an experience of being asked:

> *… if it was like a special friendship, you know? … Like, you know, am I really feeling like I want to be with her in a relationship way, or was it more of just, you know, you wanted to be really close to a particular person, and I just, I just remember feeling like ohhh right, this isn't, we're not, we're not taking it seriously (laughs), oh right, that's the direction we're going down. So you know, I, I don't think I really gave him an answer, I think I was just a bit… shocked, that that's what he was really asking me.* (Isobelle).

This provides an example of denial and invalidation of LGBTQ+ identities within clinical mental health spaces. There may also have been an interaction with the clinicians' own context as a man, in a patriarchal society, perhaps leading to additional assumptions about the nature of female relationships, dismissing romantic or sexual relationships between women; thus, clinician biases and assumptions have the power to invalidate and erase LGBTQ+ identities. Such responses, stemming from heteronormative ideas, may impact young people by adding to their compounding life-stressors, increasing risks of distress and difficulties in seeking help through mainstream channels which may be anticipated as discriminatory.

Dismissiveness could be subtle, with young people being supported by services yet the clinicians not providing validating or supportive responses to their LGBTQ+ identities: *"…with CAMHS… they were dismissive, but not really in the sense of that they were discriminating, so they still supported me regardless, even though they were dismissive about that issue*" (Verity). Indeed, the impact of hetero- and cis-normative expectations can be more subtle, but Verity's comment highlights that even in the absence of active discrimination, a detrimental impact was experienced.

Similarly, some clinicians held preconceived notions about normative expressions of gender identity, which led to unhelpful and invalidating experiences where assumptions were made that did not fit the young person's experience:

> *I always dressed quite unisex anyway, but it wasn't just in a way that they expect from a girl, and they will keep knocking on that issue and kind of saying are you having difficulties around this area, or what are you thinking, and they would just keep digging and digging and digging, and through that process, it was a lot of 'are you sure'…* (Verity).

Indeed, continued questioning of one's identity, perhaps based on heteronormative assumptions by the clinician about the ways gender identity was expected to be presented, could invalidate the young person's own understanding and experience; such questioning suggests a belief by the clinician that the young person's understanding is *wrong.* Clinicians, in their role and power as professionals and adults, are positioned as experts, and therefore such questioning of young people's identities could be understood as clinicians knowing more about the young person's identity than the young person themselves.

Clinicians also held assumptions based on age, denying the validity of young people's identities based on an idea that their young age meant their LGBTQ+ identity was not yet stable: "*it was just kind of ohhh she's 15, she's young, she's probably just figuring things out"* (Isobelle). This could be an invalidating outcome of identity disclosure, with clinicians effectively suggesting that the young person could still be heterosexual, and therefore implying this was a desirable end-point; this emphasises a heteronormative expectation of straightness. Indeed, continued questioning of someone's identity, and suggesting that it was something they needed to think carefully about, also invalidated their experiences of being LGBTQ+, suggesting it was an undesirable identity that could still be changed due to their youth: *"… are you sure?", like, "have you thought deeper about it" or something along those lines of I'll probably grow out of it"* (Verity).

Invalidating responses also included a lack of normalisation or acceptance of LGBTQ+ identity, which could further reinforce a sense of difference for young people who may already be struggling to find a space for themselves in a heteronormative world, and in a world that stigmatises experiences such as self-harm and suicidality: *"there wasn't an acceptance of it as just like… a normal thing, like just as in how people can be heterosexual, then someone can be homosexual or bisexual, this is normal"* (Verity).

One participant shared an experience that, whilst not occurring in an NHS service, emphasised the ways LGBTQ+ identity can be invalidated under the guise of emotional and spiritual support:

> *… 'I was given same-sex attraction, but this is an invitation from the Lord to dedicate my work to feeding the poor and so on'* … *not change it, but to try and view it as a gift, but like in the wrong way, like it's a gift, your sexuality, your sexuality is something to be prayed against, but actually you could live a very meaningful life of abstinence*… (Pippa).

Not only was this an invalidating experience, but one that actively denied enjoyment and acceptance of one's identity, suggesting that being LGBTQ+ is something that requires repentance.

Instead, there was a hope for unconditional acceptance of participants' experiences, rather than clinicians imposing their own views and biases:

> … *maybe just accepting the fact that this is what I identity with, rather than somewhat pushing me in different ways to consider like, like sometimes with these things you don't need to think that deep about it, that it is just what it is…* (Verity).

The problematising and invalidation of LGBTQ+ identities also included pathologisation, in the assumption that LGBTQ+ identity was in some way a symptom of a mental health condition:

> *…it was problematic because they were using my bisexuality and kind of the gender fluidity, to justify a diagnosis that I don't have, and they were seeing that as a symptom, which was an issue, because then it means they are treating me for something I literally don't have…* (Verity).

Such views invalidated the lived experiences of being LGBTQ+, further emphasising that it was not in line with the expected norm within mental health services, as well as suggesting that it was something in need of *treatment*, positioned as akin to mental illness.

Indeed, Verity reflected on an experience where an unexpectedly large number of people accessing a particular mental health service were LGBTQ+, leading to questions about whether mental illness is conflated with non-conformity with heteronormative expectations.

> *…they sent me to a specialist service where a lot of the patients there went, because we kind of befriended each other … most of them were homosexual, or bisexual, or different sexual orientations, and it made me think about what part of it is us being ill as defined by professionals, and what part of it is just they don't, they're not accepting us the way we are. Because it feels a bit strange to have that many of us in the service.* (Verity)

Invalidation could also be rejecting; clinicians held power to reject young people, their identities, and their experiences, including the power to deny them appropriate support, linked to the clinician's wider assumptions about experiences associated with LGBTQ+ identities. Indeed, mental health difficulties or personality characteristics being attributed to identity could lead to rejection:

> *… for many of the people with like a different, not what they consider a normal identity, some people are excluded from services, because of that. Not because of their identity, but because of the things that services attribute to their identity…* (Verity)

Rejections could, understandably, lead to young people feeling powerless when disclosing their LGBTQ+ identity to mental health clinicians. Indeed, inhabiting an identity perceived as outside of the expected social norms, as constructed by mental health services, was considered to lead to risk of relational rejection: *"…it tended to mean that I didn't sort of trust them as much, because you know, that was a part of me, and they very obviously did not like that part of me"* (Alice).

Thus, LGBTQ+ identity disclosure posed a threat to young people's access to support, including at times when disclosure was requested on information-gathering forms: *“I feel like whatever I say on that form is gonna be used against me, one way or the other*” (Verity).

Participants spoke of the emotional impact of invalidation and rejection: “*I just felt so, so rejected. Felt rejected from my break up, and I felt rejected from my therapist, like it wasn’t good*” (Isobelle). For young people who self-harm or experience suicidality, and who are LGBTQ+, who often have experienced rejections in other aspects of their lives too (Ryan et al., 2009), clinician rejections may compound these experiences. The continued rejection, even in clinical spaces which are ostensibly designed to be supportive spaces, may be retraumatising, or reproduce the distress associated with those rejections, and perpetuate a sense of not belonging.

Participants reflected on the detrimental impact identity disclosure had on mental health outcomes, when the clinical response had been rejecting or invalidating: “… *ended up with a huge decline in my mental health because I was not receiving the support that I should have been because I didn’t trust them*” (Alice).

Whilst it was not always possible to directly attribute a decline in mental health to the rejecting or invalidating response of clinicians to LGBTQ+ identity disclosures, there was a sense that the associated lack of safety and trust contributed to difficulties using support:

> *… I ended up drinking myself into a stupor and taking three overdoses, so I dunno, I cannot say if that would or wouldn’t have happened, but you know, it contributed, and we could have had a really productive conversation. I could have opened up about a lot of things*. (Isobelle)

There was also fear that further openness about their lives could be detrimental and lead to additional rejections: *“I really didn’t want to sort of open up and be prone to them deciding that they didn’t like more parts of me”* (Alice). Indeed, denying one’s own identity due to powerlessness in the relationship, and in order to protect oneself, could have a consequence of impacting the journey of recovery: “*it didn’t feel great, because I was just like, I’ve lied to you, like I, I want to help myself, but I’ve just had to lie*” (Zoe).

Participants spoke of a consequence of the powerlessness they experienced in mental health services, whereby they felt a need to hide or deny their LGBTQ+ identity in order to protect themselves*: "…but as the time progresses, whenever they ask me to fill out forms, I just say prefer not to say"* (Verity). Indeed, participants described taking action to protect themselves from further invalidation or rejection, such as by diverting conversations away from LGBTQ+ identity: *"I was just deliberately diverting away any conversations that they wanted to have about those issues. I was just kind of like, I'm not going to discuss it if you're not gonna actually understand it."* (Verity).

3.4.3 Theme 2: Making Sense of Identity

A second theme was developed to represent the experience of figuring out one's own LGBTQ+ identity, alongside mental health service interactions, and the value of these interactions being used as a space for meaningful identity exploration. The first subtheme explores why exploration was desired by participants, and the second explores how this could be achieved. In the context of a world that privileges heterosexual and cisgender identities, there may be limited understanding from some services and clinicians of the unique challenges faced by LGBTQ+ young people who self-harm or feel suicidal; clinicians may not be aware of the value of, and need for, affirmative exploration. Indeed, the subsequent impact of this may be to add further stressors to young people's lives, potentially increasing their emotional distress, and making it difficult for them to feel safe enough to access help and disclose their LGBTQ+ identities.

3.4.3.1 Subtheme 1: A Need For Exploration

Not only did participants hope for acceptance and validation as an outcome of disclosing their LGBTQ+ identity in their encounters with mental health services, they wanted an opportunity for exploration: "*I think I would have been better if they had … sort of asked more questions when I told them*" (Alice). This included utilising LGBTQ+ identity disclosure as an avenue for wider openness and exploration:

> *… if I had just had that one little in with how I was feeling about myself and my sexuality, then, I don't know, maybe that could have, I could have opened up a bit more about other things, I could have just, you know, that could have been the floodgates, he didn't, you know, he didn't open them…* (Isobelle).

There was a desire for clinicians to recognise that LGBTQ+ young people experienced life in the context of a world that privileges and expects heterosexuality, and exploration of this context was then missed: *"I feel like sometimes it could have been looked into more, because of the unique struggles that you get and the experiences that come with being LGBTQ+"* (Alice).

Thus, there was a hope for clinicians to enable space to explore young people's experience of their identity, holding in mind specific difficulties that might arise for LGBTQ+ young people, without making their own assumptions. Exploration could both help the clinician to understand the young person's life context, and support the young person in making sense of themselves in the heteronormative world. I was aware that whilst I opened space for participants to discuss their LGBTQ+ identity explicitly within the interviews, I did not explicitly provide the same for their experiences of self-harm or suicidality, due to the nature of the research questions focusing on LGBTQ+ identity disclosure; this may have hindered participants' ability to share their experiences in this context. Indeed, in my attempts to create an open and affirming space for LGBTQ+ identity disclosure, I may have privileged this topic, perhaps limiting the space for discussion around self-harm or suicidality.

It can be a confusing and difficult process to make sense of being LGBTQ+, in a world that does not hold this as the expected norm, and this process could take time:

> *I don't think I'd ever sort of maybe articulated myself that I'm like anything other than sort of straight or anything. And then when I was on the ward …. I remember just get-, feeling really distressed and angry that other people who were much younger than me were like [pause] aware of that kind of thing, and comfortable with that kind of thing, and it was sort of this safe thing for them to disclose in their own lives ...* (Pippa).

There was a loss associated with beginning to recognise one's own LGBTQ+ identity in a heteronormative environment, and an internalisation of heteronormative expectations:

> *I was actually grieving, I guess, the fact that I thought I was going to be in like a nuclear, normal, straight couple, and that I was gonna make it work, and I was gonna be accepted by everything and everyone, and actually that was over…* (Isobelle).

For some, the impact of heteronormative expectations also led to recognition that being heterosexual provided people with an easier experience of life. This left some individuals attempting to deny their own developing identity, to attempt to fit in with social expectations: "… *after that I was a little bit like, well I'm, well, I'm, it's gonna be simpler to be straight, so I'm just gonna be straight from now on, but that was just, an interesting moment*" (Pippa).

The impact of experiences related to being LGBTQ+ were for some a factor in the mental health difficulties they were experiencing. Therefore, where there was a lack of follow-up exploration or conversation after disclosure, there were missed opportunities by clinician to explore and understand the young person's wider context:

> I *wanted him to talk to me way more about it because, you know, as awful as I felt about having home patient, and you know, having recovery like thrusted upon me, I then had a break up on top of it, and I was 15. I was emotionally all over the place …* (Isobelle).

Lack of exploration following disclosure also had potential to impact mental health outcomes, such as being a barrier to fully engaging in sessions, and impacting the therapeutic relationship: "*maybe if he'd explored that a bit more, responded in more of a validating way, I, yeah, I think I could have talked about it, I think we could have, I think we could have actually done some therapy…*" (Isobelle). Indeed, not taking the opportunity to explore experiences related to one's LGBTQ+ identity further had consequences of preventing young people from having space to make sense of their identity:

"*I was kind of grappling with my sexuality, and it would have been really great to talk about that more, and in a better light, and we didn't and I then spent much, much longer having to unpick that*" (Isobelle).

3.4.3.2 Subtheme 2: Enabling Affirmative Exploration

Despite the desire for meaningful, affirmative exploration of LGBTQ+ identity in mental health services, this opportunity was not always taken up by the clinician following identity disclosure: *"she basically just went "ohhh, okay" and then just moved on, and that was basically it" (*Zoe*).*

Young people may come to NHS mental health services at various points in their journey of identity discovery. Mental health service contact represented an opportunity for exploring LGBTQ+ identity, to help young people in making sense of their identities and position within a heteronormative world. Participants valued experiences where space for both disclosure and exploration were enabled, with suggestions that active listening could support clinicians to gently and curiously introduce this topic of conversation:

> *… just looking for a bit of an opening, like if someone was talking about having a very, very loyal best friend, and their best friend has got a boyfriend, and they're feeling a bit upset about that, you know, that's a, that's, that's, that's quite a nice opening or something…* (Pippa).

Indeed, it was valued when mental health services offered an opportunity to build an understanding of one's own LGBTQ+ identity in a comfortable space:

> *…I came out again … it just felt great, and I don't think I would have reached that epiphany moment as soon if I hadn't been able to talk about it comfortably with like, in therapy and with other people…* (Isobelle).

Sometimes LGBTQ+ identity disclosure arose as a result of forms being filled out which contained questions about sexual orientation and gender identity. Whilst these could for some be a useful way of promoting LGBTQ+ identity disclosure, these forms limited opportunity for exploration or conversations about how being LGBTQ+ was experienced in the context of their lives:

> *Like if it feels like an equality monitoring form, that can be fine, but I guess it probably won't lead, it probably isn't the time when someone's gonna say that they're having a bit of a gay panic and they're not sure*… (Pippa).

There was a hope that the topic of LGBTQ+ identity could be introduced in a casual or conversational manner, showing an understanding of the young person's context and life experiences: "*I suppose that just sort of bringing it up kind of naturally when you're like, just being, being really like paying attention to times where it would be a relevant question to ask…*" (Pippa). This may have reduced a sense of disclosure being a tick-box exercise, for the service rather than the individual. Indeed, it was appreciated when clinicians understood the nuances of experiences associated with being LGBTQ+: "*I just guess it just made me feel really happy that someone was, not happy, but really that people can do nuance and stuff like that?*" (Pippa).

It was important for exploration to be meaningful, and not to instead be fuelled by heteronormative expectations which could lead to the aforementioned experiences of invalidation. Exploration that was unhelpful, such as questioning of identity validity, had potential to lead young people to question their lived-realities, or risked setting them back in their journey of self-acceptance:

> *I think for like a hot second I was a bit like, what's he saying this for, am I figuring things out? Am I, like am I digging into this too much? Like, I dunno, like he had me second guessing a little bit…* (Isobelle).

Participants shared experiences of the ways clinicians' responses could reinforce the harmful heteronormative expectations of wider society, in the perception of an LGBTQ+ identity as *different* to their preconceived ideas about acceptable identities. Indeed, young people desiring exploration of their LGBTQ+ identity, existing within a heteronormative world, was not a sign of lack of certainty in their identity; continued questioning about the validity of identity by clinicians was perceived to demonstrate a lack of understanding by clinicians about the purpose of identity exploration:

> *…at first I wasn't entirely 100% sure on what my identity was, what I was sure about was I definitely did not have what they perceived as a normal identity, and because I was young, I was still at the stage of exploring what that means for me, but it doesn't mean that I wasn't sure, in a way, because I think it is that kind of innate feeling that you have…* (Verity)

Questioning the certainty of someone's identity negated the confusion and uncertainty associated with coming to terms with an identity that the surrounding world views as *different*, thereby denying them space for meaningful exploration.

Opportunities for exploration were not limited to the clinician-young person relationship. Participants also noted the value of having connections with others with similar experiences, such as being around other LGBTQ+ young people and seeing these identities accepted and normalised. This was important in participants' processes of exploring and making sense of their LGBTQ+ identities, which could otherwise be isolating:

> *I think I felt like at university they were much more accepting of all different kinds of walks of life and identities, so I didn't, you know, I, I've never been around so many different people. Different ethnicities, different cultures, different sexualities, so it was really kind of opening and I'd never had that before…* (Isobelle).

This emphasises the barriers experienced to identity exploration in environments that privilege a heteronormative value system, such as healthcare.

3.4.4 Theme 3: The Importance of Relationships

A third theme was developed to recognise the importance of the clinical relationship in the experience and ongoing impacts of LGBTQ+ identity disclosure in NHS mental health services. This included participants' experiences of clinicians' emotional responses to their disclosures, and clinician characteristics which contributed to more beneficial experiences of disclosure.

Disclosure of LGBTQ+ identity within mental health services is held in the context of the clinical relationship (as well as the context of the wider service and systemic factors). Relationships require work on both sides, and there was a need for the clinician to bring something to the relationship to facilitate a sense of safety, rather than expecting safety to be automatic:

> *…it was like my first appointment I was like, why, I, I don't know you at all, like it just, I don't know. Just talk to me, tell me a bit about yourself, so I can feel a bit more like, safer, around you, and like comfortable knowing you and then I'll open up…* (Zoe).

For purposes of this study, the intentions of the clinicians in the interactions described cannot be known, as they were not interviewed. However, there is importance in considering their emotional reactions as experienced by the participants; ultimately, regardless of intention, the reading of the emotional reaction by the young person is key to understanding the experience of LGBTQ+ identity disclosure from their perspective.

Participants noticed a range of emotional responses from clinicians to their LGBTQ+ identity disclosure, some of which were overtly negative, and impacted their sense of comfort and safety in the space, and going forwards in their mental healthcare. Specifically, disgust, shock and embarrassment were noted by participants as the responses of their clinicians to their LGBTQ+ identity disclosure: *"it would have been nicer if the older clinicians just hadn't been so disgusted with me when I brought it up*" (Alice); "*With my psychiatrist she was just kind of, I don't know, it was it kind of felt like she was almost just a bit embarrassed or something, because she kind of just went like 'oh okay*'…" (Zoe); "*I think she was quite shocked*" (Zoe). Some responses were also experienced to be judgements by clinicians: "*you definitely did get some sort of judgemental looks and very quick change of subjects…*" (Alice).

Anxiety was noted to represent clinicians' uncertainty, which impacted participants' experiences of disclosing their LGBTQ+ identity. Indeed, some clinicians were perceived to be afraid or unsure of how to approach conversations around sexual and gender identity. Participants considered some of the potential anxieties clinicians might hold, in line with their heteronormative assumptions and biases. Indeed, one participant wondered whether clinicians may worry about how they might come across themselves, due to their own biases:

> *I think a lot of people are quite anxious about entering into conversations with people who are struggling with like internalised homophobia and stuff, in case they may, like they accidentally give them the impression that they are also homophobic*… (Pippa).

The same participant also wondered whether the anxiety of some clinicians was attributed to a belief that conversations around sexuality were inappropriate for young people. This demonstrates awareness of homo/bi/trans/ace-phobia and ageist assumptions that can exist in the reactions of clinicians, which could then prevent disclosure or impact experiences of disclosure: *“maybe clinicians are worried about that because they might have this sort of slightly homophobic preconceived notion that talking about sexuality and LGBTQ identities is the same as having a totally inappropriate off record conversation with the child”* (Pippa).

Indeed, participants also experienced an anxiety of clinicians attempting to meet their own needs, for example to prove themselves as progressive, or engaging in performative acts of allyship that did not centre the needs of the young person and their experiences related to their LGBTQ+ identity: *“I think it kind of exemplified people kind of wanting to show that they’re allies and wanting to, having that kind of strong agenda for themselves and stuff*” (Pippa). However, for others, practical signs of allyship signalled safety: “*she had a safer vibe, like I could tell she, she had like pride pins on her lanyard as well”* (Zoe). Such responses signal the pervasiveness of heteronormative assumptions in UK society, such that clinicians aim, and perhaps fail, to find ways to move against these assumptions.

Participants hoped for responses from clinicians following their LGBTQ+ identity disclosure that would demonstrate an understanding of their experiences, which was not always the reality: *“I thought that going to therapy and talking about what your, you know, your woes and life problems that you’d be like not judged for it, and taken at face value”* (Isobelle). Indeed, there was a fear that clinicians would not understand their experiences: “*I didn’t know if she’d like fully understand, I don’t know, she just didn’t give me like very, the vibe I wanted*” (Zoe).

Instead, participants valued relationships and interactions where the clinician made an effort to understand their LGBTQ+ identity in the context of their lives, centring the young person's perspective:

> … *she didn't jump straight into sort of say that she's a great ally or anything, or, I don't know, what sexuality is herself, she, she didn't jump in with that at all, I just got the sense that I didn't need to explain why that would be incredibly distressing…* (Pippa).

There was importance placed on trust within the relationship, and trust needed to be earned rather than expected, before an individual might feel safe enough in the relationship to speak about their LGBTQ+ identity and associated experiences: "*I think with my psychiatrist I didn't tell her until I knew, I think like at least 6 months or so because I thought I want to build up trust with her*" (Zoe). Indeed, as researcher I held a role of building a relationship very quickly with participants, for a short-term encounter; there was disparity in the length of interviews, which may have been related to difficulties for participants feeling sufficiently safe in sharing aspects of their lives with a person they had only briefly met, online. Thus, there was an experience of how important safety and trust were within the interview space as well.

Participants' sense of whether a clinician would be understanding, trustworthy, or provide a safe space, involved an internal decision based in part on the general characteristics of the clinician and quality of the relationship. When the characteristics of the clinician did not enable a safe enough space, a process of withdrawal could occur, as a protective mechanism: "*I picked out the issues with the individual clinicians and sort of decided, no, I don't really like them anymore, and so, stopped seeing them as willingly or as often*" (Alice).

Whilst recognising the potential bias in this assumption, two of the youngest participants shared a preference for speaking about LGBTQ+ identity with younger clinicians: "*the younger clinicians, I sort of felt, a little bit more safe in their presence*" (Alice). There was a view that clinician age was a factor in assessing potential safety of the therapeutic space: "*not to kind of stereotype, but she was, she was a lot older. I didn't know if she'd like fully understand*" (Zoe). As researcher, I was aware of my relative youth, and proximity in age to some participants; this may have enabled such responses to be voiced, but equally leads to questions about what also may not have been voiced due to this proximity.

However, where clinician responses to LGBTQ+ identity disclosure were supportive or encompassed more positive emotions, this was appreciated: *"… it felt nice to have like a positive reaction, like she was supportive of it and like she wanted to know more*" (Zoe). Similarly, participants appreciated when clinicians showed a genuine interest in their experiences following disclosure of LGBTQ+ identity: "*I just think she was just generally really interested in stuff that was going on, around what was going on*" (Pippa), and showed the young person that they were being heard *"… she was actively listening to me and wanted to know, so it felt nice"* (Zoe). Indeed, I noticed this within my own interactions with participants in the interviews, where I aimed to build a connection, a sufficiently trusting and affirmative relationship to enable participants to share their honest experiences. My experience was that participants felt able to share positive, negative and neutral experiences, and perhaps that my validation and curiosity promoted such openness, enabling reflections on the impact of relationships.

Relationships where clinicians accepted and normalised LGBTQ+ identity were valued; in the context of the relationship, clinicians could position themselves as someone who the young person could be open with: *"I think she just made it quite normal to talk about umm, so unrelated context factors, like she, that was just kind of, I feel like that was something that she always seemed like really amenable to"* (Pippa). A response of the relationship not changing following sexual orientation disclosure was named as helpful:

> *I feel like nothing was really different when I mentioned it, it was just they asked the same questions they would have asked if I had brought up if I was straight, or you know, just that sort of thing*" (Alice).

Normalising approaches also had a positive impact in enabling space for thinking and considering the impact and experience of being LGBTQ+ in a heteronormative world:

> *…just having it normalised and not be a big deal, like we talked about things a little bit obviously, to think like okay well because it's had an impact on how you're feeling like in yourself, have you like had any like self resentment and stuff like that. But just being able to talk about it openly, not being judged, having it kind of be a neutral thing*… (Isobelle).

Considering the importance of understanding, supportive relationships, which accept the young person's context, as someone experiencing difficulties such as self-harm or suicidal ideation and living in a heteronormative world as someone who is LGBTQ, training for clinicians was also noted as important, to increase awareness of these experiences:

> *…it's just having more awareness and training on this patient group… when you do go into practice, you see all these people, and if you're not aware, you're not, you can't, you don't really know how to treat them the way that they should be treated* (Verity).

4.0 DISCUSSION

4.1 Overview

This chapter provides a discussion of the findings of this study, situated within the wider context outlined throughout this report, through a lens of the pervasiveness of heteronormativity in NHS mental health services. This includes consideration of the research questions and wider literature, as well as a review of the quality of the study, limitations, reflections of the researcher, and implications for clinical practice and research.

4.2 Context: Research Questions and Wider Literature

The research questions for this study aimed to explore the following topics: For young people who identify as LGBTQ+, who have engaged in suicidal thinking and/or self-harm, and have used NHS mental health services:

1. What is their experience of disclosing their LGBTQ+ identity to mental health service clinicians?

2. What was the impact of their disclosure?

The concepts of experience and impact here are linked, and therefore discussed together within this section, the experience being what it is like for the young person in the moment of disclosure, and on an emotional level, which then has an impact on the consequences both short and long term. The themes developed through the analysis are used to respond to the research questions, situated alongside reflections and existing literature.

The mixed age range of participants enabled thinking about the impact of LGBTQ+ identity disclosure over a longer period; whilst younger participants spoke of this in the context of quite recent disclosures, older participants reflected on the longer-term impact of disclosure, including the ways this affected their process of figuring out their own identity.

4.2.1 Power and Powerlessness

An experience of clinicians holding power, alongside the powerlessness of the service-user, was highlighted throughout by participants. This power dynamic was both part of the experience, and the subsequent impact of disclosure; powerlessness was felt, and also had consequences such as increased distress.

4.2.1.1 Having No Voice

The experience of choosing to disclose LGBTQ+ identities involved an internal process, weighing up the potential costs and benefits of disclosure, specifically the potential risks and consequences. Indeed, previous research has identified an internal decision-making process and assessment of a situation that occurs before, during, and after coming-out (Cox & Gallois, 1996; Martos et al., 2015). The experience of the clinician holding power, in comparison to the powerlessness felt by the participant, appeared a key factor in this assessment of safety. There was a fear the clinician could wield this power in a way that denied the young person a voice, or a choice.

For adolescents and young adults, this assessment of safety and power may be impacted by the privileging of adult perspectives in paternalistic institutions such as the NHS, and potential assumptions of clinicians regarding cognitive decision-making capacity and developmental stage; given that adolescent brains are still developing, there may then be assumptions that they cannot know their own mind (Casey et al., 2008; LeFrançois, 2013; McCann & Sharek, 2014). For young people who experience self-harm or suicidality, which are often private experiences, associated with self-stigma and shame (Hassett & Ibister, 2017; Idenfors et al., 2015; McAndrew and Warne, 2014; Wadman et al., 2018), there may be an additional assessment of power and relational safety, for example related to fears of forced treatment (Mughal et al., 2021). This may add to potential difficulties with openness in the clinical interaction. These factors may further reduce a young person’s ability to feel safe to be open about experiences and difficulties, and their sense of autonomy and control. Indeed, young people value being treated like adults, able to be involved in their own care and decisions (Wadman et al., 2018).

For young people who are silenced and disempowered, including through the internalisation of heteronormative shame (Meyer, 2003), and accessing services that privilege age and heteronormative expectations, the experience of choosing to disclose their LGBTQ+ identity may be particularly difficult. The findings highlight the power held by clinicians, as professionals and adults, to facilitate opportunities for LGBTQ+ identity disclosure, and to provide a safe-enough, affirmative space for these disclosures. Young people may hope for clinicians to take on this role (Zullo et al., 2021), recognising the fear and powerlessness experienced as barriers to initiating disclosure conversations for young people themselves. However, this opportunity is not always taken up by clinicians (Rossman et al., 2017), silencing young people further, leaving them powerless to share their identity and experiences.

The experience of disclosure was affected by confidentiality concerns, as was the longer-term impact of (non-)disclosure, in relation to fears of who else might be informed. Whilst recognising the constraints of NHS services and the requirement for parent or guardian involvement in aspects of care, particularly for young people under the age of 16 (NHS Choices, 2016), the findings highlight the importance of transparency and involvement of young people in their care. Participants appeared aware and accepting of constraints regarding safeguarding and risk management, where others would be informed, but experienced fears about who might find out about their LGBTQ+ identity. For young people who also experience difficulties with self-harm or suicidality, there is likely to be sharing of information between parents/guardians and clinicians, sometimes without the explicit consent of the young person (Paul et al., 2006); this may increase anxiety about information sharing regarding LGBTQ+ identity (Zullo et al., 2021). Indeed, if self-harm or suicidality is impacted by difficulties related to LGBTQ+ identity, such as homo/bi/trans/ace phobia (Kuper et al., 2014; Meyer et al., 2021), there may particular worries that their identity will be shared without their consent, which could lead to unsafe situations, or increased self-harm, if their families are not supportive of LGBTQ+ identities (Ryan et al., 2009).

These experiences of fear and uncertainty understandably had the impact of silencing some young people, reducing openness in the clinical relationship. Similar concerns regarding lack of autonomy have been highlighted previously (Crockett et al., 2022; Zullo et al., 2021). Despite the drive in NHS services to include service-users in decisions and to provide transparency in communication (NICE, 2011; Department of Health, 2014), there is often a lack of choice and involvement (Westberg et al., 2022; Worral-Davis, 2008); autonomy can be further dismissed in favour of clinicians privileging adult, sanist (privileging those perceived to be 'mentally well'), heteronormative perspectives (LeFrançois, 2013), and thus making assumptions, for example about where information about LGBTQ+ identity can be shared. Anxiety for young people about information sharing may heighten distress, increasing risks of self-harm or suicidality.

In my role as both researcher and clinician, I reflected on the power imbalance present in the interviews, and how this may have impacted responses. In explicitly asking about LGBTQ+ identity disclosure, but not about self-harm or suicidality, I may have limited participants' sense of power and autonomy to choose to speak about this, as perhaps I held the power to open or silence this conversation.

4.2.1.2 Invalidation and Rejection

Participants shared experiences of identity invalidation, whereby their LGBTQ+ identity was assumed to be related to their young age, or to their mental health difficulties, and therefore changeable. LGBTQ+ identities can be dismissed and invalidated based on heteronormative assumptions by clinicians and services (Crockett et al., 2022; Somerville, 2015; Stewart & O'Reilly, 2017); this sends a message that these identities are not desirable, and can be changed by therapeutic input. Such practices could constitute conversion therapy, a harmful practice which causes lasting damage in people's lives, including to their sense of identity, emotional wellbeing, and relationship to help (American Medical Association, 2019). The ongoing lack of protection for all LGBTQ+ individuals from conversion therapy at a government level means such practices are liable to continue in NHS settings, causing harm (Stonewall, 2021).

Similarly, experiences being seen solely in relation to a mental health diagnosis negate the wider life context of a person (Filson, 2016). Pathologisation of LGBTQ+ identities by clinicians may be internalised by the individual, increasing distress, including in the form of increased self-harm or suicidality (Herdt, 1998; LeFrançois, 2013). Indeed, assumptions about the context of mental health difficulties can be used to invalidate LGBTQ+ identities (Morris et al., 2022); this leads to questions about why heterosexuality, as another sexual orientation, is not then also pathologised in this way? Biases towards heterosexuality are prevalent in daily life, often invisible to those who are privileged in these ways: why is heterosexuality not assumed to be a youthful phase, or to be caused by mental health difficulties, or assigned derogatory attributes (Rochlin, 1972)?

Clinicians also held the power to exclude individuals from care, linked to assumptions related to LGBTQ+ identity. The concept of accepting or rejecting someone from support suggests there is a particular type of *acceptable* presentation of a service-user who is *worthy* of support. LGBTQ+ young people may already have experienced neglect and rejection in the context of the heteronormative expectations of society (Herek & Garnets, 2007; Ryan et al., 2009), or due to their experiences of self-harm or suicidality (Mitten et al., 2016; Mughal et al., 2021; O'Keeffe et al., 2021; Wadman et al., 2018), thus they receive a further message that they are not welcome or do not belong when mental health services also hold the power to reject and neglect. From an MST perspective (Meyer, 2003), mental health services can then be understood to be perpetuating the external discrimination, and perhaps the internalisation of this stigma, faced by LGBTQ+ young people in other areas of their lives, contributing to further emotional distress.

Rejection and invalidation can increase a feeling of worthlessness (Standbrook, 2020); what message does a young person, experiencing distress and struggling to find a place for themselves in a heteronormative world, take on from a clinician who rejects them or dismisses their identity in a time of need? Participants identified the impact of an exacerbation of their mental health difficulties. It is understandable, therefore, that participants were wary of future disclosures of LGBTQ+ identity, feeling forced to hide their identities, aiming to protect themselves from further rejection or invalidation. This may impact their relationship to help in the longer-term (Reder & Fredman); by providing rejecting or dismissive responses to LGBTQ+

identity disclosure, clinicians position these young people as *not belonging* within the heteronormative framework of mental health services and UK society, increasing barriers to accessing appropriate and affirmative mental healthcare as a result of systemic discrimination.

LGBTQ+ young people who also experience self-harm or suicidality may be particularly impacted by anticipated rejection and invalidation. These difficulties can become the focus of interactions within NHS mental health services, which whilst important in promoting safety, can dismiss focus on the context of individuals' lives (Beale, 2022). The risk-oriented and risk-averse nature of services may be experienced as a projection of the clinician's fear, and can reduce autonomy, leaving services-users feeling invalidated, and experiencing dehumanising and rejecting interactions (Standbrook, 2020). Such experiences may be further enhanced for young people disclosing LGBTQ+ identities, given the ways they are already ostracised in wider UK society (Bachmann & Gooch, 2017).

Whilst clinicians are unlikely to intend their responses to be rejecting or invalidating, the present findings show young people who experience self-harm or suicidality, and who are LGBTQ+, do experience interactions in these ways. NHS services aim to provide compassionate and inclusive care, and value service-user feedback (Rethink, 2005; NICE, 2011). In refusing to listen to the perspectives of service-users that do not match with our internal clinician narrative (a further dismissal of their experiences), we fail in this endeavour and limit opportunities for progress and change.

4.2.2 Making Sense of Identity

Developing awareness of one's LGBTQ+ identity can be confusing, particularly when surrounded by heterosexual expectations (Boe et al., 2020; Herek & Garnets, 2007), and there is no single trajectory for this process (BPS, 2019; Hunt, 2020). Participants experienced the process of understanding their own identity as an emotive one, which could involve different steps, sometimes in multiple directions, to figuring out what language and ways of understanding themselves made most sense to them. From an MST perspective, coming to terms with one's LGBTQ+ identity could also equate to an increase in experiences of stigma, discrimination, and harm

(Mongelli et al., 2019), which may increase distress and confusion experienced as part of this process.

Participants hoped for this process to be spoken about with clinicians, in an affirmative manner, and with consideration of the heteronormative context, yet often this was missed or dismissed by clinicians. This impacted quality of care; exploration in a meaningful, affirmative way, supports both young people's and clinicians' understanding of their experiences (Iacono, 2019). However, exploration could be used by clinicians to deny LGBTQ+ identities, based on heteronormative, ageist or sanist assumptions about identity development and stability. Previous research has highlighted similar concerns, with LGBTQ+ identities being rejected as a temporary phase rather than valid identities (McCann & Sharek, 2014), paving the way for harmful conversion practices, with a view that identity can still be changed to fit heterosexual norms, adding to a sense of not belonging (Crockett et al., 2022; Somerville, 2015; Stewart & O'Reilly, 2017).

NHS assessment processes aim to gather a quick but thorough understanding of a service-user's experiences and needs, to plan suitable interventions (NICE, 2016). This requires an understanding of the young persons' life context, and an ability to promote open and honest communication. Lack of exploration following LGBTQ+ identity disclosure meant clinicians missed important information in understanding the young person's needs, preventing them from being able to support effectively, or jointly make sense of these experiences. Indeed, understanding the life history and context of an individual provides key insights into experiences, and communications of distress, such as self-harm, for example increasing awareness of the impact of systemic factors, including stigma and discrimination (Gulliver et al., 2010; Mangnall & Yurkovich, 2008). The additional proximal and distal life stressors experienced by minoritised groups (Meyer, 2003), such as LGBTQ+ young people, are important to understand when providing support; recognising the factors that underlie and perpetuate these stressors, such as the heteronormative environment, highlights a direction for change.

4.2.3 The Importance of Relationships

Experiences of clinicians' overtly negative emotional responses, including disgust, embarrassment, and shock, emphasised that being LGBTQ+ was perceived as outside of expected societal norms. Such responses can reinforce the heterosexual and cisgender norms prevalent in both mental health services and wider UK society, positioning the young person as *an outsider* and reducing their sense of belonging (Gamarel et al. 2014). Discriminatory or negative responses in relationships may then be internalised, leading young people to feel shame and stigma towards themselves, further impacting their mental health (Meyer, 2003). From an attachment perspective, a safe-enough base is needed in the relationship, to facilitate change to improve mental health difficulties or reduce emotional distress (Bowlby, 1988; Barber et al., 2006). Therefore, work is needed within mental health systems to move away from homo/bi/trans/ace-phobic biases and assumptions more actively, to promote safety.

Participants' experiences could be understood as a 'moment of truth' (Johnson & Nemeth, 2014), whereby the clinician's response to LGBTQ+ identity disclosure informed the young person's decision about whether the clinician could provide the care they needed. Thus, a rupture in the relationship was experienced when the response was not supportive or affirmative, impacting the ongoing therapeutic relationship and potentially future interactions with other clinicians. These ruptures appeared not to be repaired or even noticed by clinicians, highlighting the often-invisible nature of heteronormativity to those who are not directly affected by it (Warner, 1991). Subsequently, there was an impact on engagement in support, with young people enacting strategies to protect themselves, for example disengaging from the relationship by withdrawal or reduced openness. Whilst the priority is therefore to improve affirmative responses within NHS services, a further question for exploration arises; is there scope for clinicians to repair these relationships?

The clinician's response impacted openness in the relationship, and lack of trust can inhibit openness (Mechanic & Meyer, 2000). Given that openness is paramount in ensuring mutual understanding between service-user and clinician (Eliacin et al., 2015; Ryan et al., 2010), the effectiveness of mental health interventions may be impacted as a result. Indeed, the development of trust and safety impacted participants' abilities to feel understood, and to be open about their LGBTQ+ identity and wider life experiences. Trust cannot be an automatic assumption; as a relational, bidirectional process, it requires work from both sides (Brown et al., 2009; Eliacin et al., 2015; Habermas, 1987), with participants valuing more informal approaches to relationship building. From an attachment perspective, for individuals whose life experiences mean they are fearful of others or expect rejection, it is understandable that trust will not be automatic (Green et al., 2011; Griffin & Bartholomew, 1994).

Relational safety can be impacted by past experiences, such as trauma and rejection, and consequently protective strategies may be activated in the face of potentially unsafe relationships (Sweeny & Taggart, 2018), such as disengagement. Previous research highlighted processes involved in assessing the safety of a clinical space, for example looking for affirmative signs like rainbow flags (Zullo et al., 2021). Whilst affirmative signs of safety were alluded to in the current study, there was also acknowledgement of the potential performative nature of allyship; aiming to be an ally did not intrinsically make the space safe enough to be open about LGBTQ+ identities.

Static characteristics, such as age, have also been linked to relational safety, with assumptions that younger clinicians may be more affirmative in their approach to LGBTQ+ identities, perhaps linked to changes in public perceptions in recent decades (Zullo et al., 2021). This was again found in the current study, particularly for the youngest participants. Whilst recognised as a potentially inaccurate method of assessing safety of disclosing LGBTQ+ identity, in the context of a heteronormative world and NHS and the lack of power young people experience in clinical relationships, any signs of potential allyship will likely be looked for, to aid their decision-making (Zullo et al., 2021).

The more affirmative and supportive experiences of participants in their LGBTQ+ identity disclosures in NHS mental health services highlighted the importance of acceptance, validation, and opportunity to continue the conversation. Positive and affirmative experiences of LGBTQ+ identity disclosure are associated with beneficial health-related outcomes (Kamen et al., 2015), and participants reflected on increased feelings of safety and comfort following affirmative experiences, where they were heard and understood. These outcomes are not difficult for clinicians to achieve, even in a short appointment, and are ostensibly key criteria within an initial appointment, yet individual biases and assumptions, alongside systemic heteronormativity, may limit affirmative practice.

4.3 Critical Review

To provide additional context for understanding and interpreting this study, an assessment of research quality is important (Braun & Clarke, 2021). A critical review is discussed in this section, considering the quality and limitations of the study, alongside researcher reflexivity, in line with the analytic process used in the study (Braun & Clarke, 2021).

4.3.1 Quality of Research

Whilst there are varied approaches to evaluating the quality of qualitative research, for purposes of this study, Yardley's (2015) principles are utilised to inform evaluation. This framework was chosen due to the focus on areas considered important within the overall research, which aimed to recognise the wider context through the lens of the pervasiveness of heteronormativity, to hear young people's voices, and impact clinical practice.

4.3.1.1 Sensitivity to Context

The individual, social, cultural, and political context in which young people disclose LGBTQ+ identities was considered, particularly in relation to systemic heteronormativity. A review of existing literature, including peer-reviewed research, government policy, and social media accounts enabled an understanding of the context the research was situated in, and the existing knowledge base.

The inclusion of a service-user consultant, who provided feedback on the research plan and interview schedule, promoted thinking about setting up the space to feel safe-enough for LGBTQ+ young people, increasing sensitivity to context. If time had permitted, additional joint thinking with multiple service-user consultants at all points of conception, development and realisation of this project, would have been beneficial, to further centre the life context of LGBTQ+ young people, and demonstrate commitment to reducing experiences of powerlessness.

Despite attempts for qualitative approaches to rebalance power for the participant (O'Connor & O'Neill, 2004), there is still an inherent power imbalance in a researcher-participant relationship; for example, the researcher holds power over where information about the participant is distributed. The positioning of participants as 'young people', and individuals who have used mental health services, may also have increased the imbalance of power, by enacting sanist and ageist assumptions (LeFrançois, 2013). Thus, steps were taken to develop a safe-enough environment for participation, and to enhance the quality of the research with sensitivity to context: As researcher, I briefly shared my own relationship to the study topic, and introduced myself using my pronouns, inviting participants to do the same. I aimed to provide an affirmative and validating stance during the interviews, using empathic responses to promote a supportive environment, demonstrating sensitivity to context.

The impact of pervasive heteronormativity was considered throughout this study, promoting awareness of the wider socio-political context of being LGBTQ+ in the UK. This enabled consideration of current and historical narratives in society and NHS services regarding identities perceived to be outside of the expected heterosexual and cisgender norms, enabling awareness of the inherent powerlessness experienced by many LGBTQ+ young people.

The reflexive approach enabled reflection on the researcher's views and assumptions alongside the existing research and participants' voices at all stages, to provide a narrative around the context and conceptualisations used in this study.

4.3.1.2 Commitment and Rigour

The study was developed utilising evidence of best-practice for rigorous qualitative research, from an RTA perspective (Braun & Clarke, 2021); the 6 stages of RTA were followed, and conversations with the research supervisor were utilised to provide an outside perspective and reduce insular thinking. Despite the small number of participants, RTA was chosen over other methods such as IPA. This was to best respond the research questions and aims, whilst adhering to the critical realist epistemology, utilising the reflexive approach to enable interpretation of the analysis within the context of a heteronormative world, and NHS mental health services.

A commitment was held to the aims and research questions; interview questions were deliberately broad, to enable a wide range of views, and opportunities were offered for participants to provide additional thoughts, which were utilised by several participants. Several participants made recommendations regarding changes to clinical practice to support LGBTQ+ young people, suggesting they felt able to utilise the space to share their views, and the researcher held a commitment to presenting these recommendations in this report as part of centring their perspectives.

4.3.1.3 Coherence and Transparency

This report aims to provide a transparent account of the research and process, including the thinking of the researcher at each stage, to inform the reader of the context of the findings. An extract from the researcher's notes demonstrating the reflexive process is included in Appendix U, to increase transparency into the thinking behind decisions involved in this study. Similarly, transparency was important with participants, who were openly informed about the aims of the study and offered opportunities to ask questions throughout the process.

The later discussion of study limitations also aids transparency and coherence, providing additional information to consider when assessing and interpreting the findings.

4.3.1.4 Impact and Importance

Several participants commented on the value of the research topic to them. The study aimed to centre the voices of young people and have an impact in terms of applications to clinical practice, and participants actively shared their experiences and recommendations, suggesting there was importance to them in the impact on clinical practice.

To take this impact further, dissemination will aim to promote reflection and change around clinician approaches to LGBTQ+ identity disclosure for young people, enabling participants' voices to be heard by clinicians and NHS services. It is important that dissemination does not simply speak to those who are already thinking about these topics, but to those for whom this is a new or perhaps more unknown area of work, impacted by heteronormative beliefs. There is an aim to share the findings in various formats and spaces, including as short and accessible recommendations to clinical teams, in peer reviewed journals, and conferences, to enhance the impact of the research in spaces where there is opportunity for change.

4.3.2 Study Limitations

The limitations of the study are explored here in the context of recruitment, and what may have contributed to difficulties in this area, as well as limitations in the sample, and study design.

4.3.2.1 Recruitment

Whilst the sample was smaller than the aim of 10-12 participants, and was limited in representation of several and intersecting aspects of identity, the voices of the five young people who did participate provided an important insight into their experiences. For purposes of this study, any one experience alone was instrumental in contributing new understandings of LGBTQ+ identity disclosure; indeed, any one negative experience occurring in NHS mental health services was considered by the researcher to be one too many, and therefore important to highlight. However, additional experiences, perspectives and themes may have been derived from analysis of further interviews, which may have contributed a more holistic view of the experience and impact of LGBTQ+ disclosure in mental health services, particularly for those with other intersecting marginalised identities who may have different experiences of the process and impact of disclosure (Purdie-Vaughns, & Eibach, 2008).

Various difficulties were faced in recruiting eligible participants. The original plan included recruitment through NHS services. However, due to the long process for gaining NHS ethical approval, and limited timeframes available due to the study being part of a university course, this arm of the study was unfortunately abandoned. Despite the importance within NHS services of feedback from service-users (Rethink, 2005; NICE, 2011), this highlights some of the difficulties for researchers in accessing the views of young people in contact with mental health services. The bureaucratic process, whilst ethically important, could be understood to essentially silence the voices of this group of young people further, preventing them from having the opportunity to be heard within this research, and reducing opportunities for their experiences in services to improve.

The study advert and approach may also have been biased towards those who had at least some negative experiences of LGBTQ+ identity disclosure in NHS mental health settings, given the framing of the study as related to heteronormativity. Thus, those with more neutral or positive experiences, or who did not relate to experiences of heteronormativity in mental health services, may have chosen not to participate. This was acknowledged in the setting up of the study, and it was considered that despite potential for such bias, there was an established basis for recognition of the impact of heteronormativity in healthcare (Law et al., 2015; LeFrançois, 2013; Morris et al., 2022). Similarly, there was importance to hearing narratives of negative experiences, as any one negative experience can be used to improve support for this group of young people.

It may have been difficult for participants to speak about poor experiences in NHS services to a researcher who identified as an NHS clinician in the study advert, reinforcing the power imbalance of clinician and service-user (Joseph-Williams et al., 2014). As researcher, I noticed my own reluctance to be particularly assertive with recruitment, as I did not want to perpetuate harmful experiences such as lack of control for this group of young people (Westberg et al., 2022; Zullo et al., 2021). Thus, despite having ethical approval to reach out to potentially eligible individuals directly on social media, I chose not to take this approach due to the sensitive topic of the study, leaving it to the young people themselves to choose to reach out, rather than pressure coming from an adult, clinical figure. However, this may have reduced opportunities for potential participants to engage in the study.

4.3.2.2 Participant Characteristics

Whilst there was variety in participants’ age, all were over 16. The requirement for parental consent may have been a factor preventing younger adolescents from participating, given the context of confidentiality concerns outlined by participants in this study. Some young people may not have wanted their parents to know their

LGBTQ+ identity, or their experiences of self-harm and suicidality (Fisher & Mustanski, 2014). Therefore, the voices of young people who chose not to participate for such reasons, amongst others, were not able to be heard, and thus important perspectives and experiences may have been missed.

The majority of participants were white, limiting the cultural diversity of the study. There are known barriers to accessing NHS mental health services for marginalised communities, and the often harmful experiences within services, including the impact of institutional racism (Halvorsrud et al., 2018; Healy & McKee, 2004). Indeed, powerlessness and voicelessness experienced by racialised individuals accessing mental health services (Sainsbury Centre for Mental Health, 2002) interacts with the powerlessness experienced in the context of being LGBTQ+ and young in age (Schmitz & Tabler, 2019). Therefore, this study may not have captured the views of young people inhabiting additional marginalised identities, such as their ethnicity or disability, whose experiences of LGBTQ+ identity disclosure are likely impacted by these intersecting elements of marginalisation.

Interestingly, all participants had disclosed their LGBTQ+ identity to multiple clinicians, having accessed mental health services for a period greater than one year. Their ability to compare experiences, both helpful and harmful, over time, perhaps increased their desire to have their voices heard and promote change. Whilst this was useful in providing insight into a variety of experiences and post-disclosure impacts, this sample may have missed differences in perspectives from those who accessed fewer services, or who only had one experience of disclosure without additional comparisons. Indeed, there are differences in how difficulties with self-harm are experienced by those for whom difficulties persist longer-term, compared to shorter-term (Storey et al., 2005); those who experienced longer-term access to mental health services may have had a different relationship to their mental health needs, and to LGBTQ+ identity disclosure in mental health services, than those who did not seek help, were unable to access services, or for whom shorter-term support was sufficient.

All participants were female or used she/her pronouns. Self-harm is more commonly reported by young women, and therefore the study requirement for openly identifying with these experiences may have increased the likelihood of female participants taking part (Hawton et al., 2002). Similarly, whilst some participants spoke of gender fluidity, no participants explicitly identified as transgender or non-binary. These voices are particularly important to recognise as missing from this study, given the continued discrimination and identity denial experienced by transgender young people in both healthcare and media spaces in the UK (Bachman & Gooch, 2017). This rhetoric may have contributed to difficulties young people faced in accessing this study, in a fear of discrimination that could result from an encounter with a mental health professional. There may have been concerns about the safety of the space, and whether it would be an affirmative one; participation necessitated a new disclosure, to the researcher, and thus the aforementioned process of assessing safety was likely to have occurred internally for all potential participants. Young people may have chosen to avoid speaking about their experiences, to protect themselves (Grossman & D'Augelli, 2006).

To promote engagement, self-harm and suicidality were not explicitly asked about during the interviews, as the research questions focused on experiences of LGBTQ+ identity disclosure, for this group of young people, rather than explicitly about their self-harm experiences. It was hoped that this would enable young people to hold some of the power in the interview, to choose whether self-harm and suicidality was a topic they wanted to speak about, and to encourage participation in the study. Often these can be private experiences, and confidentiality practices can be somewhat opaque (Wadman et al., 2018), so it was thought young people may feel safer participating knowing they could choose whether to speak about these experiences. However, a limitation of this approach was that potential links between self-harm and suicidality and identity disclosure experiences were not explicitly explored, and the lack of explicit questioning may have limited opportunities for participants to make these links in the interviews, reducing the focus on this aspect of their experience in the analysis.

4.3.2.3 Study Development

There were limitations in the method used, which was developed primarily by the researcher, in part due to limited timeframes. Thus, the interview questions and topics covered may have been biased, in line with the researcher’s views and expectations. Whilst participants were encouraged to bring additional ideas not explicitly covered by the questions, it was still a researcher-led interview. The critical-realist stance of this study held an assumption that there were observable lived-realities and consequences of heteronormativity, for those positioned as inhabiting identities outside of this expected norm; however, this stance was determined by the researcher. This may have limited alternative understandings of the world that might have been held by participants, and the impact of the bidirectional process of the interview on the construction of knowledge (Pearce, 2002). Indeed, a social-constructionist stance may have enabled more focus on the direct and varied lived-experiences of young people, including their constructions of identity (in the context of heteronormativity, and other social contexts), through their choice of language (Butler, 2003).

Whilst there was input from a service-user consultant in developing the interview questions, it would have been beneficial to have co-developed the entire study in collaboration with young people, for example using a Participatory Action Research format (Freire, 1972). This could have enabled more choice and autonomy on behalf of the young people, promoting change to systems as a direct part of the research (Minkler et al., 2002). As the findings of this study emphasise the lack of power, including lack of voice and autonomy experienced by participants, centring young peoples' perspectives in research about their experiences is paramount.

RTA as an analytic approach is often utilised with larger samples. However, despite the small sample in the current study, RTA was chosen due to the broad focus, enabling themes to be developed across all the interviews (Braun & Clarke, 2021). In addition, RTA promoted active reflexivity that allowed for researcher experiences to be incorporated into the analysis, alongside the framework of pervasive heteronormativity and MST (Braun & Clarke, 2021). Similarly, Braun and Clarke (2021) suggest that practicalities of data collection be incorporated into decisions around sample size; in the present study, limited timeframes and difficulties accessing a group of individuals who may not want to disclose their LGBTQ+ identity to another healthcare professional may have reduced the potential pool of participants available. The relatively small sample in this study may have been more suited to an IPA approach, which could have provided opportunities for in-depth exploration of experiences, focusing on the individual interview content rather than the interviews as a whole (Smith et al., 2009). This may have led to a different focus of the themes developed, given the differences in length of the interviews, but equally may have missed interesting threads of commonalities across the interviews.

4.3.3 Reflexivity

As researcher, I was aware I came from a particular position, in my relationship to heteronormativity, having witnessed and experienced impacts that I associated with pervasive heteronormativity in mental health services. Thus, the findings were interpreted and discussed through this lens, which was only one possible lens out of many; the key findings may have resonated differently with another researcher, and led to different, unexplored avenues of importance. Similarly, participants words were shared in the context of their relationship to me, as researcher, which may have been different to relationships developed with another researcher, due to my personal style and connection to the topic (Eide & Kahn, 2008). Different topics or ideas may have arisen in the context of a different researcher-participant relationship. Indeed, as a white, cisgender researcher, adding to my position of power and privilege, alongside my roles as clinician and adult, there may have been topics young people chose not to mention due to the power imbalance (Milligan, 2016).

I was aware that I was relatively open in my reactions, rather than taking a neutral stance, for example providing validation and reassurance. This was part of an aim to promote a compassionate and safe-enough space, to provide a different experience to the silencing and invalidation being spoken about by participants. I did not want to re-enact those damaging experiences, and instead aimed to provide a space where they could feel accepted and heard. This was in line with the ethos of RTA, which posits that it is not possible nor desirable to extricate oneself from the research (Braun & Clarke, 2023). However, whilst empathy and validation can increase trust and interview depth (Mauthner et al., 2002), a power imbalance remains, with the words of the interviewees, shared in the context of the researcher-participant relationship, being also shared on a wider public scale by the researcher (Kvale, 2006).

This research aimed to promote change to clinical practice; as a clinician, I was aware of a drive to present the findings in a manner that would be acceptable to other clinicians. However, I was also aware this could further silence young people's voices, and aimed to resist this drive and present the findings in a way that honoured emotional valence and language used by participants. Through this, it was hoped experiences and impacts of heteronormativity in practice (often invisible to those not directly affected), can be witnessed and recognised by clinicians, promoting thinking about our own practice and work within teams and services. However, I acknowledge that the interpretations of the words of young people in the findings are my own, and therefore cannot be directly seen to represent young people's perspectives entirely (Braun & Clarke, 2021).

4.4 Implications

The power held by clinicians to silence, invalidate, and reject young people due to their LGBTQ+ identity is discriminatory and causes harm (Grant et al., 2011; Hunt, 2020). Alongside missed opportunities for conversations around sexual and gender identity, and difficulties in clinical relationships following LGBTQ+ identity disclosure, this highlights the need for change. Participants provided specific thoughts on how this could be achieved, which are considered here alongside researcher-derived recommendations from the results.

4.4.1 Clinical Implications

Young people's voices, as those who are directly experiencing these situations, provide clarity on the changes needed within mental health systems to improve their experiences and outcomes related to LGBTQ+ identity disclosure; sharing these experiences with clinical audiences has power to promote change (Sweeny & Taggart, 2018). These implications are considered at the individual level of the clinical relationship, the service level, and wider policy level, accounting for the impact of heteronormativity in all areas of life impacting experiences of this group of young people in NHS mental health services.

4.4.1.1 Individual Implications

Participants expressed a desire for having a voice in their mental healthcare experiences, and to be included in conversations around decisions related to LGBTQ+ identity disclosure. Confidentiality was important to consider in clinical interactions; participants shared a preference for LGBTQ+ disclosure to occur on their terms. Participants hoped to be involved in decision processes, for example by clinicians holding open and honest conversations about information sharing.

This may be particularly important for young people who also experience difficulties with self-harm or suicidality, for whom contact between clinicians and parents/guardians is common. There is importance to mentalising the young person's perspective about what it might be like, knowing there is this contact, in their assessment of safety of LGBTQ+ disclosure and in subsequent clinical interactions. Indeed, previous research has noted the importance of clear conversations around the limits of confidentiality for this group of young people (Zullo et al., 2021). Transparent conversations about what information is being shared are therefore important, specifically naming that LGBTQ+ identity will not be shared unless agreed with the young person.

Participants recommended clinicians not make assumptions about how and when a young person might feel able to disclose their LGBTQ+ identity, for example not asking in front of parents, and providing multiple, subtle opportunities to disclose in their own time. This could reduce pressure to have a fully formed sense of identity, and could increase empowerment and choice, which may be limited in other areas of young people's healthcare experiences (Westberg et al., 2022). This approach also encourages clinicians to be aware of the potential fluidity of identity development (Mosher, 2001), and the potential that a young person might still be making sense of their identity or in the process of coming out to themselves internally.

Similarly, participants hoped for opportunities to speak in more depth about their LGBTQ+ identities, to make sense of this part of themselves, in a heteronormative world, and to bring themselves and their experiences more holistically into sessions. Participants acknowledged how integrating opportunities into conversation in a more subtle or casual manner could aid their decision to disclose, and enable affirmative exploration.

There was a bidirectional impact of clinical relationships on experiences of LGBTQ+ identity disclosure; there is importance to clinicians providing space for affirmative, compassionate, and meaningful experiences of disclosure, which in turn could improve the quality of the relationship. This included not assuming heterosexuality, and using gender-neutral language. Compassion and understanding by clinicians in response to LGBTQ+ disclosure, including an understanding of how difficult the process of disclosure might be, may enable young people to be more able to explore topics that might be important to them.

Trust can take time to build, particularly for young people who may have experienced rejections, and cannot be assumed or expected at the start of clinical interactions. Building trust is not always solely related to a clinician's own reaction, but also the history and context of the young person's life, including the impact of prior LGBTQ+ identity disclosure experiences on their relationship to help (Reder & Fredman, 1996). This could include prior experiences within the same relationship; participants noted how ruptures in the context of LGBTQ+ identity disclosure can lead to decisions not to trust or be open with clinicians, as a protective reaction. However, in some instances where clinicians take the time to repair these ruptures, perhaps by demonstrating understanding, openly reflecting on their actions, and showing willingness to learn and change, relationships may improve (Safran et al., 2011; Walser & O'Connell, 2021).

Whilst there is no one clear *right* way of approaching LGBTQ+ identity disclosure or exploration, given that different young people hold different preferences, there is importance to holding an affirmative stance, transparent conversations, and enabling space for further conversation.

4.4.1.2 Service Implications

Given the power held by clinicians to silence and invalidate LGBTQ+ young people, consciously or unconsciously, there is importance to considering the current levels of understanding and knowledge in this area amongst clinicians, recognising this is an ongoing process for all. Experiences of invalidation related to LGBTQ+ identities are discriminatory and harmful. Indeed, patterns of invalidation and rejection present in other areas of young people's lives can be replicated in mental health services, causing iatrogenic harm (Bloom, 2006). With a drive towards trauma-informed understandings within NHS services, there is importance not only to considering the ways current systems can retraumatise service-users, but to actively move against these systems to prevent continued harm (Beale, 2022; Sweeney et al., 2016; Tickle, 2022).

Although only one participant explicitly spoke of training, there was wider recognition of a lack of competence and confidence amongst some clinicians, including uncertainty in how to approach conversations around LGBTQ+ identity, impacting young peoples' decisions to disclose and ability to utilise support. Clinicians are known to want further training, to improve confidence and understanding in this work (Acosta et al., 2019; McDermott et al., 2018), and yet despite this desire for more from all sides, appropriate training has not been realised on a wide scale.

Whilst training is important, the process and frame of training needs to be considered, to promote effectiveness. Staff trainings, when provided in a one-off session, are unlikely to facilitate lasting change (Burge et al., 2021; Tickle, 2022), and therefore ongoing support, learning, and thinking is required. Ultimately, a shift in the wider culture of services and NHS is required, to prevent the harm that continues to be experienced in mental health services (Beale, 2022). Within the fast-paced NHS service structure, thinking is needed about how best to incorporate ongoing learning regarding experiences of LGBTQ+ young people, to facilitate reflection and lasting change to ways of working, accounting for the wide-reaching effects of heteronormativity.

4.4.1.3 Policy Implications

Changes at policy level are needed to negate the potential for harm to this group of young people in NHS mental health services, to enable more affirmative care. Clinical Psychologists, in our professional aim to improve lives, hold a responsibility for actively challenging discrimination and harmful practice, within healthcare and the wider social world, where contexts such as heteronormativity impact the lives of people we support (Rahim & Cooke, 2019). Current guidance encourages validation of LGBTQ+ identities, and utilising affirmative and accepting exploration, alongside awareness of the historical and social context of stigma and discrimination for LGBTQ+ people (BPS, 2019). However, as guidelines, these are not necessarily adhered to by all, and are not specific to the needs of young people; given the invalidating and silencing experiences in the current study, and the context of age as a factor increasing powerlessness, additional guidelines for adolescents and young adults may be beneficial to support clinical practice.

There is a need for young people to be protected from practices which may constitute conversion therapy, and which lead them to feel their identities are not valid or acceptable. The continued government resistance to a complete ban on conversion therapy (Stonewall, 2021) creates a heteronormative environment of fear for young people accessing mental health services. Clinical Psychologists have a role in lobbying for change to these discriminatory systems, which enable an environment which allows NHS mental health services to continue responding to LGBTQ+ young people experiencing distress in rejecting, invalidating, and negative ways.

4.4.2 Research Implications

Whilst research to include participants from a broader range of cultural and social backgrounds would be helpful in further assessing the current landscape (Purdie-Vaughns, & Eibach, 2008), action to promote change is also needed. The findings of this study, combined with previous research already calling for action (Hunt et al., 2019; LeFrançois, 2013; McDermott et al., 2018), suggests that despite ongoing evidence of the negative impact of heteronormativity present in NHS mental health care, meaningful and lasting change has yet to be realised.

Further research could evaluate interventions and approaches aimed at changing the current system, to reduce harmful outcomes of invalidation and powerlessness, and improve understanding and attitudes towards LGBTQ+ young people. This may include training programmes, with an aim for changing attitudes (a need also highlighted by Hunt and colleagues, 2019), integrated with ongoing support or supervision arrangements within organisations. This could improve awareness and understanding of the needs of LGBTQ+ young people who experience difficulties with self-harm or suicidality, and their social context, in day-to-day clinical practice. Wider scale research, at an organisational level, is likely to be important, as cultural change requires change throughout an organisation (Nutley & Davies, 2001).

4.5 Conclusions

This study provides an insight into experiences of young people who have experienced self-harm or suicidality, in their disclosures of LGBTQ+ identities in NHS mental health services, including powerlessness, with young people's voices silenced and their identities invalidated, and feeling unsafe in the clinical relationship. These experiences are likely exacerbated for this group of young people, being LGBTQ+ and experiencing self-harm or suicidality, given the additional stigma and discrimination for these groups in wider society. Resulting impacts were identified, including hiding their identities, disengaging from support, deteriorating mental health, and not having opportunities to explore their identity in meaningful ways.

Thus, there appears continued reliance on heteronormative assumptions within NHS mental health services, to the detriment of young people's mental health and sense of identity. Rejection and invalidation can amount to discrimination and lead to iatrogenic harm, and the existence of these experiences warrants further consideration of the ways LGBTQ+ young people who self-harm or experience suicidality are responded to in NHS mental health services; imminent changes are needed to prevent ongoing harm.

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APPENDICES

Appendix A: Search Terms for Literature Search 1

The terms varied slightly between databases, due to the use of Subject Index terms which varied across databases, but were kept as consistent as possible.

Database 1: PsycInfo

((DE "LGBTQ" OR DE "Gender Identity" OR DE "Sexual Orientation" OR DE "Asexuality" OR DE "Bisexuality" OR DE "Homosexuality" OR DE "Transgender" OR DE "Coming Out" OR "heteronormative" OR "heteronormativity" OR "rainbow") AND (DE "Mental Health Services" OR DE "Community Mental Health Services" OR DE "Counseling" OR DE "Mental Health Programs" OR DE "Psychiatric Hospital Programs" OR DE "Counselors" OR DE "Mental Health Personnel" OR DE "Psychologists" OR DE "Social Workers" OR DE "Therapists" OR DE "Psychiatric Nurses" OR DE "Psychiatrists" OR DE "Psychotherapists") AND ("teenage" OR "young person" OR "young people" OR "youth" OR "adolescent" OR "young adult"))

Database 2: Academic Search Ultimate

((DE "BISEXUALS" OR DE "GAY people" OR DE "LESBIANS" OR DE "LGBTQ students" OR DE "TRANSGENDER people" OR DE "LGBTQ identity" OR DE "SEXUAL minorities" OR DE "ASEXUAL people" OR DE "LGBTQ youth" OR DE "LGBTQ+ people" OR DE "SEXUAL minority youth" OR DE "BISEXUAL youth" OR DE "GAY youth" OR DE "LESBIAN youth" OR DE "LGBTQ teenagers" OR DE "LGBTQ young adults" OR DE "COMING out (Sexual orientation)” OR DE "TRANSGENDER youth" OR "RAINBOW" OR "heteronormative" OR "heteronormativity") AND (DE "CHILD mental health services" OR DE "MENTAL health services" OR DE "MENTAL health personnel" OR DE "CLINICAL psychologists" OR DE "PSYCHIATRIC nurses" OR DE "PSYCHIATRISTS" OR DE "PSYCHOTHERAPISTS" OR DE "MENTAL health practitioners" OR DE "PSYCHIATRIC social workers" OR DE "PSYCHOLOGISTS") AND ("teenage" OR "young person" OR "young people" OR "youth" OR "adolescent" OR "young adult"))

Database 3: CINAHL

(("sexual orientation" OR "SEXUAL minority" OR "ASEXUAL" OR "BISEXUAL" OR "GAY" OR "LESBIAN" OR "LGBT" OR "COMING out" OR "TRANSGENDER" OR "RAINBOW" OR "heteronormative" OR "heteronormativity") AND ("mental health service" OR "MENTAL health personnel" OR "PSYCHIATRIC nurse" OR "PSYCHIATRIST" OR "PSYCHOTHERAPIST" OR "MENTAL health practitioner" OR "social worker" OR "PSYCHOLOGIST") AND ("teenage" OR "young person" OR "young people" OR "youth" OR "adolescent" OR "young adult"))

Database 4: Scopus

TITLE-ABS-KEY (({sexual orientation} OR {SEXUAL minority}
OR {ASEXUAL} OR {BISEXUAL} OR {GAY} OR {LESBIAN} OR {LGBT}

OR {COMING out} OR {TRANSGENDER} OR {RAINBOW} OR {heteronormative} OR {heteronormativity}) AND ({mental health service} OR {mental health personnel} OR {PSYCHIATRIC nurse} OR {PSYCHIATRIST} OR {PSYCHOTHERAPIST} OR {mental health practitioner} OR {social worker} OR {PSYCHOLOGIST})
AND ({teenage} OR {young person} OR {young people} OR {youth} OR {adolescent} OR {young adult})) AND (LIMIT-TO (LANGUAGE ,"English"))

Appendix B: Literature Search 1: Flow Chart of Process

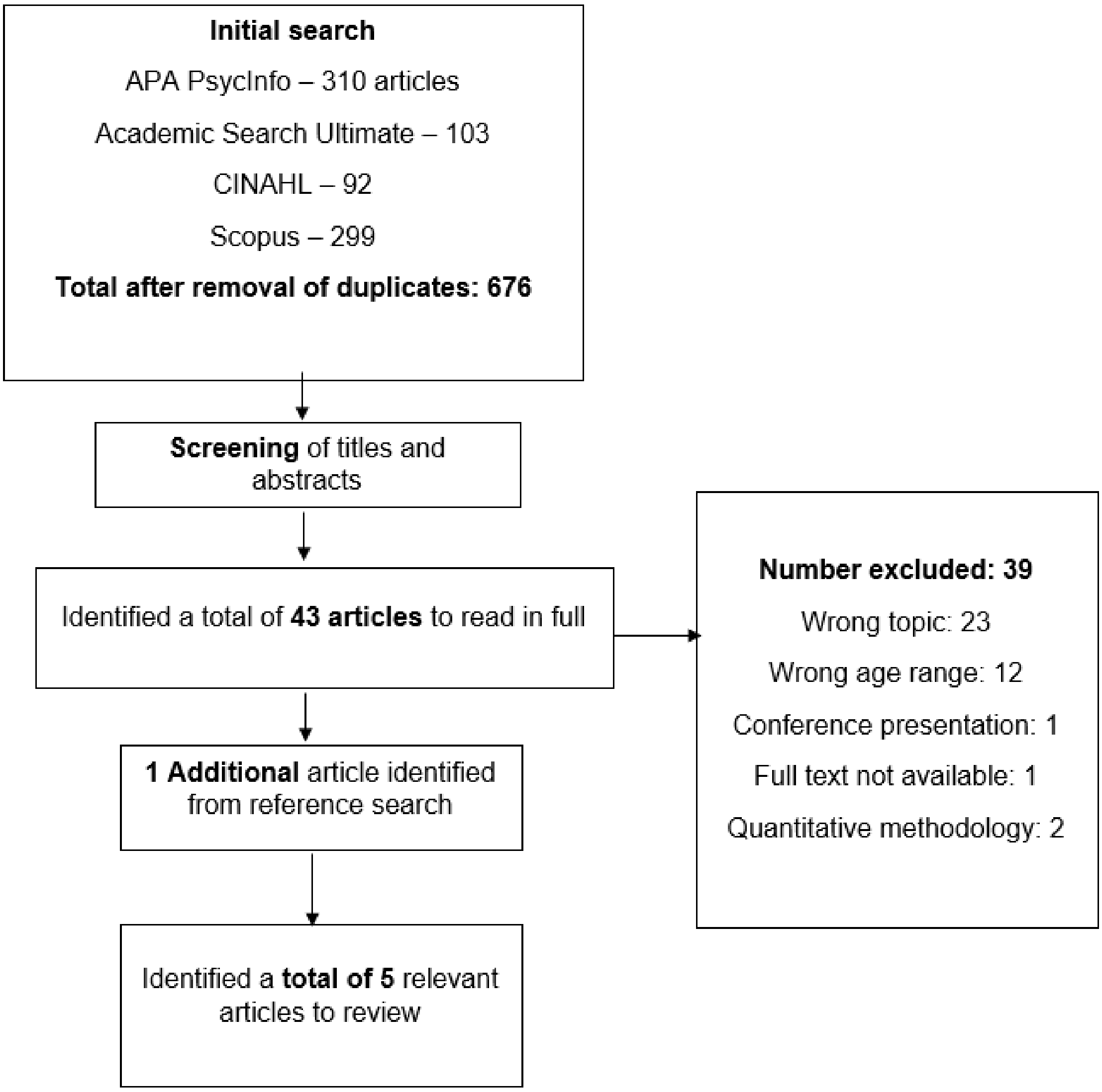


Figure 2

Flow Chart of literature search 1

Appendix C: Table of Studies Included in Literature Search 1

Table II.

Summary of studies selected in first literature review

Authors	Title	Year	Key Themes	Country	Age range	Sample Size
Crockett et al.	Barriers and Facilitators to Mental Health Help-Seeking and Experiences with Service Use among LGBT+ University Students in Chile	2022	Experiences, LGBTQ+ university students, mental health services	Chile	18-23 years	24
Carlile.	"It's like my kid came back overnight": Experiences of trans and non-binary young people and their families seeking, finding and engaging with clinical care in England.	2021	Experiences, transgender and non-binary young people, families, NHS	England	5-20 years	13 families
Acosta et al.	Identify, Engage, Understand: Supporting Transgender Youth in an Inpatient Psychiatric Hospital.	2019	Experiences, transgender young people, inpatient mental health	United States of America (USA)	13-17 years	9
Zullo et al.	Treatment Recommendations and Barriers to Care for Suicidal LGBTQ Youth: A Quality Improvement Study.	2021	Experiences, LGBTQ+ young people, suicidality, mental health services	USA	12-25 years	41

Hunt.	Experiences of therapy in a gender and sexually diverse world.	2020	Young people, experiences, LGBTQ+ disclosure, therapy	UK (spoke about experiences in other countries)	13-25 years	8

Appendix D: Search Terms for Literature Search 2

As above, terms varied slightly between databases, due to the use and language of Subject Index terms available in some databases.

Database 1: PsycInfo

(("Suicide" OR "Suicidal Behavior" OR "Nonsuicidal Self-Injury" OR "Suicidality" OR "self-harm" OR "self harm" OR "self injury") AND ("young people" OR "youth" OR "teenage" OR "adolescent" or "young adult") AND (DE "Mental Health Services" OR DE "Community Mental Health Services" OR DE "Counseling" OR DE "Mental Health Programs" OR DE "Psychiatric Hospital Programs" OR DE "Counselors" OR DE "Mental Health Personnel" OR DE "Psychologists" OR DE "Social Workers" OR DE "Therapists") AND ("experience" OR "stigma" OR "discrimination" OR "feedback" OR "views" OR "attitude" OR "help-seek" OR "seeking help"))

Database 2: Academic Search Ultimate

(("Suicide" OR "Suicidal Behavior" OR "Nonsuicidal Self-Injury" OR "Suicidality" OR "self-harm" OR "self harm" OR "self injury") AND (DE "CHILD mental health services" OR DE "MENTAL health services" OR DE "MENTAL health personnel" OR DE "CLINICAL psychologists" OR DE "PSYCHIATRIC nurses" OR DE "PSYCHIATRISTS" OR DE "PSYCHOTHERAPISTS" OR DE "MENTAL health practitioners" OR DE "PSYCHIATRIC social workers" OR DE "PSYCHOLOGISTS") AND ("teenage" OR "young person" OR "young people" OR "youth" OR "adolescent" OR "young adult") AND ("experience" OR "stigma" OR "discrimination" OR "feedback" OR "views" OR "attitude" OR "help-seek" OR "seeking help"))

Database 3: CINAHL

(("Suicide" OR "Suicidal Behavior" OR "Nonsuicidal Self-Injury" OR "Suicidality" OR "self-harm" OR "self harm" OR "self injury") AND ("CHILD mental health services" OR "MENTAL health services" OR "MENTAL health personnel" OR "CLINICAL psychologists" OR "PSYCHIATRIC nurses" OR "PSYCHIATRISTS" OR "PSYCHOTHERAPISTS" OR "MENTAL health practitioners" OR "PSYCHIATRIC social workers" OR "PSYCHOLOGISTS") AND ("teenage" OR "young person" OR "young people" OR "youth" OR "adolescent" OR "young adult") AND ("experience" OR "stigma" OR "discrimination" OR "feedback" OR "views" OR "attitude" OR "help-seek" OR "seeking help"))

Database 4: Scopus

TITLE-ABS-KEY (({Suicide} OR {Suicidal Behavior} OR {Nonsuicidal Self-Injury} OR {Suicidality} OR {self-harm} OR {self harm} OR {self injury}) AND ({mental health service} OR {mental health personnel} OR {PSYCHIATRIC nurse} OR {PSYCHIATRIST} OR {PSYCHOTHERAPIST} OR {mental health practitioner} OR {social worker} OR {PSYCHOLOGIST}) AND ({teenage} OR {young person} OR {young people} OR {youth} OR {adolescent} OR {young adult}) AND ({experience} OR {stigma} OR {discrimination} OR {feedback} OR {views} OR {attitude} OR {help-seek} OR {seeking help})) AND (LIMIT-TO (LANGUAGE , "English"))

Appendix E: Literature Search 2: Flow Chart of Process

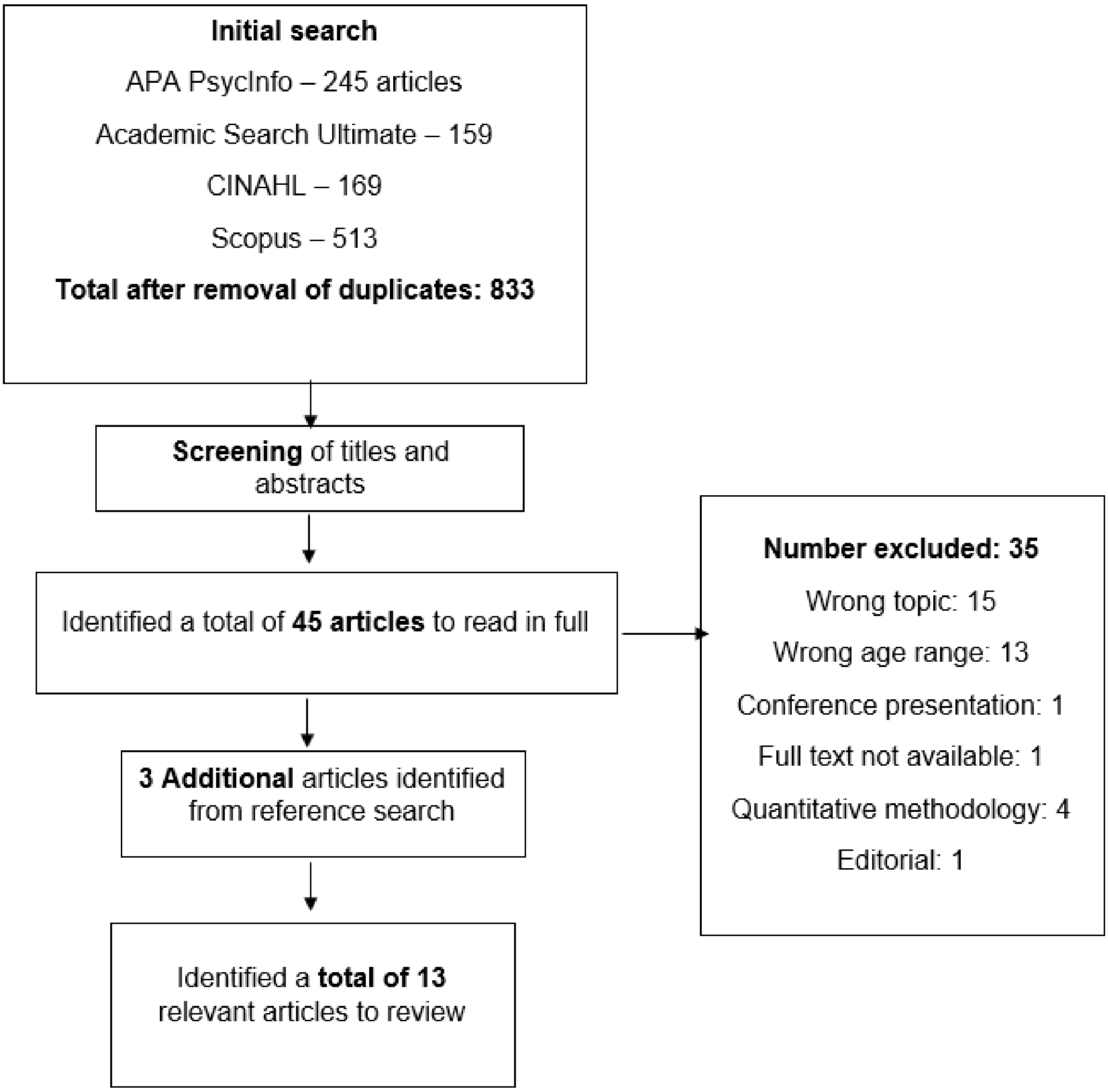


Figure 3

Flow Chart of Literature Search 2 Process

Appendix F: Table of Studies Included in Literature Search 2

Table III.

Summary of studies selected in second literature review

Authors	Title	Year	Key Themes	Country	Age range	Sample Size
Jordan et al.	Providing Meaningful Care: Learning From the Experiences of Suicidal Young Men	2012	Experiences, healthcare, suicidality, young men	Northern Ireland	Young men (but age range not defined)	36
Balcombe et al.	Engagement with young people who self-harm	2011	Experiences, CAMHS, self-harm, young people	UK	12+ young people (exact range not specified, but all accessing CAMHS)	3
Zullo et al.	Treatment Recommendations and Barriers to Care for Suicidal LGBTQ Youth: A Quality Improvement Study	2021	Experiences, LGBTQ+ young people, suicidality, mental health services	USA	12-25	41
Mughal et al.	Experiences of general practice care for self-harm: A qualitative study of young people's perspectives	2021	Young people, experiences, mental health support, self-harm	UK	16-25	13
Gilmour et al.	Review: The views and experiences of suicidal children and	2019	Review, experiences, support, young	Review – multiple countries	11-25	n/a - review

	young people of mental health support services: A meta-ethnography		people, suicidality			
Idenfors et al.	Professional care as an option prior to self-harm: A qualitative study exploring young people's experiences	2015	Young people, views, professional support, self-harm	Sweden	17-24	9
Wadman et al.	Experience of Self-Harm and Its Treatment in Looked-After Young People: An Interpretative Phenomenological Analysis	2018	Experiences, young care-experienced people, support, self-harm	UK	14-21	14
Clamp	What outcome goals do young people aged 16 to 20 years who self-harm have for therapy and what in therapy helped or hindered them in achieving these goals.	2021	Young people, outcomes, IAPT, self-harm	UK	16-20	10
Hassett & Isbister.	Young Men’s Experiences of Accessing and Receiving Help From Child and Adolescent Mental Health Services Following Self-Harm	2017	Young men, CAMHS, self-harm/ suicidality	UK	16-18	8

McAndrew, & Warne.	Hearing the voices of young people who self-harm: Implications for service providers	2014	Self-harm, narratives, young people	UK	13-17	7
Storey, et al.	Supporting young people who repeatedly self-harm	2005	Experiences, self-harm journey, support, young people, A&E	UK	16-22	74
Mitten et al.	The perceptions of adolescents who self-harm on stigma and care following inpatient psychiatric treatment	2016	Young people, experiences, stigma, inpatient mental health	Canada	14-19	12
Murray & Wright.	Integration of a suicide risk assessment and intervention approach: The perspective of youth.	2006	Retrospective experience, risk assessment, adolescent, mental health services	Canada	14-19	3

Appendix G: Recruitment Emails

Organisations relevant to LGBTQ+ young people and mental health were approached for potential recruitment. Below is an example of an email sent to introduce the study and request recruitment support:

Dear XXXX,

I am a Trainee Clinical Psychologist at the University of East London, and am looking into options for recruiting participants for my thesis project. I am conducting a piece of research to explore the experiences of young people who identify as LGBTQ+ and who have disclosed this identity within NHS mental health services (CAMHS). The aim is to hear young people's voices and experiences in their own words, via 1:1 interviews, to promote more helpful practices within CAMHS.

I am wondering if it would be possible to advertise / recruit for participants through your organisation? I am currently at an early stage of planning, and would of course be happy to provide all relevant ethical, safeguarding, procedural information etc in due course. Currently I am at the stage of scoping out where I might be able to recruit participants, but actual recruitment would not be until the summer. Very happy to discuss further.

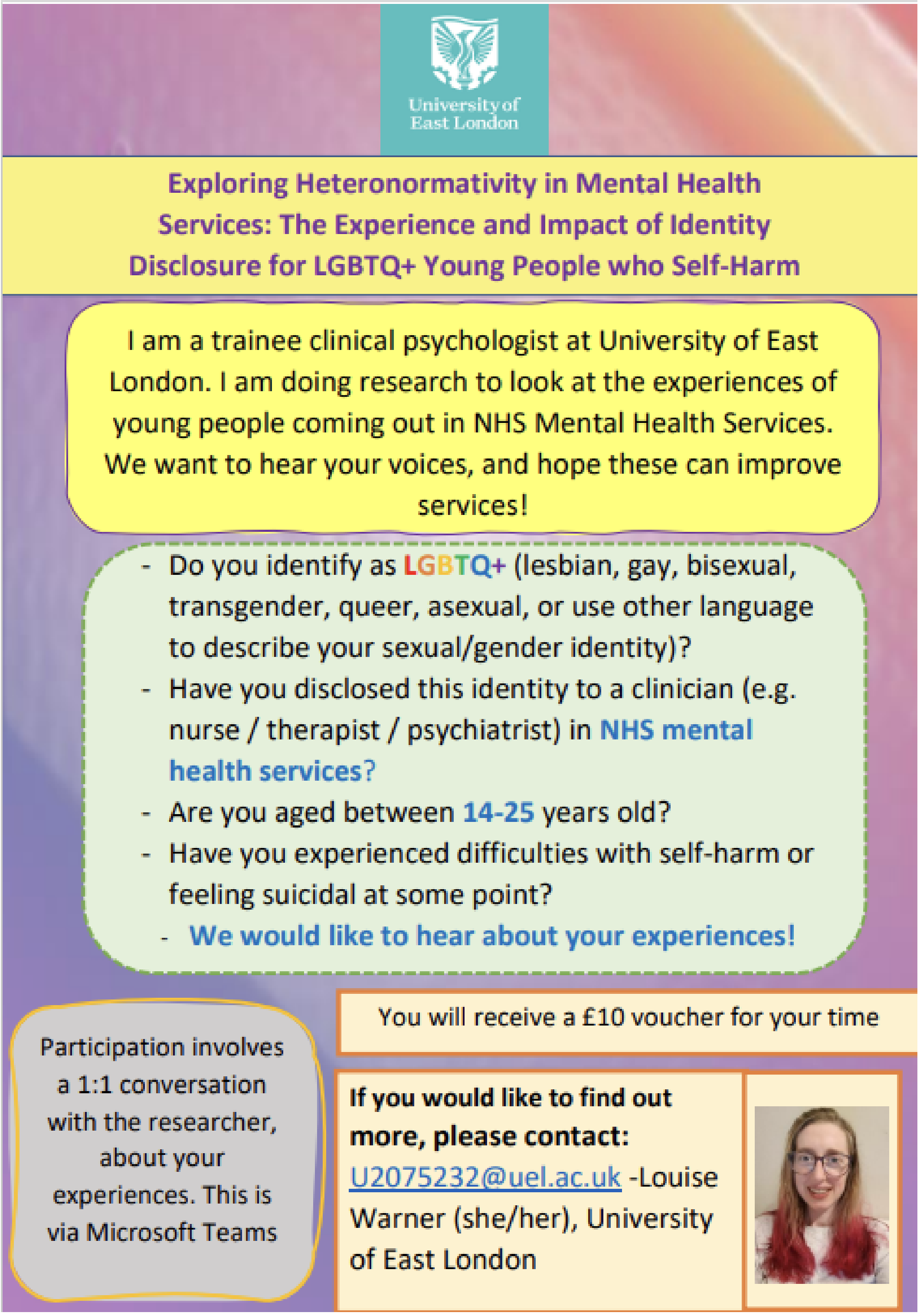
Many thanks,
Louise

Louise Warner (she/her)
Trainee Clinical Psychologist
University of East London

Appendix H: Study Advert

There were two iterations of the study advert used for recruitment.

Final version:



University of East London

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

I am a trainee clinical psychologist at University of East London. I am doing research to look at the experiences of young people coming out in NHS Mental Health Services. We want to hear your voices, and hope these can improve services!

- Do you identify as LGBTQ+ (lesbian, gay, bisexual, transgender, queer, asexual, or use other language to describe your sexual/gender identity)?
- Have you disclosed this identity to a clinician (e.g. nurse / therapist / psychiatrist) in **NHS mental health services?**
- Are you aged between **14-25** years old?
- Have you experienced difficulties with self-harm or feeling suicidal at some point?
- **We would like to hear about your experiences!**

Participation involves a 1:1 conversation with the researcher, about your experiences. This is via Microsoft Teams

You will receive a £10 voucher for your time

If you would like to find out more, please contact: U2075232@uel.ac.uk -Louise Warner (she/her), University of East London

Earlier version:

University of East London

Exploring the Experience and Impact of Heteronormativity in CAMHS

I am a trainee clinical psychologist at University of East London. I am doing research to look at the experiences of young people coming out in CAMHS. We want to hear your voices, and hope these can improve services!

- Do you identify as **LGBTQ+** (lesbian, gay, bisexual, transgender, queer, asexual, or use other language to describe your sexual/gender identity)?
- Have you disclosed this identity to a clinician (e.g. nurse / therapist / psychiatrist) in **NHS CAMHS**?
- Are you aged between **14-20** years old?
- Have you experienced difficulties with self-harm or feeling suicidal at some point?

We would like to hear about your experiences!

Participation involves a 1:1 conversation with the researcher, about your experience in CAMHS. This is via Microsoft Teams

You will receive a £10 voucher for your time

If you would like to find out more, please contact:
U2075232@uel.ac.uk -Louise Warner (she/her), University of East London

Appendix I: Demographics Questionnaire

University of
East London

Demographic Information

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People Who Self-Harm

How old are you? ___________________________________

How do you describe your ethnicity? ____________________________

How do you describe your gender identity? _______________________

How do you describe your sexual orientation? _________________________

Approximately how long have you been going to NHS mental health services? (please tick the box below)

☐	☐	☐	☐
Less than 1 month	1-6months	6-12 months	Over 1 year

Inclusion criteria:

We need to check that you meet the criteria for the study at this time, to ensure we are able to use the data of all participants who kindly give their time to the study. Please can you confirm if the following statements are correct for you by ticking the boxes below:

1) You have disclosed your gender or sexual identity to an NHS mental health services clinician? ☐
2) Have you ever self-harmed or experienced thoughts of suicide? ☐

3) Are you currently experiencing a mental health crisis? ☐

(Please note, if you are experiencing a mental health crisis at this time, you will unfortunately be unable to participate at this time)

(For researcher use) Participant number:

Appendix J: Interview Schedule

1) Have you disclosed your LGBTQ+ identity to a mental health service clinician?

(Prompts):

- Who was the clinician (job role) and what kind of service?

2) Can you tell me about your experience of this?

(Prompts):

- What did it feel like for you?
- What led to the decision to disclose? Was it a decision?
- Was there anything you liked about this experience?
- Was there anything you'd want to have been different?

3) Have you previously disclosed this aspect of your identity (within MH services or outside)? Can you tell me about that experience? What was similar / different?

4) How did your experience of coming out in MH services impact you?

(Prompts):

- Ask about what happened after, what did it feel like?
- Were there any changes after?
- Were there any changes in how you felt about MH services or the clinician?

Appendix K: University of East London Ethics Application and Risk Assessment

University of
East London

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;

MSc/MA RESEARCH;

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form
(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you

	will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Louise Warner**
2.2	**Your supervisor's name:**	**Dr Matthew Boardman**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Lorna Farquharson** 3rd supervisor (if applicable)

2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**15/05/2023** Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	**Exploring the Experience and Impact of Heteronormativity in CAMHS**
3.2	**Summary of study background and aims (using lay language):**	Heteronormative healthcare services can create barriers for young people who identify as LGBTQ+. Unpleasant experiences have been reported following identity disclosure within general medical settings. Levels of emotional distress, suicidality and self-harm are high in this population, yet limited research has specifically looked at disclosure of LGBTQ+ identities with mental health settings. The current study aims to investigate young people's experiences of disclosing their LGBTQ+ identities to a clinician within NHS Child and Adolescent Mental Health Services (CAMHS), and the resulting impacts. Specifically, the study will focus on young people who have experienced self-harm or suicidal ideation, recognising the high prevalence within LGBTQ+ populations and the potential for additional stigmatisation related to these intersecting identities. Thematic Analysis will be used to establish salient themes regarding the experience and impact of disclosure in CAMHS. It is hoped the findings will increase clinical understandings of young people's identity disclosure experiences within CAMHS, and promote development of services that can better meet their needs.
3.3	**Research question(s):**	For young people who have experienced self-harm / suicidal ideation, and who identify as LGBTQ+: 1) What is their experience of disclosing their LGBTQ+ identity to CAMHS clinicians? 2. What was the impact of their disclosure?
3.4	**Research design:**	This study will use Reflexive Thematic Analysis (TA; Braun & Clarke, 2006) to analyse 1:1 semi-structured interviews with young people. Participants will be given the option of in person or online

		interviews, to promote engagement, as the sensitive nature of the interviews may prevent some young people engaging from their homes.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Approximately 10-12 participants will be recruited. They will be young people aged 14-20 who identify as LGBTQ+ and who have disclosed this identity to a clinician in Child & Adolescent Mental Health Services (CAMHS). Inclusion criteria: 1) Aged 14-20, 2) identify as LGBTQ+, 3) have disclosed this identity to a CAMHS clinician at least once, 4) history of self-harm or suicidal ideation. Exclusion criteria: 1) currently experiencing a mental health crisis (self-identified or as identified by their CAMHS clinician) , 2) for those under the age of 16, they will be unable to participate if they are unable to provide parental consent
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited from two potential sources: NHS CAMHS (XXXX), and LGBTQ+ charities. For recruitment that will occur through NHS services, an application is being made for NHS ethical approval. Links have been made with a contact at these places. Recruitment will be via adverts emailed out, to be distributed by these service contacts. An alternative strategy will involve recruitment via social media sites for LGBTQ+ young people, if not enough participants are accessed via the initial recruitment method. This will involve posting the study advert on social media sites, via an account made specifically for the research.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	A brief demographics questionnaire has been developed by the researcher and will be completed at the start of the interview, including questions about age, ethnicity, sexual and gender identity, and length of time in CAMHS. This will also confirm they meet the inclusion criteria. This is included in the appendices of this document. This will be to provide context to the interview findings. A draft interview schedule is included in the appendices. Interviews will be recorded via Microsoft Teams software, and then transcribed. This will be the case both for interviews that take place on line and for any in-person interviews (the researcher's laptop will be used to audio record via Microsoft Teams in the room).
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Participants will be provided with an information sheet and consent form prior to the study. This will inform about limits to confidentiality and anonymity. They will be informed of the in-depth nature of thematic analysis, and small number of participants, highlighting that interview extracts used in reports

		may reduce anonymity. Despite this, identifiable information will not be included in the write-up, therefore the likelihood of any data being identifiable is low. Parental consent will be required for participants under the age of 16. The inclusion of participants aged up to 20 aims to promote opportunities to hear the views of those who may not want their parents to be aware of their participation, and who are able to provide consent on their own due to their age being above 16. If participants consent to involvement, a time will be arranged for 1:1 interview, over Microsoft Teams and will be recorded, to enable qualitative transcriptions of the content of the interviews. A short demographics questionnaire will also be completed, to provide context for the interviews, and to confirm the participant meets the inclusion criteria. Following interview, a debrief conversation and document will be provided: Speaking about experiences of identity and mental health service use may be distressing for some young people. Participants will be informed that they can withdraw their data up to 3 weeks after the date of their interview, including at any time during the interview. A debrief procedure will encourage young people to speak to their support network (family, friends, professionals) if needed, and will provide information on helplines (e.g. Childline). They will also be asked if they have any questions, and if they would like anything to be removed from their transcript.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☒	**NO** ☐
	If yes, please detail why it is necessary.	To compensate participants for their time.	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	£10 vouchers for amazon or lovetoshop will be provided to each participant to compensate participants for their time.	
3.11	**Data analysis:**	Transcripts of the interviews will be analysed using Thematic Analysis, to draw out themes from across all the interviews.	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	**Participants' transcripts will be given a participant number in chronological order and a pseudonym to be used in reports, and all identifiable information will be removed during transcription, including details of location and names of services and clinicians.**	
4.3	**How will you ensure participant details will be kept confidential?**	**Consent forms with participants' names will be stored separately from the transcripts, in a separate folder which is password protected, on the UEL OneDrive. Participant numbers and the associated details will be held in a separate folder until the end of the project, to allow for participants' data to be found if they choose to withdraw after the interview.**	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	**Transcripts and demographics questionnaires will be securely stored online on the UEL onedrive system in a password protected folder. Audio/video recordings from Microsoft Teams will be stored in a secure UEL OneDrive folder and password protected, and will be deleted once transcription is completed and checked. Consent forms which contain personal information, and any information related to the vouchers (e.g. email addresses) will be stored in a folder password protected on UEL OneDrive separate from the transcripts and recordings. A separate list of participant names and their associated participant numbers will be held in a password protected folder on UEL onedrive. Any printed documents relating to participants will be scanned and saved in the online folder, and then will be shredded.**	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	**Only the researcher and supervisor will have access to the data, and the participant information. The thesis**	

		examiner will also have access if required to the anonymised data.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	**The anonymised transcripts will be held securely on the UEL OneDrive for 3 years following completion of the thesis, accessible by the research supervisor.**	
4.7	**What is the long-term retention plan for this data?**	**The anonymised transcripts will be held securely on the UEL OneDrive for 3 years following completion of the thesis, accessible by the research supervisor. The audio/video recordings will be deleted once transcribed and checked, and the consent forms and demographics questionnaires will be deleted once the thesis is completed.**	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	**It may be distressing for some young people to speak about their experiences in mental health services and aspects of their identity. A debrief sheet will contain information about places to contact for support, e.g. encouraging participants to speak to their healthcare professionals if they need additional support, as well as crisis lines and Childline. This information will also be discussed at the end of the interview. The young person**	

		will also be able to choose not to answer any questions that they feel are particularly difficult during the interview if preferred, and will also be informed they can say as much or as little as they like in response to the questions. The researcher is also equipped with skills to manage distress through their role as a clinician in the NHS. For interviews that take place in-person at UEL Stratford campus, COVID-19 risk will be minimised by the use of masks and social distancing.		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	**The research will address topics that are personally relevant to myself as the researcher. Any difficulties associated with this will be managed through conversations and planning with supervisor. For interviews that take place in-person at UEL Stratford campus, COVID-19 risk will be minimised by the use of masks and social distancing.**		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	**Online via Microsoft Teams**		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard).	**YES** ☐		

	Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.	

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☒	**NO** ☐
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or		

	sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**001703313953**	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☒	**NO** ☐
	If yes, please provide their details.	**I will be recruiting with the support of charities in the South and West of England, specifically: XXXX and XXXX. Contacts at these organisations have agreed to send out the study advert via their mailing lists or via contacting their members. I will also be recruiting via NHS services (XXXX CAMHS), and am completing NHS ethical approvals for this purpose.**	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are	**YES** ☒	

	collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.	

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Louise Warner**
8.3	**Student's number:**	**2075232**
8.4	**Date:**	**07/02/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

Student checklist for appendices – *for student use only*

Documents attached to ethics application	**YES**	**N/A**
Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒

Permission(s) from an external organisation(s)	☒	☐
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☒	☐
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

UEL Risk Assessment Form

Name of Assessor:	**Louise Warner**	**Date of Assessment:**	**8th February 2022**
Activity title:	**Research Project. Title: Exploring the experience and impact of heteronormativity in CAMHS**	**Location of activity:**	**UEL Campus at Stratford and online via Microsoft Teams**
Signed off by Manager: (Print Name)	**Matthew Boardman** [redacted]	**Date and time: (if applicable)**	**8th March 2022**
Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.). If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:			
Thesis research study involving qualitative 1:1 interviews with 10-12 participants aged 14-20 years old, who have experience of difficulties with self-harm or suicidality, to explore their experiences of disclosing LGBTQ+ identities in NHS CAMHS. Primarily, this study will take place online via Microsoft Teams, unless online interviews would be a significant barrier to the participant, then a room on Stratford UEL campus will be used for in-person interviews.			
Overview of FIELD TRIP or EVENT:			
n/a			

General Risk Assessment Form template

UEL Risk Assessment Form

Name of Assessor:	**Louise Warner**	**Date of Assessment:**	**8th February 2022**
Activity title:	**Research Project. Title: Exploring the experience and impact of heteronormativity in CAMHS**	**Location of activity:**	**UEL Campus at Stratford and online via Microsoft Teams**
Signed off by Manager: (Print Name)	**Matthew Boardman** [redacted]	**Date and time: (if applicable)**	**8th March 2022**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.).
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

Thesis research study involving qualitative 1:1 interviews with 10-12 participants aged 14-20 years old, who have experience of difficulties with self-harm or suicidality, to explore their experiences of disclosing LGBTQ+ identities in NHS CAMHS. Primarily, this study will take place online via Microsoft Teams, unless online interviews would be a significant barrier to the participant, then a room on Stratford UEL campus will be used for in-person interviews.

Overview of FIELD TRIP or EVENT:

n/a

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating

Psychological distress	Researcher & Participants	It may be distressing for some young people to speak about their experiences of identity and mental health service use. The researcher works as a clinician in the NHS and therefore has skills in managing distress. A debrief form and conversation at the end of interview will signpost to relevant organisations for additional support, and the young person will be encouraged to speak with their support network (family, friends, professionals) if needed. Participants will also be informed they can answer as much or as little as they like during the interview. The topic is also of personal significance to the researcher, and this will be managed via conversations and planning with the research supervisor.	1-2	1	1		1-2
Covid-19 risk	Participants and researcher	Most interviews will take place online to mitigate the risk of COVID-19. In the event that a young person is unable to participate online, an in-person interview will be offered at Stratford campus. Masks will be worn, and seating will be 2m apart to comply with COVID-19 safety recommendations	1	1	1		1

Appendix L: UEL Ethical Approval Letter

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	**Fevronia Christodoulidi**
Supervisor:	**Matthew Boardman**
Student:	**Louise Warner**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐

Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of

	this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	APPROVED

Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:

HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☒
LOW	Approve and if necessary, include any recommendations in the below box.	☐
Reviewer recommendations in relation to risk (if any):	**The researcher declares that she identifies a 'personal involvement' to the topic and mentions that if triggered during the study, she will have access to supervisor(s) for support. I assume that she could also access personal therapy, which would be my recommendation, if that is perceived as feasible and beneficial. This also links to the 'insider/outsider' researcher positioning discourse and process, therefore I believe that the research would be strengthened if the student engages with personal therapy in the process which will also inform her 'reflexive' stance in her TA approach**	

Reviewer's signature

Reviewer: (Typed name to act as signature)	**Dr Fevronia Christodoulidi**
Date:	**28/03/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

Appendix M: UEL Ethical Approval Amendments

Throughout the study, a total of six amendments were made to the ethical approvals. These are listed below, in chronological order, starting with the earliest. Information that identifies organisation supporting recruitment is redacted using "XXXX". A safeguarding document was requested by one organisation, and therefore mentioned in the ethics application amendments below, however this was never finalised or used as recruitment with that organisation did not go ahead, and therefore is not included here.

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☐
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Louise Warner**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**
Name of supervisor:	**Matthew Boardman**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Addition to participation information sheet informing participants that if they wish to receive a voucher for taking part, they will need to provide personal information including their name, address, date of birth, and national insurance number. This personal information will be stored separately to participant responses/transcripts.	Initial participant information sheet did not include the need for date of birth, home address, and national insurance number in order to receive voucher.
Addition to participant information sheet informing participants that a demographic information sheet will be used to gather information on age, ethnicity, sexual orientation, gender identity, and length of time in CAMHS. This information will be held separately to their consent forms.	Did not mention explicitly the use of demographic information sheets in information sheets previously.
Proposed amendment	Rationale for proposed amendment

Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student’s signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**05/05/2022**

Reviewer’s decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	**Under what is the research: should read ‘this will take place on MS Teams’, remove the word ‘usually’. Only include that an Amazon voucher will be offered. Under what happens to my responses: ensure it is clear that data will be stored ‘in a separate electronic folder’. If you have NHS Ethical Approval, worth including the IRAS number in the PIS.**	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**06/05/2022**	

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☐
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Louise Warner**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**
Name of supervisor:	**Matthew Boardman**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
Additional source of recruitment – an additional charity organisation (XXXX) has agreed to put up the study advert in their waiting room area. I have attached the confirmation email from my contact at this organisation.	To increase potential recruitment base, and increase likelihood of meeting target participant numbers.
Proposed amendment	
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student’s signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**26/05/2022**

<table>
<tr><th colspan="3">Reviewer’s decision</th></tr>
<tr><td>Amendment(s) approved:</td><td>YES
☒</td><td>NO
☐</td></tr>
<tr><td>Comments:</td><td colspan="2">Please enter any further comments here</td></tr>
<tr><td>Reviewer:
(Typed name to act as signature)</td><td colspan="2">Trishna Patel</td></tr>
<tr><td>Date:</td><td colspan="2">27/05/2022</td></tr>
</table>

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
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5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Louise Warner**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**
Name of supervisor:	**Matthew Boardman**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
Additional source of recruitment – an additional charity organisation (XXXX) has agreed to distribute the study advert to their groups. I have attached the confirmation email from my contact at this organisation.	To increase potential recruitment base, and increase likelihood of meeting target participant numbers.
Proposed amendment	
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**09/06/2022**

Reviewer's decision

Amendment(s) approved:	**YES** ☒	**NO** ☐

Comments:	Please enter any further comments here
Reviewer: (Typed name to act as signature)	**Trishna Patel**
Date:	**10/06/2022**

University of
East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
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5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES**

	☒

Details	
Name of applicant:	**Louise Warner**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**
Name of supervisor:	**Matthew Boardman**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Additional source of recruitment – an additional organisation (XXXX) has agreed to distribute the study advert via their LGBTQ+ Newsletter and via Twitter. I have attached the confirmation email from my contact at this organisation.	To increase potential recruitment base, and increase likelihood of meeting target participant numbers.
Updated participant information sheets and consent form to be more consistent with the wording approved by NHS ethics – amendments to wording highlighted in yellow. This includes the addition of a pre-interview consent & information meeting to enable participants time to ask questions and consider whether they want to participate, before committing.	I am recruiting both via NHS services (with NHS ethics approval) and non-NHS services, and therefore think it is important for the PIS to be as consistent as possible across the two. I have therefore amended my PIS for the non-NHS route to reflect the wording that has been required for my NHS ethics PIS.
Safeguarding document	One organisation I am hoping to recruit from had asked for a safeguarding policy / document to be written up, and had particular questions they wanted answered. I have therefore drafted this document and attached here.
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**14/07/2022**

Reviewer's decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**18/07/2022**	

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Louise Warner**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**
Name of supervisor:	**Matthew Boardman**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
Proposed amendment – To recruit via personal networks (i.e. utilising a snowballing approach to recruitment: sharing my study advert with people I know, and asking if they know anyone who may be interested in participating who they can pass on the study advert to). Recognising the potential power dynamics of asking people I know to support in finding potential participants, this will be reflected on in the write-up, and participants will be assured that participation is voluntary and they can withdraw up to 3 weeks after interview, as per original proposal.	Due to a lack of participants accessed via other avenues of recruitment over a period of five months, this proposed amendment aims to increase potential recruitment base, and increase likelihood of meeting target participant numbers.
Proposed amendment	
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student’s signature	
Student: (Typed name to act as signature)	**Louise Warner**
Date:	**30/09/2022**

Reviewer’s decision		
Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**30/09/2022**	

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Louise Warner**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	Exploring the Experience and Impact of Heteronormativity in CAMHS (New proposed title: Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm) – see title change request form for further detail.
Name of supervisor:	**Matthew Boardman**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Proposed amendment – To extend the age range of the study to recruit young people up to age 25, who have used either CAMHS or adult mental health services. To continue the same methods of recruitment as previously (social media, personal networks).	Due to a lack of participants accessed over a period of five months, this proposed amendment aims to increase potential recruitment base, and increase likelihood of meeting target participant numbers. Attached documentation reflects the age range change and associated title change – wording changes highlighted in yellow.
Proposed amendment – Recruitment via TikTok (social media recruitment already covered by previous ethical approval – but would like to request to be able to actively approach TikTok account users who appear to meet my study criteria, to explain the study and see if they might like to take part)	To increase the likelihood of accessing potential participants, given the age range of 14-25 year olds are a population active on TikTok.
Proposed amendment – IRAS ethical approval process requested I split the consent and PIS forms into 3 separate categories: under 16s, over 16s, and parents/guardians. I have therefore updated my non-NHS versions of the forms to be the same, for consistency.	To be consistent with the approach requested by REC.
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**04/11/2022**

Reviewer's decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	**The amendments to the ethics application and research project do not cause any ethical issue.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**08/11/2022**	

Appendix N: Title Change Approval

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Louise Warner**
Programme of study:	**Clinical Psychology Doctorate**
Title of research:	**Exploring the Experience and Impact of Heteronormativity in CAMHS**

Name of supervisor:	**Matthew Boardman**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Exploring the Experience and Impact of Heteronormativity in CAMHS
New title:	Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm
Rationale:	To account for a change in the age range due to recruitment difficulties – to look at experiences of young people up to age 25, and therefore no longer just experiences in CAMHS, but in mental health services as a whole. Also to account for the intersectionality element of the research questions – looking at the experiences of those who are both LGBTQ+ and experience difficulties with self-harm. Additional amendment form is attached to account for the ways the title change impacts the process of data collection, and associated documents changing the wording to reflect the new age range and extension to adult mental health services as well as CAMHS.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**04/11/2022**

Reviewer's decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the approved amendments made to the research.**	

Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**
Date:	**08/11/2022**

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Louise Warner**
Programme of study:	**Clinical Psychology Doctorate**
Title of research:	Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm
Name of supervisor:	**Matthew Boardman**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm
New title:	Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm or Feel Suicidal
Rationale:	Requested amendment following viva – to account for the thesis looking at experiences of young people who are LGBTQ and have experience of self-harm or suicidality.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student’s signature

Student: (Typed name to act as signature)	**Louise Warner**
Date:	**07/09/2023**

Reviewer’s decision

Title change approved:	**YES** ☒	**NO** ☐

Comments:	**The title change was suggested in the viva.**
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**
Date:	**08/09/2023**

Appendix O: Participant Information Sheets

04/11/2022 Version 4

Participant Information Sheet (PIS) – Young Person, under 16

PARTICIPANT INFORMATION SHEET:

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Contact person: Louise Warner (Trainee Clinical Psychologist)
Email: u2075232@uel.ac.uk

Who Am I?

My name is Louise Warner (she/her). I am a Trainee Clinical Psychologist at the University of East London. As part of my studies, I am doing research looking at the experiences of LGBTQ+ young people who have told their NHS mental health clinicians about their sexual or gender identity.

What is the research?

I want to **hear the views of young people** who have disclosed their LGBTQ+ identity to a NHS mental health services clinician (e.g. nurse, psychiatrist, therapist), to **help promote improved services**. In particular, I am looking at the experiences of young LGBTQ+ people who also have experienced self-harm or suicidal ideation.

If you agree to take part, and your parent/guardian agrees to this, it would involve a 1:1 research interview, which would be an informal conversation where I will ask about your experiences in mental health services related to your LGBTQ+ identity. This will take place on **Microsoft Teams**.

You will be offered a **£10 voucher** for Amazon for your participation.

Who can take part?

You are eligible to take part if:

- You are **aged 14-25** (if you are under 16, you will need permission from a parent/guardian)
- You identify as **LGBTQ+** (or use other language)
- You have used **NHS Mental Health services** (CAMHS or adult) and have told a clinician there (e.g. nurse, psychiatrist, therapist) about your **LGBTQ+ identity** at least once
- Have experienced **self-harm or of suicidal feelings** at some point in time

We welcome the participation of young people who have been seen in mental health services in the past as well as currently. It is entirely up to you whether you take part or not, **participation is voluntary.**

What happens to my responses?

If you take part, the first step is a **consent & information meeting** via Microsoft Teams. You will be sent this information sheet and the assent form (agreement to participate), and a consent form for your parent/guardian, and in the brief meeting you and your parent/guardian will have the opportunity to discuss with the researcher any questions you might have before signing the assent form.

Then, if you choose to participate, you will have a **1:1 meeting via Microsoft Teams** with the researcher, who will ask questions about your experiences in mental health services. The conversation with the researcher will be recorded on Microsoft Teams and will be written up into a document called a Transcript. The researcher will ask if you would like to see a copy of this to check it is accurate.

We will collect some information about you, which will be gathered via a **demographic information** sheet. This information will include your age, ethnicity, gender, sexual orientation, and length of time in mental health services. Your transcript and demographic information will be kept in a separate electronic folder, separate from the folder where your consent form is kept.

Quotes from your transcript may be used in reports and documents written up by the researcher (e.g. thesis submission, and any presentations or publications in future). These will all be **anonymous** – this means it will not say your name, and will not contain any information that would identify you.

To collect your **voucher**, you will need to provide your date of birth, national insurance number, and home address. If you would like to receive a copy of the results of the research, you can provide your **email address.** All this information will be kept confidential, in a separate, password protected folder to your transcript.

Once the project is finished, your Transcript will be held for 3 years by my supervisor (Dr Matthew Boardman) in a secure online folder. This is University policy.

How will we use information about you?

We will need to use information from you for this research project. This information will include your **name and contact details**. People will use this information to do the research to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a **code number** instead. We will keep all information about you **safe and secure**.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that **no-one can work out that you took** part in the study.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (**GDPR**). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the **personal data it processes is held securely** and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

Are there any disadvantages to taking part?

It may be distressing for some young people to speak about experiences related to their identity and mental health service use. If you find it very distressing, please do let the researcher know.

You do not have to answer any questions you do not want to answer. You can also **leave the study at any time**, if you change your mind and decide you no longer want to take part. You do not need to give an explanation, and there will be no consequences. Just let the researcher know. Please note, you are able to withdraw any time until I begin analysis of the responses, which is likely to be within approximately 3 weeks following your interview.

All participants will be given Information about organisations you can contact for **support**. We encourage you to speak about your participation in the study with people in your support network (e.g. family, friends, professionals).

The responses you give are confidential. However, if we were very concerned about you or someone else's safety (e.g. if there was significant risk of harm to yourself or others), we may need to contact another professional (or if under 16, your parent/guardian) to let them know so they can provide some additional **support**.

Anything else I need to know?

The research has been **approved** by the School of Psychology Research Ethics Committee

If you would like further information about my research, or have any **questions or concerns**, please contact me:

Louise Warner (Trainee Clinical Psychologist): u2075232@uel.ac.uk
OR
Dr Matthew Boardman (research supervisor): m.boardman@uel.ac.uk

OR
If you wish to make a complaint to someone independent, you can contact:

Chair of School Research Ethics Committee: Dr Trishna Patel (Email: t.patel@uel.ac.uk)

The sponsor of the research is UEL

Thank you for reading this information sheet

04/11/2022 Version 4

Participant Information Sheet (PIS) template (young person – 16 and over)

PARTICIPANT INFORMATION SHEET:

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Contact person: Louise Warner (Trainee Clinical Psychologist)
Email: u2075232@uel.ac.uk

Who Am I?

My name is Louise Warner (she/her). I am a Trainee Clinical Psychologist at the University of East London. As part of my studies, I am doing research looking at the experiences of LGBTQ+ young people who have told their NHS mental health clinicians about their sexual or gender identity.

What is the research?

I want to **hear the views of young people** who have disclosed their LGBTQ+ identity to a clinician in an NHS mental health service (e.g. nurse, psychiatrist, therapist), to **help promote improved services**. In particular, I am looking at the experiences of young LGBTQ+ people who also have experienced self-harm or suicidal ideation.

If you agree to take part, it would involve a 1:1 research interview, which would be an informal conversation where I will ask about your experiences in NHS mental health services related to your LGBTQ+ identity. This will take place on **Microsoft Teams**.

You will be offered a **£10 voucher** for Amazon for your participation.

Who can take part?

You are eligible to take part if:

- You are **aged 14-25** (if you are under 16, you will need permission from a parent/guardian)
- You identify as **LGBTQ+** (or use other language)
- You have used NHS Mental Health services (**CAMHS or adult services**) and have told a clinician there (e.g. nurse, psychiatrist, therapist) about your **LGBTQ+ identity** at least once
- Have experienced **self-harm or of suicidal feelings** at some point in time

We welcome the participation of young people who have been seen in CAMHS/adult mental health services in the past as well as currently. It is entirely up to you whether you take part or not, **participation is voluntary.**

What happens to my responses?

If you take part, the first step is a **consent & information meeting** via Microsoft Teams. You will be sent this information sheet and the consent form, and in the brief meeting you will have the opportunity to discuss with the researcher any questions you might have before signing the consent form.

Then, if you choose to participate, you will have a **1:1 meeting via Microsoft Teams** with the researcher, who will ask questions about your experiences in mental health services. The conversation with the researcher will be recorded on Microsoft Teams and will be written up into a document called a Transcript. The researcher will ask if you would like to see a copy of this to check it is accurate.

We will collect some information about you, which will be gathered via a **demographic information** sheet. This information will include your age, ethnicity, gender, sexual orientation, and length of time in mental health services. Your transcript and demographic information will be kept in a separate electronic folder, separate from the folder where your consent form is kept.

Quotes from your transcript may be used in reports and documents written up by the researcher (e.g. thesis submission, and any presentations or publications in future). These will all be **anonymous** – this means it will not say your name, and will not contain any information that would identify you.

To collect your **voucher**, you will need to provide your date of birth, national insurance number, and home address. If you would like to receive a copy of the results of the research, you can provide your **email address.** All this information will be kept confidential, in a separate, password protected folder to your transcript.

Once the project is finished, your Transcript will be held for 3 years by my supervisor (Dr Matthew Boardman) in a secure online folder. This is University policy.

How will we use information about you?

We will need to use information from you for this research project. This information will include your **name and contact details**. People will use this information to do the research to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a **code number** instead. We will keep all information about you **safe and secure**.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that **no-one can work out that you took** part in the study.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data Protection Regulation (**GDPR**). Where the University processes particularly sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the **personal data it processes is held securely** and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

Are there any disadvantages to taking part?

It may be distressing for some young people to speak about experiences related to their identity and mental health service use. If you find it very distressing, please do let the researcher know.

You do not have to answer any questions you do not want to answer. You can also **leave the study at any time**, if you change your mind and decide you no longer want to take part. You do not need to give an explanation, and there will be no consequences. Just let the researcher know. Please note, you are able to withdraw any time until I begin analysis of the responses, which is likely to be within approximately 3 weeks following your interview.

All participants will be given Information about organisations you can contact for **support**. We encourage you to speak about your participation in the study with people in your support network (e.g. family, friends, professionals).

The responses you give are confidential. However, if we were very concerned about you or someone else's safety (e.g. if there was significant risk of harm to yourself or others), we may need to contact another professional (or if under 16, your parent/guardian) to let them know so they can provide some additional **support**.

Anything else I need to know?

The research has been **approved** by the School of Psychology Research Ethics Committee

If you would like further information about my research, or have any **questions or concerns**, please contact me:

Louise Warner (Trainee Clinical Psychologist): u2075232@uel.ac.uk
OR
Dr Matthew Boardman (research supervisor): m.boardman@uel.ac.uk

OR
If you wish to make a complaint to someone independent, you can contact:

Chair of School Research Ethics Committee: Dr Trishna Patel (Email: t.patel@uel.ac.uk)

The sponsor of the research is UEL

Thank you for reading this information sheet

04/11/2022 Version 4

PARTICIPANT INFORMATION SHEET: Parent/Guardian

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Contact person: Louise Warner (Trainee Clinical Psychologist)
Email: u2075232@uel.ac.uk

Who Am I?

My name is Louise Warner (she/her). I am a Trainee Clinical Psychologist at the University of East London. As part of my studies, I am doing research looking at the experiences of LGBTQ+ young people who have told their mental health services clinician about their sexual or gender identity.

What is the research?

I want to **hear the views of young people** who have disclosed their LGBTQ+ identity to a clinician in NHS mental health services (e.g. nurse, psychiatrist, therapist), to **help promote improved services**. In particular, I am looking at the experiences of young LGBTQ+ people who also have experienced self-harm or suicidal ideation.

If a young person agrees to take part, it would involve a 1:1 research interview, which would be an informal conversation where I will ask about their experiences in mental health services related to their LGBTQ+ identity. This will take place on **Microsoft Teams**.

Whilst young people aged under 16 can provide assent to take part in the study, it is a requirement that the **parent/guardian** also gives consent as those under the age of 16.

They will be offered a **£10 voucher** for Amazon for their participation.

Who can take part?

A young person is eligible to take part if:

- They are **aged 14-25** (if they are under 16, they will need permission from a parent/guardian)
- They identify as **LGBTQ+** (or use other language)
- They have used **NHS Mental Health services** (CAMHS or adult) and have told a clinician there (e.g. nurse, psychiatrist, therapist) about their **LGBTQ+ identity** at least once
- Have experienced **self-harm or of suicidal feelings** at some point in time

We welcome the participation of young people who have been seen in mental health services in the past as well as currently. It is entirely up to you whether you take part or not. **Participation is voluntary, and we encourage you to discuss with your child whether they would be interested in participating.**

What happens to their responses?

If a young person takes part, the first step is a **consent & information meeting** via Microsoft Teams. They will be sent this information sheet and the consent form, and in the brief meeting they will have the opportunity to discuss with the researcher any questions they might have before signing the consent form. For participants under 16, we ask that a parent/guardian joins for this meeting.

Then, if they choose to participate, they will have a **1:1 meeting via Microsoft Teams** with the researcher, who will ask questions about you're their experiences in mental health services. The conversation with the researcher will be recorded on Microsoft Teams and will be written up into a document called a Transcript. The researcher will ask if they would like to see a copy of this to check it is accurate.

We will collect some information about them, which will be gathered via a **demographic information** sheet. This information will include their age, ethnicity, gender, sexual orientation, and length of time in mental health services. Their transcript and demographic information will be kept in a separate electronic folder, separate from the folder where their consent form is kept.

Quotes from their transcript may be used in reports and documents written up by the researcher (e.g. thesis submission, and any presentations or publications in future). These will all be **anonymous** – this means it will not say their name, and will not contain any information that would identify them.

To collect the **voucher**, they will need to provide their date of birth, national insurance number (for over 16s), and home address. If they would like to receive a copy of the results of the research, they can provide your **email address.** All this information will be kept confidential, in a separate, password protected folder.

Once the project is finished, their Transcript will be held for 3 years by my supervisor (Dr Matthew Boardman) in a secure online folder. This is University policy.

How will we use information about the young person?

We will need to use information from them for this research project. This information will include their **name and contact details**. People will use this information to do the research to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see their name or contact details. Their data will have a **code number** instead. We will keep all information about them **safe and secure**.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that **no-one can work out that they took** part in the study.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (**GDPR**). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the **personal data it processes is held securely** and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

Are there any disadvantages to taking part?

It may be distressing for some young people to speak about experiences related to their identity and mental health services. If they find it very distressing, they will be encouraged to let the researcher know.

They do not have to answer any questions they do not want to answer. They can also **leave the study at any time**, if they change their mind and decide they no longer want to take part. They do not need to give an explanation, and there will be no consequences. They just let the researcher know. Please note, they are able to withdraw any time until I begin analysis of the responses, which is likely to be within approximately 3 weeks following their interview.

All participants will be given Information about organisations they can contact for **support**. We encourage them to speak about their participation in the study with people in their support network (e.g. family, friends, professionals).

The responses they give are confidential. However, if we were very concerned about their safety or someone else's safety (e.g. if there was significant risk of harm to themselves or others), we may need to contact another professional (or if under 16, their parent/guardian) to let them know so they can provide some additional **support**.

Anything else I need to know?

The research has been **approved** by the School of Psychology Research Ethics Committee.

If you or the young person would like further information about my research, or have any **questions or concerns**, please contact me:

Louise Warner (Trainee Clinical Psychologist): u2075232@uel.ac.uk
OR
Dr Matthew Boardman (research supervisor): m.boardman@uel.ac.uk

OR
If you or the young person wish to make a complaint to someone independent, you can contact:
Chair of School Research Ethics Committee: Dr Trishna Patel (Email: t.patel@uel.ac.uk)

The sponsor of the research is UEL.

Thank you for reading this information sheet

Appendix P: Assent and Consent Forms

Assent Form – Young Person, under 16

ASSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Contact person: Louise Warner (Trainee Clinical Psychologist)

Email: U2075232@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 4th November 2022 for the above study and that I have been given a copy to keep.	
I have had the chance to think about the information, ask questions, and these have been answered in a way that makes sense to me	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw before my data has been analysed, approximately 3 weeks after the interview, then my data will not be included in the analysis. If I withdraw after this time, my data may already be included in the analysis and it will not be possible to remove.	
I understand that the interview will be recorded using Microsoft Teams	
I understand that my personal information and data, including audio/video recordings, from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I understand that my parent or guardian will need to provide consent for my participation.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

………

Participant’s Signature

………

Researcher’s Name (BLOCK CAPITALS)

………

Researcher’s Signature

………

Date

………

Consent Form – Young Person, 16 and over

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Contact person: Louise Warner (Trainee Clinical Psychologist)

Email: U2075232@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 4th November 2022 for the above study and that I have been given a copy to keep.	
I have had the chance to think about the information, ask questions, and these have been answered in a way that makes sense to me	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw before my data has been analysed, approximately 3 weeks after the interview, then my data will not be included in the analysis. If I withdraw after this time, my data may already be included in the analysis and it will not be possible to remove.	
I understand that the interview will be recorded using Microsoft Teams	
I understand that my personal information and data, including audio/video recordings, from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	

I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

………

Participant’s Signature

………

Researcher’s Name (BLOCK CAPITALS)

………

Researcher’s Signature

………

Date

………

Consent Form – Parent/Guardian

CONSENT FROM PARENT OF GUARDIAN ON BEHALF OF YOUNG PERSON TO PARTICIPATE IN A RESEARCH STUDY

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Contact person: Louise Warner (Trainee Clinical Psychologist)

Email: U2075232@uel.ac.uk

	Please initial
I confirm that I have read the parent/guardian information sheet dated 4th November 2022 for the above study and that I have been given a copy to keep.	
I have had the chance to think about the information, ask questions, and these have been answered in a way that makes sense to me	
I understand that the young person's participation in the study is voluntary and that they may withdraw at any time, without explanation or disadvantage.	
I understand that if they withdraw before their data has been analysed, approximately 3 weeks after the interview, then their data will not be included in the analysis. If they withdraw after this time, their data may already be included in the analysis and it will not be possible to remove.	
I understand that the interview will be recorded using Microsoft Teams	
I understand that their personal information and data, including audio/video recordings, from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from the interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify the young person.	

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to the name young person taking part in the above study.	

Participant’s Name (BLOCK CAPITALS)

……

Parent/Guardian Name (BLOCK CAPITALS)

……

Parent/Guardian Signature

……

Researcher’s Name (BLOCK CAPITALS)

……

Researcher’s Signature

……

Date

……

Appendix Q: Final Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Louise Warner
PI/Researcher ID (e.g. ORCiD)	0000-0002-8676-4583
PI/Researcher email	U2075232@uel.ac.uk
Research Title	Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm
Project ID	
Research start date and duration	February 2022 – September 2023

Research Description	The proposed study will explore the experiences of young people who identify as LGBTQ+ disclosing this identity to clinicians in NHS mental health services and the impact of this disclosure. Specifically, participants will be young people who have experienced self-harm or suicidality, due to the high prevalence of these difficulties amongst LGBTQ+ adolescents, and the additional stigma associated with these experiences. Approximately 10-12 young people aged 14-25 will be recruited, from charities, social media, personal networks and NHS services. Each young person will be asked to participate in a 1:1 interview with the researcher. These will usually take place online, via Microsoft Teams, unless this would be a significant barrier to participation, in which case a room will be booked at UEL. The findings will be analysed using Thematic Analysis.
Funder	N/A – part of professional doctorate
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	03/02/2022
Date of last update (of DMP)	05/04/2023
Related Policies	• BPS Practice Guidelines Third Edition 2017 • NHS England response to the specific equality duties of the Equality Act 2010 • Research Data Management Policy • UEL Data Backup Policy • UEL statement on Research Ethics • UEL statement on Research Integrity
Does this research follow on from previous research? If so, provide details	n/a
Data Collection	

What data will you collect or create?	Approximately 10-12 young people aged 14-25 will be interviewed by the researcher in a 1:1 interview, via Microsoft Teams, or in person at UEL. Recordings will be in .mp4 format (Teams) for each of the 10-12 participants. Teams transcriptions will be in .vvt format and downloaded into .docx format (approx. 10-12 – one for each participant). Demographic information will be gained via a pseudonymised questionnaire (information on age, gender, ethnicity, length of time in mental health services, and confirmation of inclusion criteria being met). This will be stored in a .docx file (approx. 10-12, one per participant). The data will be processed via qualitative thematic analysis, and all documents pertaining to this will be in .docx format. Any paper copies of documents will be scanned and saved in .pdf format, and shredded afterwards. All documents will be stored in password protected folders on UEL OneDrive. Personal identifying data will include signed consent forms, which will contain names and signatures of the young person and/or their parent. These will be stored as .docx files in a password protected folder on UEL OneDrive. If participants request a copy of the findings of the data, their email address will also be stored in a password protected .docx file until the end of the study. If they do not consent to this, their email address will not be stored and any emails sent by the young people / their parents expressing interest in participating in the study will be deleted following completion of the interview phase (after the young person has been offered an opportunity to check their transcript – up to 3 weeks after interview). Forms allowing the use of vouchers as compensation for their time will hold personal data (names, addresses, email), and will be stored in .docx files.
How will the data be collected or created?	Due to COVID-19, interviews will take place online via Microsoft Teams, unless this would prevent a particular young person from taking part, in which case face-to-face interviews will be offered either at UEL campus. Interviews will be 30-60mins in length (including for in-person interviews), and then will be transcribed and analysed by the researcher, and downloaded from Microsoft Stream Microsoft Word document. It is anticipated most interviews will take place online, unless there is a significant barrier to participation virtually. Interviews will be recorded via Microsoft Teams (including for in-person interviews) and auto-transcribed. These transcriptions will be checked and edited by the researcher.

	Audio/video recordings will be deleted once transcripts have been written and checked. Participants will be allocated a participant number and a pseudonym (for use in any reports), and all identifiable information (names, dates, details that might lead the young person to be recognisable) will be removed or pseudonymised in the transcripts. Consent forms and forms allowing the use of vouchers as compensation for their time will hold personal data (names, addresses, email). Indirect demographic identifiers (age, gender, ethnicity, length of time in mental health services, and confirmation of meeting inclusion criteria for the study) will be collected via a questionnaire prior to interview, and this will be pseudonymised with the same participant number as their transcript, and saved in a .docx file. The demographic questionnaires will completed at the start of the interview, on a shared screen on Microsoft Teams so both myself and the person being interviewed can see the questions, and I will type the responses into the word document. Audio files will be saved with titles of: "interview participant number_date of interview (format YYYY-MM-DD) e.g. Interview01_2022-02-15. Transcripts will be saved as "transcript participant number_date of interview (format YYYY-MM-DD) e.g. Transcript01_2022-02-15. Consent forms will be saved with participant number in the format consent participant number_date (YYYY-MM-DD) e.g. consent01_2022-02-15. Demographic information questionnaires will be saved with titles of demographics participant number_date (YYYY-MM-DD) e.g. demographics01_2022-02-15.
Documentation and Metadata	
What documentation and metadata will accompany the data?	Blank consent form, participant information sheets (both parental consent and young person assent/consent where appropriate – for those under age 16). These will be held in a separate folder to the main data, and will be password protected. A debrief sheet and an interview schedule / guide will also be included in .docx format.
Ethics and Intellectual Property	

Identify any ethical issues and how these will be managed	Both UEL and NHS (IRAS) ethical approval will be sought prior to recruitment. Information sheets will be provided for young people (and their parents, if under the age of 16) prior to the interview, and they will be given an opportunity to ask questions before beginning the interview. Written consent will be gained from the young person (and their parent if under the age of 16). Participants who are under the age of 16 but unable to provide parental consent will be thanked for their interest in the study but informed that they are unable to participate. The associated email correspondence will be deleted after the final contact. Participants will be informed of their right to withdraw and will be given a deadline of 3 weeks after their interview is completed, after which time their data may already be included in the analysis. Data will be stored on secure UEL OneDrive, data are encrypted and stored within the EU in compliance with the Data Protection Act 2018 and GDPR principles and data will be pseudonymised to and only accessible by the researcher and supervisor. Pseudonymised data will only be identifiable to the researcher and supervisor, via a key that links participant number to name, and for confidentiality purposes this will be stored in a separate password protected folder. Distress that may occur during the interview will be managed in line with how the researcher would manage such occurrences in clinical work, including safeguarding and risk concerns. Participants will be signposted to relevant support organisations following interview.
Identify any copyright and Intellectual Property Rights issues and how these will be managed	**N/A**
Storage and Backup	
How will the data be stored and backed up during the research?	Data will be stored on the UEL OneDrive. Transcripts and audio/video files will be held in a separate folder to the consent forms and other identifiable documentation. . Transcripts will be edited and downloaded into a word document Any hard copies of consent forms will be scanned and stored in the above-mentioned ways, and hard copies will be shredded. Video recordings will be done via Microsoft Teams on the researcher's university account and will be stored on the Microsoft Stream Library, as well as the UEL OneDrive.

	(Both parental consent and young person assent/consent where appropriate – for those under age 16). Will be held in a separate folder to the main data and will be password protected. This will be stored alongside a list of participant names and allocated participant number, which will also be password protected and in .excel format. NVivo will be used to analyse data and therefore data will be accessed on this programme, to aid data analysis.
How will you manage access and security?	Data stored on UEL OneDrive are encrypted, limited to me and secured through Multi-Factor authentication. The pseudonymised transcripts will be accessible only to the researcher, supervisor, and examiners. Any sharing of data between these individuals would be via secure links via UEL OneDrive. Consent forms will be stored on UEL OneDrive, and any hard copies shredded following being scanned and save on UEL OneDrive. All files containing personal information (consent forms, transcripts, audio files).
Data Sharing	
How will you share the data?	Participants will be informed via the information sheet that short quotes from their transcripts will be used in the write-ups of the project (thesis submission and any publications), and these will be pseudonymised (allocated a pseudonym to protect their anonymity). Any information that may be identifiable will be excluded from the extracts. The final thesis write-up will be uploaded and viewable on the UEL repository. Individual parts of the data (e.g. transcripts) will not be shared outside of the research team, as this could lead to transcripts becoming identifiable.
Are any restrictions on data sharing required?	Only the final write-up of the thesis will be shared via UEL Research Repository; individual data including transcripts will not be shared outside of the research team.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	The consent forms saved on the UEL OneDrive will be kept until the thesis has been examined and passed, after which they will be deleted from the server. Audio and video files will be saved until transcription is completed and checked, and then will be deleted.

What is the long-term preservation plan for the data?	Transcripts will be kept for 3 years by the research supervisor on the UEL OneDrive, then will be deleted, to allow for transcripts being needed as part of preparing further future publications.
Responsibilities and Resources	
Who will be responsible for data management?	Louise Warner – Trainee Clinical Psychologist Supervised by Dr Matthew Boardman
What resources will you require to deliver your plan?	Laptop, Microsoft Teams software, UEL OneDrive.
Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 05/04/2023	Reviewer name: Joshua Fallon Assistant Librarian (Research Data Management)

Guidance

Brief information to help answer each section is below. Aim to be specific and concise.

For assistance in writing your data management plan, or with research data management more generally, please contact: **researchdata@uel.ac.uk**

Administrative Data

Related Policies

List any other relevant funder, institutional, departmental or group policies on data management, data sharing and data security. Some of the information you give in the remainder of the DMP will be determined by the content of other policies. If so, point/link to them here.

Data collection

Describe the data aspects of your research, how you will capture/generate them, the file formats you are using and why. Mention your reasons for choosing particular data standards and approaches. Note the likely volume of data to be created.

Documentation and Metadata

What metadata will be created to describe the data? Consider what other documentation is needed to enable reuse. This may include information on the methodology used to collect the data, analytical and procedural information, definitions of variables, the format and file type of the data and software used to collect and/or process the data. How will this be captured and recorded?

Ethics and Intellectual Property

Detail any ethical and privacy issues, including the consent of participants. Explain the copyright/IPR and whether there are any data licensing issues – either for data you are reusing, or your data which you will make available to others.

Storage and Backup

Give a rough idea of data volume. Say where and on what media you will store data, and how they will be backed-up. Mention security measures to protect data which are sensitive or valuable. Who will have access to the data during the project and how will this be controlled?

Data Sharing

Note who would be interested in your data, and describe how you will make them available (with any restrictions). Detail any reasons not to share, as well as embargo periods or if you want time to exploit your data for publishing.

Selection and Preservation

Consider what data are worth selecting for long-term access and preservation. Say where you intend to deposit the data, such as in UEL's data repository (https://repository.uel.ac.uk) or a subject repository. How long should data be retained?

Appendix R: Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Exploring Heteronormativity in Mental Health Services: The Experience and Impact of Identity Disclosure for LGBTQ+ Young People who Self-Harm

Thank you for participating in my research study on your **experiences of disclosing LGBTQ+ identities within Mental Health Services**. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the **Participant Information Sheet**, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.), for example through **journal articles, conference presentations, talks**. In all material produced, your identity will remain **anonymous**: it will not be possible to identify you personally.

You will be given the option to receive a **summary of the research findings** once the study has been completed for which relevant contact details will need to be provided. This is voluntary.

Anonymised research data will be securely stored by Dr Matthew Boardman (research supervisor) for a **maximum of 3 years**, following which all data will be deleted.

What if I been affected by taking part?

We hope to minimise the risk of any adverse effects from the research, but recognise there may be parts that have been **challenging, distressing or uncomfortable** in some way. We encourage you to speak with people in your support network if possible (e.g. family, friends, GP, therapist if relevant). You may also find the following resources helpful for further support:

Childline: speak to someone about how you are feeling - 0800 1111

Childline 1:1 online chat: https://www.childline.org.uk/get-support/1-2-1-counsellor-chat/

Samaritans: speak to someone about how you are feeling – 116 123

Shout: support via text – text "Shout" to 85258

Emergency: if you feel at immediate risk of harming yourself or others, you can contact 999 or attend A&E for urgent support and care.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any **questions or concerns**, please do not hesitate to contact me.

Louise Warner: u2075232@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor (Dr Matthew Boardman) School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: m.boardman@uel.ac.uk

or

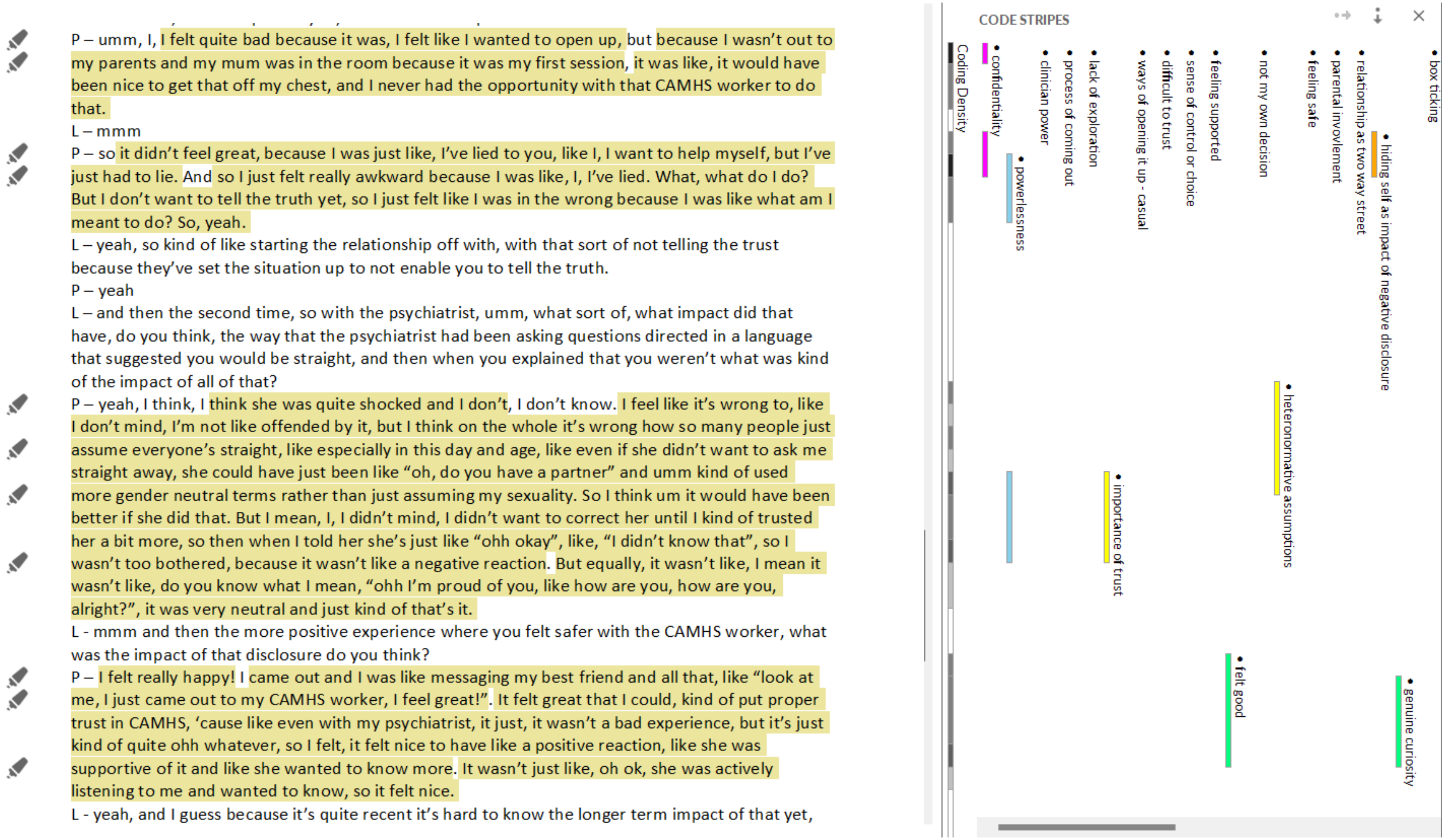
Thank you for taking part in my study

Appendix S: Codes and Transcript Example Extract

First, a list of codes is presented, followed by an extract of coded transcript. Second, a coded example of transcript, using P for participant and L for researcher initial.

- adult vs child services
- assumption of identity confusion
- at the right pace
- attempting to fit in - heteronormativity
- being told to supress identity
- better off straight
- box ticking
- CAMHS are bad in general
- clinical relationships
- clinician acceptance reaction
- clinician ally agenda - tokenism
- clinician attributes
- nice person
- clinician egotistical
- clinician fear
- clinician power
- clinician shock
- clinician think age inappropriate conversation
- clinicians trying but not quite getting it
- clinician embarrassed
- confidentiality
- conflating sexuality with other things
- confusion on all sides
- consequence of identity denial self
- cumulative impact
- dance of decision
- denial of support
- denied own identity
- difficult to trust
- difficulty being open
- difficulty talking about the hard stuff
- disclosure age
- disclosure as opportunity - or not taken opportunity
- disclosure is not a one time thing
- disgust
- dismissive responses - clinician
- easier to support others than self
- emotional impact - looking back and wondering
- family homophobia
- family journey of support
- fear of being seen differently
- fear or uncertainty of response
- feeling accepted
- importance of style of approach
- importance of training
- importance of trust
- importance of validation
- initial disclosure
- lack of change in systems
- lack of exploration
- lack of follow up
- lack of private space
- LGBTQ unique struggles
- longer term impact - not deterred
- missing of important conversations
- Multiple disclosure
- my choice
- negative experience
- negative impact of disclosure on self
- NHS vs other
- not being listened to
- not feeling accepted
- not just words
- not my own decision
- not supported
- not understood
- others are open and I am not
- out of my control
- parental involvement
- pathologisation of identity
- patient vs professional
- personal reaction to disclosure
- power of choice
- powerlessness
- process of coming out
- professional types
- questions based asking
- reaction of self - disappointed
- relationship as two way street
- relevance to wellbeing
- role of therapist - mediation
- safe to be open
- seamless questioning
- search for validation
- self- withdrawal from relationship
- self-acceptance

feeling comfortable	self-blame
feeling heard	sense of control or choice
feeling invalidated	signs of safety or affirmative signs
feeling judged	stigma of CAMHS
feeling rejected	testing out disclosure
feeling safe	the changing times
feeling supported	the damage
feeling uncomfortable	the impact of coming out - family
feeling understood	the individual clinician
felt good	therapist invalidation
figuring out own identity	therapist lack of understanding
genuine curiosity	therapist response as barrier to therapy
getting the nuance	they viewed it as an issue
happiness with openness	threat of the clinician
hard to bring it up again	tokenistic acts and shows
heteronormative assumptions	treated as normal
heteronormativity - grieving for that	unable to be open
hiding self as impact of negative disclosure	unexpected
homophobia in the world	unsure of feelings
needed to be in the right mindset	valence of experience
impact - desire for it to have been different	wanting to be open
impact of judgement	wanting to come out on own terms
impact on and of mental health	ways of opening it up - casual
impact on self - identity denial or confusion	weirdness of question
importance of openness by clinician	wellbeing context
importance of community	what happens to info about disclosure
importance of considering context	
importance of consistency in care	
importance of exploration	



P – umm, I, I felt quite bad because it was, I felt like I wanted to open up, but because I wasn't out to my parents and my mum was in the room because it was my first session, it was like, it would have been nice to get that off my chest, and I never had the opportunity with that CAMHS worker to do that.

L – mmm

P – so it didn't feel great, because I was just like, I've lied to you, like I, I want to help myself, but I've just had to lie. And so I just felt really awkward because I was like, I, I've lied. What, what do I do? But I don't want to tell the truth yet, so I just felt like I was in the wrong because I was like what am I meant to do? So, yeah.

L – yeah, so kind of like starting the relationship off with, with that sort of not telling the trust because they've set the situation up to not enable you to tell the truth.

P – yeah

L – and then the second time, so with the psychiatrist, umm, what sort of, what impact did that have, do you think, the way that the psychiatrist had been asking questions directed in a language that suggested you would be straight, and then when you explained that you weren't what was kind of the impact of all of that?

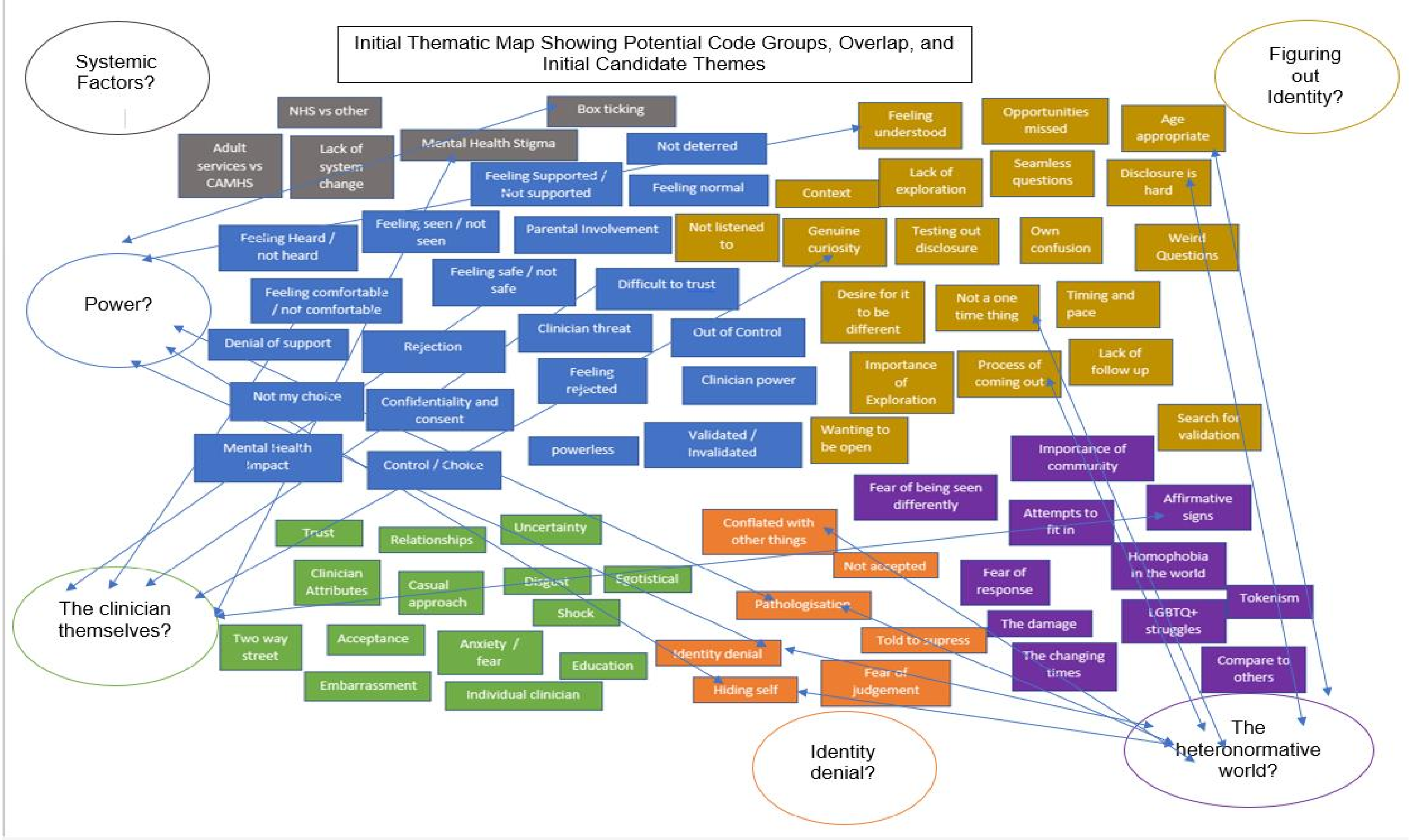
P – yeah, I think, I think she was quite shocked and I don't, I don't know. I feel like it's wrong to, like I don't mind, I'm not like offended by it, but I think on the whole it's wrong how so many people just assume everyone's straight, like especially in this day and age, like even if she didn't want to ask me straight away, she could have just been like "oh, do you have a partner" and umm kind of used more gender neutral terms rather than just assuming my sexuality. So I think um it would have been better if she did that. But I mean, I, I didn't mind, I didn't want to correct her until I kind of trusted her a bit more, so then when I told her she's just like "ohh okay", like, "I didn't know that", so I wasn't too bothered, because it wasn't like a negative reaction. But equally, it wasn't like, I mean it wasn't like, do you know what I mean, "ohh I'm proud of you, like how are you, how are you, alright?", it was very neutral and just kind of that's it.

L - mmm and then the more positive experience where you felt safer with the CAMHS worker, what was the impact of that disclosure do you think?

P – I felt really happy! I came out and I was like messaging my best friend and all that, like "look at me, I just came out to my CAMHS worker, I feel great!". It felt great that I could, kind of put proper trust in CAMHS, 'cause like even with my psychiatrist, it just, it wasn't a bad experience, but it's just kind of quite ohh whatever, so I felt, it felt nice to have like a positive reaction, like she was supportive of it and like she wanted to know more. It wasn't just like, oh ok, she was actively listening to me and wanted to know, so it felt nice.

L - yeah, and I guess because it's quite recent it's hard to know the longer term impact of that yet,

Appendix T: Initial Thematic Map



Appendix U: Extract from Researcher Reflexive Notes

November 2022

There have been difficulties in recruiting young people via Twitter and other social media sites, and I am aware that my own views on social media may be impacting this to an extent, in terms of the ways I interact with the account. However, I'm also aware there are many people who I follow, or who follow me, who appear to meet the criteria for my study. I'm wondering about what might be getting in the way of these young people reaching out to participate, and aware that one factor might be the framing of the study and the way I am advertising it. By using the word 'heteronormativity' in the title, I am effectively limiting the number of young people who might choose to take part to those who recognise and resonate with this term, or who feel comfortable speaking about their experiences within this frame.

Thinking about why I chose to frame the research in this way, I am aware I picked language that resonated for me, within my own experiences related to this topic. However, from my own personal experience and the experiences of others around me – friends, clients, colleagues – and from evidence in other research, I felt there was sufficient grounds for using this term. I think my hope was also that it would encourage young people to speak about more negative experiences, which could be difficult for them to be open about with an unknown researcher, given that they would not know in advance if I was a safe person to speak with about this. Therefore, I think my hope in choosing this language was that it would be a signal to those who might want to participate that I was someone they could speak to about more difficult experiences, or experiences framed in the context of pervasive heteronormativity. However, again I am aware that the concept of what is safe or not safe here was chosen by me, based on perhaps my own experiences of safety or unsafety, and my own assumptions about what the process of assessing relational safety might look like for potential participants. Therefore, I decided to keep the language of the advert as it was in subsequent posts on social media, but held a curiosity ongoing about the potential impact of this language.