The emotional health and wellbeing of young people who identify as lesbian, gay, bisexual or trans

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Introduction

This chapter examines evidence on the experiences of young lesbian, gay and bisexual (LGB) people, and the implications for their emotional health and wellbeing, based on a study of schools and youth work settings in South Yorkshire, England. In doing so, it also draws on other (inter)national evidence which indicates the transferability of the findings, and makes suggestions for future support for lesbian, gay, bisexual and trans (LGBT) young people. This is important in linking to three of the (2010) Marmot review objectives, concerning children, young people and adults maximising their capabilities and control over their lives; healthy sustainable places (e.g. schools and other youth-focussed settings), and ill-health prevention.

The study explored barriers and facilitators to issues about (homo)sexuality, homophobia, (trans)gender identities and/or transphobia being included within schools and youth work settings. Whilst the research sought to include trans participants, unfortunately this material is limited, but care has been taken throughout to use the specific acronyms of ‘LGB’ or ‘LGBT’ where appropriate. Where implications for trans young people can be drawn out, these have been included.

The chapter begins by briefly reviewing the study methods, continuing with an outline of some of the existing evidence and practice in this field. This is followed by an overview of the study findings, and suggestions for practice.

Study methods

The study employed a two-stage methodology: a self-completion survey of young people (online and paper-based), and a follow-up stage of individual interviews and group discussions with young people, youth workers, and secondary school teachers with a responsibility for personal, social, health and economic education (PSHE) and/or LGBT issues. Utilising and extending existing relationships, recruitment was via schools, youth work settings, and other local authority, NHS and voluntary sector contacts. In total, there were 146 survey respondents and 74 participants involved in qualitative methods (see Table 1), including nine one-to-one interviews with staff, and eight discussion groups with young people. This approach was taken to gather a range of in-depth perspectives, drawing on the views and experiences of (minority/marginalised) 'lay' groups to identify and explore the issues linking identities and health. This adds to our understanding of current public health concerns, and enables more flexibility, trust-building and participant input than traditional quantitative and/or biomedical approaches allow (see chapter one for further discussion).

Table 1: Participant details

Participants	**Settings**			**Total**
	School	**LGBT-specific youth service**	**Generic youth service**	
Staff	4	3	2	9
Young people (aged 11-12 inclusive)	2 groups (=26 individuals)	2 groups (=19 individuals)	4 groups (=20 individuals)	65
Total	**30**	**22**	**22**	**74**

The sample included both staff and young people who identified as LGB and heterosexual, though this chapter draws more heavily on data from LGB young people. Most young people were engaged in compulsory schooling, though a minority were in some form of further education or employment, and a small number were not involved in any education, training or employment. The majority of participants were 'white'. Whilst recognising that issues other than/in addition to sexuality (e.g. ethnicity, social class) are also likely to impact upon experiences of homophobia and/or health inequalities (see chapters 1 and 7), an in-depth analysis of these factors was beyond the scope of this study.

All interviews and discussions were digitally recorded and written up. These transcripts, and the open text survey data, were analysed thematically. The chapter draws on this qualitative data, using anonymised extracts from participants, with pseudonyms and some demographic information.

Underpinning theory and policy: linking homophobia to public health

Recent years have seen a rise in interest in inequalities or prejudice facing LGBT people in the UK, and internationally. There is growing awareness, for instance, about health inequalities affecting LGBT communities in the UK (Fish, 2007). Within this, particular attention is often paid to (poorer) mental health (King, Semlyen, See Tai et al, 2008; McNeil, Bailey, Ellis et al, 2012). For young LGBT people specifically, evidence from the UK and the US suggests higher incidences of self-harm, depression and/or attempted suicide compared with their heterosexual counterparts (McNamee, Lloyd and Schubotz, 2008; Robinson and Espelage, 2011). They are also said to be more likely to suffer poorer physical health arising from higher incidences of alcohol, drug and/or tobacco use (Espelage, Aragon, Birkett et al, 2008; Rivers and Noret, 2008), and may have poor experiences and/or a lack of access to appropriate healthcare or advice (Buston, 2004; Formby, 2011a). Caution is needed, however, to not over-state these 'risks', or portray LGBT people as inherently unhealthy and/or 'victimised'.

In line with a social model of health, a body of evidence suggests that LGBT health inequalities are linked to external contexts, as are numerous other health inequalities, and that we should examine and address homophobia in this light. Public health interventions could therefore acknowledge the lack of control some young people may have over their lives and related health outcomes; for example, young people may experience adverse reactions to their sexual and/or gender identities from parents and other family members (Formby, 2012; Valentine et al, 2003). This may render the home environment hostile, and can lead to

homelessness. Equally, schools and other settings where young people spend their time can be experienced as hostile and/or limiting young people's potential/capabilities. Existing research looking at LGB experiences of schooling in the UK, for instance, has identified discriminatory attitudes among some staff and broader invisibility of same-sex relationships and identities (Ellis and High, 2004; Formby, 2011b), as well as the prevalence of homophobic bullying and poor or inadequate responses from some schools (McNamee et al, 2008; Warwick et al, 2001). Studies have suggested that LGB young people are rarely included in the (formal) school curriculum because staff are uncomfortable, lacking confidence, or fearful about including LGB issues within their teaching, particularly regarding sex and relationships education (SRE) (DePalma and Atkinson, 2006; Formby, 2011b).

Historically, the policy framework has not supported matters of LGBT inclusion. The infamous 'Section 28', for instance, forbade English, Welsh and Scottish local authorities (although ironically not schools) from 'promoting' homosexuality as a "pretended family relationship" and created a climate of fear regarding teaching about LGB identities or relationships, the legacy of which still remains (Greenland and Nunney, 2008). More specifically, the most recent (English) governmental guidance on SRE (DfEE, 2000: 4) continues to 'promote' the importance of (by definition, heterosexual) marriage for child-rearing and 'family life'. In addition, PSHE within which some, though not all, of this teaching could fall remains non-statutory in England, resulting in 'patchy' practice (Formby and Wolstenholme, 2012). Recent cuts to youth and mental health services in the UK (Puffett, 2013a, b) are also likely to impact upon LGBT support in both the statutory and voluntary sectors.

A broad range of institutional practices are relevant to addressing public health inequalities and helping create healthy sustainable places which are supportive of all young people, regardless of their gender and/or sexual identities. UK and international research indicates that where schools are more supportive environments, they can lessen the potential for negative outcomes for LGBT pupils (Espelage et al, 2008; Tippett et al, 2010). Ill-health prevention work therefore has a place in both formal and informal curricula/settings, to prevent negative experiences in adolescence impacting upon educational attainment/inequality and/or on mental health/emotional wellbeing (Rivers, 2000; Robinson and Espelage, 2011).

Drawing on a social model of health, this chapter critiques the growing (individualist) anti-bullying agenda and argues that it risks minimising understandings of biphobia, homophobia and transphobia. Whilst the term homophobia is rooted in psychology (Adam, 1998), and not without its problems, it was nevertheless the word most used by participants to denote prejudice towards LGB (and sometimes trans) individuals/groups. The terms heterosexism and heteronormativity may imply a broader, more sociological analysis, but they are not widely understood or used as commonly as the term homophobia. Homophobia is therefore used throughout this chapter as shorthand for opposition to same-sex relationships and identities that is embedded within social structures and processes. As O'Brien (2008: 497) notes, "homophobia differs from the common definition of 'phobia' in that the fear is not rooted in individual experience, but rather in culturally learned prejudices".

The research and its findings: Experiences, consequences and responses to homophobia and bullying

Experiences of homophobia and/or bullying

The study identified a range of experiences of homophobia and/or bullying (verbal and physical), most often from those identifying as LGB, but also those with lesbian or gay parents, and those perceived to be 'different' in some way. To a certain extent, LGB participants appeared to expect and/or 'accept' this bullying, because they were aware of their 'different' status:

> "There's going to be people out there that are going to be horrible about it, you've just got to learn to deal with it... it's something that comes along with the territory... it's the society we live in" (Matt, male LGBT youth group member aged 16).

Though there were overt expressions of disapproval of LGB identities among both staff and young people, the issue of (homophobic) language use was complex. Some young people (including LGB) felt that the negative use of the word 'gay' was not homophobic, but others were aware of the potential for offense and/or for it to be understood as 'bullying'. Some (LGB) young people did find the term 'gay' used in this way offensive, and said it made them "more nervous" about 'coming out' about their sexuality, demonstrating that intention and perception were not always synonymous when concerning language use.

Other incidences of homophobia/bullying were more clear/explicit, with illustrative examples provided by a number of young people from different schools, including one person having a ‘water’ bomb of urine thrown at them whilst at school, and another having acid thrown at them within a science lesson.

Whilst most experiences of homophobia/bullying among LGB participants related to other pupils, there was also evidence of teachers at a range of schools in the region demonstrating discriminatory attitudes towards LGB pupils, which could leave them feeling isolated or vulnerable. Young people recalled teachers’ comments that were clearly negative and discriminating:

> “No wonder you get bullied because you act so gay” (Mark, male LGBT youth group member aged 15)

> “If my son or my daughter was ever gay I’d take them into the back of my garden, tie them to the wall and shoot them with a shotgun” (Becky, female LGBT youth group member aged 16).

Consequences for young people

Policies and practices within schools could also be experienced negatively by LGB pupils. Examples include several schools that made (known) lesbian/gay pupils change for physical education (PE) away from other students, making some feel marginalised and excluded, and contributing to them not attending PE and/or school. This clearly has implications for physical health and educational

attainment/inequality. In one case a student who complained about this practice was said to be “causing a fuss”, but elsewhere a student had ‘co-operated’:

> “At the end of the day it was partly my decision to do it ‘coz I was scared of stuff that would get said or done” (Mark).

Though there are potential repercussions for physical and sexual health too, the impact of bullying and other homophobic experiences was linked by staff to mental health and emotional wellbeing:

> “The impact being gay and being out and being bullied has on young people’s mental health is colossal... The amount of mental health issues in that group that we know about is immense, the ones we don’t know about makes me shudder” (Male youth worker A, supports LGBT youth group).

Some felt that these potential impacts were not always understood by other professionals, whether or not they worked directly with young people:

> “I get kids who self-harm, who have eating disorders, who run away from home because it’s not challenged... [but] some other professionals don’t see it [as] being a massive deal” (Youth worker A).

Professional responses

As with young people, there were differing professional opinions about the links between language use and homophobia. Some assumed that the use of particular language was intended to be humorous. This was not always an assumption shared by LGB young people who felt bullied. A minority of staff, however, explicitly linked negative language use to bullying, whether or not they thought that was the original intention:

> "I think for us it is the isolation that people feel when people make comments that makes them feel bullied, and it is a constant problem that yes they [young people] do use the word gay as a putdown" (Teacher A, female PSHE lead).

Generally, there was a consensus among young people, both LGB and heterosexual, that schools did not respond to homophobic bullying/language as "seriously" as they did in relation to other forms of prejudice, with racism always the example cited.

Among LGB participants, there tended to be greater disapproval of what they perceived to be schools' lack of action:

> "People still get away with it in school, it's a bit disgusting really because the school don't really do anything about it" (Gareth, male LGBT youth group member aged 14).

The prevalence of, and lack of response to, homophobia in schools was acknowledged by some professionals:

> "It makes me sad that young people don't feel they can report it but I also think that if they are getting it every day at school they just want a quiet life, they just want to come here, somewhere they can just sit and just be safe... and just be themselves and I don't think they get that at school or college" (Youth worker A).

Illustrations of what were felt to be inappropriate or inadequate responses to bullying by professionals/schools were also provided. These included the student (mentioned above) who had the urine-filled 'water' bomb thrown at them but was not allowed home to change, and the student who had acid thrown at them who was told by the teacher they were "too busy" to discuss it. Often young people felt that bullying was left unaddressed and/or that their complaints were not believed.

A particular response to bullying, in 'supporting' LGB pupils via counselling, was viewed as problematic by some, whether that related to an assumption of 'blame', or its perceived usefulness:

> "I was kind of like, hang on a minute, 'coz it kind of made me feel like, 'oh is this my fault now, is there something wrong with me?' ...You've referred me to this person because you think she'll be able to help me, but you didn't bother to check that she was going to be able to help me or not, so you've wasted my time taking me out of lessons" (Becky).

A number of young people felt that instead of providing counselling referrals, the schools should have challenged the ‘perpetrators’ of the bullying.

Valued support

Young people more often valued support which they did not equate with an ‘at fault’ or ‘victim’ identity. Many young people appreciated the LGBT-specific youth service they were involved with locally, which facilitated access to specialist and/or peer support:

> “You’re meeting other young people who have been in the same shoes as you... and if you need help you can get it, and you can just talk to people and make new friends who are in the same boat” (Gemma, female LGBT youth group member aged 18).

For more than one participant, this service was seen as making the difference between life and death:

> “This is gonna sound really dramatic but I’d probably be dead if I never came here... because of the amount of bullying that you get and the way that people talk to you, the way that people react... you feel like crap, it’s either someone’s gonna end everything for you, or you’re gonna end it for yourself” (Becky).

The safety, confidentiality and identity validation that these environments provided were often said to be crucial because of the fear young people reported related to coming out to parents and/or other staff. Specialist professionals and services were therefore important in supporting wellbeing. However, whilst specialist provision was often viewed as necessary, some staff expressed caution in case it was assumed that young LGBT people automatically need support. This may well be a hard balance to strike: to offer or provide young (LGBT) people support, at the same time as not assuming or implying everyone has a need for it.

Examining professional practices

Where incidences of homophobia were conceptualised as bullying, particularly in relation to language use, this was likely to determine the approach schools might take. Whilst some were more likely to respond to the 'victim' than the 'perpetrator' (e.g. through counselling), others were keen to frame their response within a 'zero tolerance' approach. This meant silencing or stopping all 'inappropriate' language use within an anti-bullying strategy, which met with some teacher support. Some youth workers, however, were more likely to want to give young people the 'permission' to voice potential homophobia, in order to generate discussion, and hopefully in the long-run greater awareness and/or changed attitudes.

In practice terms, it depended whether voicing particular opinions was interpreted as bullying, and therefore punishable, or whether those opinions were interpreted as a 'right' for those young people, albeit perhaps something to be 'worked on' or 'worked with'. This latter approach arguably requires more complex input and time

commitment from staff, and explicitly means giving young people the space to voice potential disapproval of LGB identities and relationships, which may not be compatible with the power dynamics and resources available within schools.

Application to policy and practice

This study broadens existing literature in looking at youth work settings as well as schools, and emphasises the prevalence of homophobia in some young people's lives, which can limit their capabilities, control and ability to prevent ill-health, whether emotional or physical. Drawing on a social model of health, homophobia is a wider problem influencing the settings young people frequent, rather than an individualised problem of bullying. How ever the problem is understood, there is clear potential for negative experiences in adolescence to impact upon emotional health and wellbeing, or a positive sense of self. Those working with young (LGBT) people therefore need to maximise the potential for meeting Marmot review objectives. Possible ways forward from the findings are now discussed.

Capabilities and control

Young LGBT people may need access to 'safe space', specialist expertise and/or peer support. These can be facilitated through LGBT groups supported by a designated worker, but care needs to be taken to not assume that all LGBT young people will want/need this (see Formby, 2012 for further discussion of 'safe spaces'). Equally, individual support may be required but care should be taken to not imply any LGBT 'fault' or inherent 'victim' status, and crucially to ensure that the young

person wants the support on offer. An alternative/additional way to support LGBT young people is to help them feel that their identities are 'accepted' and 'normal' by facilitating access to affirming events such as Pride[1], even when this may have to be kept confidential from their parents for safety reasons (Formby, 2012 explains the importance of Pride events to LGBT wellbeing).

More broadly, stronger governmental support for appropriate PSHE and/or SRE could facilitate greater LGBT inclusion within schools. This is not to suggest that these are the only curriculum areas where LGBT identities should feature, but that if delivered well and afforded status within schools, these subjects can provide space for young people to explore their own identities and wellbeing, as well as those of others.

Healthy places

If one follows the argument that the problems of homophobia and transphobia exist within wider society, then the solutions to those problems also lie in broader contexts, not just with individuals. This means that concern for young LGBT people's wellbeing should be addressed at a whole-school level, rather than just focussing on known individuals. There needs to be far greater inclusion of LGBT identities within mainstream schooling and youth work practice, rather than a focus on tackling bullying and/or 'supporting' LGBT young people (though this may also need to be provided). Arguments for inclusion can therefore be based more on

[1] Pride events celebrate LGBT communities, and often mark the history of the LGBT rights movement. They take place in many locations around the world.

equalities/diversities and public health agendas than anti-bullying and support needs agendas, which is not to suggest support services should not still be in place. If homophobia is 'culturally learned' (O'Brien, 2008) or facilitated, as evidenced in this study, and has implications for health inequalities, schools and youth work settings need to acknowledge the relevance and significance for *all* young people, and staff.

Ill-health prevention

Ideally, future policy and practice would broaden the agenda from bullying to also addressing the potential health implications of heterosexism, homophobia and transphobia, in the first instance by making LGBT identities visible across formal and informal curricula. Sometimes lack of visibility could be addressed as easily as displaying relevant posters (such as advertising local Pride events), or using more inclusive (gender-neutral) language, and not only in PSHE or LGBT-specific youth provision. This may involve support for staff who feel unconfident or unskilled in this area. LGBT history month is a useful resource to demonstrate how LGBT identities have historically been rendered invisible and/or inferior, and how current practice can begin to address this imbalance (see http://lgbthistorymonth.org.uk). The LGB charity Stonewall[2] also offer resources/services which some local authorities (such as Sheffield) engage with via the education champions programme.

A 'joined up' approach to LGBT public health could see public health professionals looking to examine less common sites of public health practice, such as schools and

[2] See www.stonewall.org.uk.

youth work settings, and could see workers in these same sites engaging more with public health issues. Public health's move from NHS to local authority jurisdiction could encourage this dialogue in the future, if practitioners, and crucially academies and free schools (see Hirst chapter), are willing to engage.

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