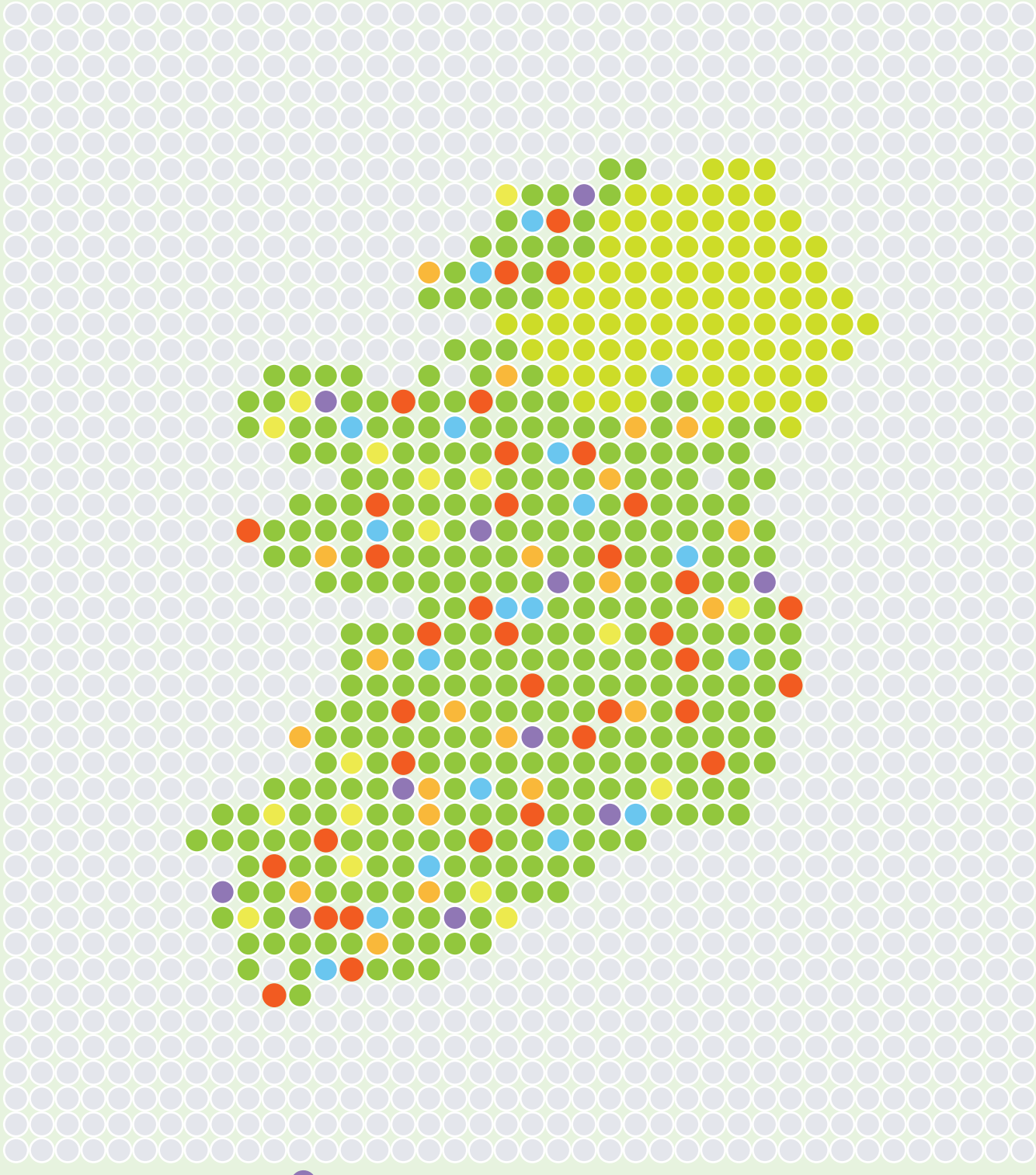

LGBTIreland

glen
gay + lesbian equality network

Supporting Lesbian, Gay, Bisexual & Trans Young People in Ireland
belong to

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Connecting For Life

The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland

Published by GLEN and BeLonG To, Dublin.

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FOREWORD

Ireland's national suicide prevention strategy Connecting for Life 2015-2020 has two intended outcomes: reduced suicide rate in the whole population and amongst specified priority groups; and reduced rate of presentations of self-harm in the whole population and amongst specified priority groups. Members of the lesbian, gay, bisexual, transgender and intersex (LGBTI) community have been shown by national and international research to have increased risk of suicidal behaviour, and have been identified as a priority group within Connecting for Life.

The LGBTIreland Report details the findings of a national study of the mental health and wellbeing of LGBTI people in Ireland, with a special emphasis on young people. It is considered to be the largest study of LGBTI people in Ireland to date, as well as the largest study of transgender people, and the first study with a sample of intersex people. It facilitates comparison with the 2009 Supporting LGBT Lives study, which was the first major research on the mental health and well-being of LGBT people in Ireland, to help assess and identify a way forward. It also makes comparison with the 2013 My World Study, which is the national study of youth mental health in Ireland.

Against this background, The LGBTIreland study was funded by the HSE's National Office for Suicide Prevention in order to add to our understanding of the link between society's negative treatment of LGBTI people and the increased risk of poor mental health, self-harm and suicidal thoughts. This information is vital in order to better design effective responses.

The findings of this study suggest that similar to the general population a large proportion of LGBTI people (approximately 70%) are experiencing positive wellbeing. However, the study also highlights particular vulnerability among young LGBTI people, and reports rates of self-harm as two times higher, and attempted suicide as three times higher, compared to their non-LGBTI peers.

While this study reports improvements in the lives of LGBTI people, it also highlights that minority stress continues to have a very real negative impact on the mental health and wellbeing of LGBTI people. I would like to acknowledge the crucial role our LGBTI partner organisations have and continue to play in leading and coordinating initiatives to improve the lives of LGBTI people in Ireland. I believe this study and its recommendations capture progress made, as well as provide a platform for collaborative efforts to help ensure that the appropriate supports and services are available for LGBTI people. I would like to thank GLEN (Gay and Lesbian Equality Network) and BeLonG To Youth Services for commissioning this study. I also wish to thank the research team led by Professor Agnes Higgins from the School of Nursing & Midwifery, Trinity College Dublin.

Connecting for Life sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. We recognise that we cannot do this alone, no single agency, no single Government Department, no single individual can reduce suicide on their own. Therefore, we must ensure that we work together, to achieve our shared and attainable goal for all people of our nation.

Gerry Raleigh
Director
HSE National Office for Suicide Prevention

PREFACE

The LGBTIreland Report is a groundbreaking study of the mental health of lesbian, gay, bisexual, transgender and intersex (LGBTI) people in Ireland. It is the result of a very productive partnership between GLEN, BeLonG To, the National Office for Suicide Prevention and Trinity College Dublin.

This report includes the findings from a national study with two distinct components. Module 1 aimed to gain a better understanding of the lives of LGBTI people with a special emphasis on young people. It looked at the factors that may impede or facilitate their mental health and wellbeing. Module 2 assessed public attitudes towards LGBT people to gain a better understanding of how the social environment can shape the lives and wellbeing of LGBTI people. Due to the extraordinary response rate received, this study is the largest study of LGBTI people in Ireland to date, the largest study of transgender people, and the first study with a sample of intersex people.

In the last two decades, Ireland has slowly but steadily made significant advancement in achieving equality for its LGBTI citizens. As a direct consequence of these developments, Ireland has evolved from a society noted for being LGBTI oppressive to being considered internationally as a forerunner in progress on equal civil rights of LGBTI people. It is heartening to see in the findings of this study that a majority of participants aged 26 and over were doing well and reported good self-esteem, happiness and life satisfaction as well as being proud of their LGBTI identity. It was also very encouraging to find that the majority of the Irish residents polled were largely positive about LGBT people, although some misunderstandings remain about sexual orientation and gender identity which need to be addressed.

However, despite recent positive social changes the study found that a very significant number of those aged under 25 did not experience the same levels of positive mental health and wellness as those older than them. Some of the findings are harrowing, especially the very elevated levels of suicidal behaviour and self-harm among LGBTI teenagers as well as the worrying levels of severe and extremely severe stress, anxiety and depression. The study confirms that 12 is the most common age for people to know they are LGBTI and that they negotiate coming out against the backdrop of a very challenging school environment where there has not been a significant reduction in anti-LGBTI bullying in recent years. The data reveals that anti-LGBTI bullying in schools can have a devastating impact on LGBTI teenagers' mental health, increasing the likelihood of reporting stress, depression, anxiety, self-harm and attempted suicide.

The LGBTIreland Report also reveals that there is a hierarchy of risk among LGBTI people, with intersex, transgender and bisexual people reporting poorer mental health outcomes compared to gay men and lesbian women. This hierarchy of risk reflects the fact that more progress has been made on reducing homophobia in Ireland than biphobia and transphobia. This hierarchy of progress highlights the need for increased advocacy and support for bisexual, transgender and intersex people and to address the diverse needs within the LGBTI community.

The exciting progress achieved for Irish LGBTI people in 2015 gives us solid ground from which we can work to achieve the recommendations in this report. Marriage equality and gender recognition were momentous milestones, but much work still needs to be done to ensure that all LGBTI people are equal, safe, included and valued across Irish society. The past continues to exert its negative legacy on many LGBTI lives. The harmful effects of stigmatisation of LGBTI identities and the associated experiences of rejection and discrimination still continue to be a reality. These can be compounded by a continuing level of misunderstanding of LGBTI sexual orientations and gender identities among the general public.

The participants who were aged 16 at the time of this study were born in 1998. This was 5 years post-decriminalisation of homosexuality, 2 years before the Equal Status Act, 12 years before the Civil Partnership Act, and 17 years before the Marriage Equality Referendum and the Gender Recognition Act. While they have seen Ireland change incrementally in the direction of being a more LGBTI-friendly country, with laws and social attitudes steadily moving in the right direction, they have also encountered a range of LGBTI-specific stresses which pose enormous challenges to their mental health. The many manifestations of homophobia, biphobia and transphobia the teenagers in this study experienced are at the core of what needs to change in Ireland henceforth.

GLEN and BeLonG To would like to express our deep appreciation to the LGBTI people who shared their experiences and stories in the survey and to the 1,000 plus Irish adults who participated in the attitudes research. Your trust has inspired us. We are sincerely grateful to the brilliant, committed and generous research team, very ably led by Prof Agnes Higgins of Trinity College Dublin, who conducted the study. The project very much benefitted from the support and expert guidance of our Research Advisory Group for which we are very grateful. We would like to extend our sincere gratitude to the HSE's National Office for Suicide Prevention, who generously funded this study and supported it at all stages. We look forward to continuing our partnership with NOSP to achieve a reduction in suicide and self-harm among LGBTI people in Ireland.

Speaking at the launch of the research Dr Mary McAleese eloquently captured the core message emanating from the findings of *The LGBTIreland Report* and the direction of change GLEN and BeLonG To hope to see evolve in the coming years:

"This scholarly report is as essential and revealing as it is horrifying. The ongoing damage is undeniable. That it involves so many young people is tragic. That it is solvable is the good news.

In May 2015 the Irish people convincingly showed their commitment to levelling the playing field for our LGBTI citizens. I know when they read this report they will be heart sore and determined that their homes, streets and schools will not be party to continuing the embedded culture which supports this level of misery. They will want to see a very different story when this research is repeated in a few years time…

We have the chance to make this country the best in the world for LGBTI citizens. It will not happen by chance but by change. We committed to that change last May and now we have to follow through, drilling down through the centuries of sediment, to the heart's core, releasing the goodness, decency and egalitarian sensibility that Ireland is capable of. The children who are in cots and buggies today, who will discover their sexual identity in twelve or so years time, have the right to grow into mentally healthy and well-adjusted teenagers. What we do now can help ensure that no bully and no homophobic, biphobic or transphobic culture will too easily deprive them of that right."

Dr Mary McAleese, Speaking at the launch of The LGBTIreland Report, March 2016

Odhrán Allen
Director of Mental Health
GLEN

Carol-Anne O'Brien
Director of Advocacy
BeLonG To

Acknowledgments

We thank all those who have assisted the project team in carrying out this research. In particular, the LGBTI participants who gave their time to complete the survey, and took the time to write their ideas, experiences and recommendations, thus giving us a wealth of information for future direction. We are also indebted to the people who completed the public attitudes survey, and in so doing have enriched the study and informed recommendations for the future.

We would like to acknowledge the wonderful support and assistance we received from the Research Advisory Group, and for their insightful comments on the various drafts. The group's membership was as follows:

Odhrán Allen (Chair)	Director of Mental Health, GLEN
Dr Carol-Anne O'Brien	Director of Advocacy, BeLonG To Youth Services
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Lisa O'Farrell	Policy Officer, Mental Health Commission
Broden Giambrone	Chief Executive, TENI
Kate Moynihan	Project Coordinator, LINC
Craig Dwyer	Policy & Projects Officer, GLEN

We are also indebted to all the organisations and individuals who assisted us in advertising and recruitment for the study, including the market research company Red C who recruited for the public attitudes survey.

We would like to thank GLEN, and BeLonGTo youth services for commissioning this study and the National Office for Suicide Prevention (NOSP) for funding it. We are immensely grateful for their ongoing support throughout the whole research project.

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List of Terms

Bisexual is a term used to describe someone who is sexually, emotionally and romantically attracted to both men and women.

Biphobia is prejudicial or discriminatory attitudes and/or behaviour directed at bisexual people, whether intended or unintended.

Bi-erasure is ignoring, removing, or re-explaining the evidence of bisexuality.

Cisgender is a term used to describe an individual's gender when their experiences of their gender correspond to the biological sex they were assigned at birth.

Coming out is a process that involves a lesbian, gay, bisexual, transgender or intersex person developing an awareness of an LGBTI identity, accepting their sexual orientation or gender identity, choosing to share the information with others and building a positive LGBTI identity (King & Smith 2004). It not only involves coming out, but staying out and dealing with the potential challenges that one might encounter as an LGBTI person.

Demi-gender is a gender identity that involves feeling a partial, but not a full, connection to a particular gender identity. Demi-gender people often identify as gender non-binary. Examples of demi-gender identities include demi-girl, demi-boy, and demi-androgyne.

Families of choice, or 'friendship families', refer to social networks outside of one's family of origin, which have been highlighted as playing a larger role in the lives of LGBT people when compared to heterosexual people.

Female-to-Male (FTM) Transgender refers to a person assigned 'female' at birth but who identifies as male.

Gay is a term traditionally used to describe a man who is sexually, emotionally and romantically attracted to other men. While the term 'lesbian' is typically used to describe women who are attracted to other women, many women with same-sex attractions self-identify as 'gay'.

Gender fluid refers to a person who does not feel confined by the binary division of male and female.

Gender identity refers to a person's deeply-felt identification as male, female, or some other gender. This may or may not correspond to the sex they were assigned at birth.

Related to this is **gender expression** which is the external manifestation of a person's gender identity. Gender can be expressed through mannerisms, grooming, physical characteristics, social interactions and speech patterns.

Gender dysphoria is the formal diagnosis used by psychologists and psychiatrists to describe transgender people who experience significant distress with the sex and gender they were assigned at birth. A diagnosis of gender dysphoria does not imply mental illness but rather is used as grounds for a person to access medical treatment such hormones and surgery.

Gender non-binary is an umbrella term for gender identities that fall outside the gender binary of male or female. This includes individuals whose gender identity is neither exclusively male nor female, a combination of male and female, or between or beyond genders. Similar to the usage of transgender, people under the non-binary umbrella may describe themselves using one or more of a wide variety of terms (e.g. androgynous, gender fluid, genderqueer, gender variant).

Gender reassignment surgery refers to a variety of surgical procedures by which the physical appearance and function of existing sexual characteristics and/or genitalia are altered to resemble that of another sex.

Heteronormative, or the 'heterosexual norm', refers to the assumption that heterosexuality is the only sexual orientation. It is closely related to 'heterosexism' (see below) and can often cause other sexual orientations to be ignored and excluded.

Heterosexual is a term used to describe someone who is sexually, emotionally and romantically attracted to a person of the opposite sex.

Heterosexism is the assumption that being heterosexual is the typical and 'normal' sexual orientation, with an underlying assumption that it is the superior sexual orientation. This assumption often results in an insensitivity, exclusion or discrimination towards other sexual orientations and gender identities, including LGBT.

Homophobia is prejudicial or discriminatory attitudes and/or behaviour directed at gay men or lesbian women, whether intended or unintended.

Internalised homophobia is the emotional and cognitive internalisation of homophobia, heterosexism and heteronormativity by lesbian, gay and bisexual people,

which has a negative impact on their self-concept and self-esteem. It can be recognised or unrecognised by the individual but has been found to lead to struggle and tension, sometimes severe, for a person when dealing with their sexual orientation.

Intersex stands for the spectrum of variations of sex characteristics that occur within the human species. It is a term used to describe individuals who are born with sex characteristics (chromosomes, genitals, and/or hormonal structure) that do not belong strictly to male or female categories, or that belong to both at the same time. 'Intersex' also stands for the acceptance of the physical fact that sex is a spectrum and that people with variations of sex characteristics other than male or female do exist.

Lesbian is a term used to describe a woman who is sexually, emotionally and romantically attracted to other women.

Lesbian/gay female is a term used in this study to denote the manner in which women self-identified. Some women identified as lesbian and others as gay, and as these groups were combined for the purpose of analysis, the term 'lesbian/gay female' is used throughout the report.

LGB is an acronym for 'lesbian, gay and bisexual'.

LGBT is an acronym for 'lesbian, gay, bisexual and transgender'.

LGBTI is an acronym for 'lesbian, gay, bisexual, transgender and intersex'.

LGBTI-friendly refers to services, programmes, groups and activities which recognise, are inclusive of and welcoming to LGBTI people.

LGBTI-specific is a term used to describe services, programmes, groups and activities that are aimed at and cater specifically to LGBTI people.

Mainstream is a term used to describe services, programmes, groups and activities which are aimed at the general population.

Male-to-Female (MTF) Transgender refers to a person assigned 'male' at birth but who identifies as female.

Minority stress is based on the premise that LGBTI people, like members of any minority group, are subject to chronic psychological stress due to their group's stigmatised and marginalised status in society. While LGBTI people are not inherently

any more prone to mental health problems than other groups in society, coping with the effects of minority stress can be detrimental to LGBT people's mental health.

Pansexual is sexual attraction toward people of any sex or gender identity.

Self-harm refers to the act of harming oneself in a way that is deliberate but not intended as a means to end their life. Examples of self-harm include cutting, scratching, hitting, or ingesting substances to harm oneself.

Sexual orientation refers to an enduring pattern of emotional, romantic or sexual attraction to men, women or both. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual. People who do not experience attraction to any sex may define themselves as asexual.

Transgender is an umbrella term referring to people whose gender identity and/or gender expression differs from conventional expectations based on the gender they were assigned at birth. This can include people who self-identify as transsexual, transvestite, cross-dressers, drag performers, genderqueer, and gender variant. Transgender is commonly abbreviated to trans.

Trans boy/man is a person who was assigned female at birth but who identifies as male or lives as a boy/man. Some trans men make physical changes through hormones or surgery; others do not.

Trans girl/woman is a person who was assigned male at birth but who identifies as female or lives as a girl/woman. Some trans women make physical changes through hormones or surgery; others do not.

Transphobia is prejudicial or discriminatory attitudes and/or behaviour directed at people who are transgender, transsexual, or people whose gender identity or gender expression differs from the traditional binary categories of 'male' and 'female', whether intended or unintended.

Transitioning is the process through which a person takes steps to live in their preferred gender. This can include changing appearance, mannerisms, name/pronouns, legal documentation, and other personal, social, and legal changes. This may also include undertaking hormone replacement therapy, gender reassignment surgery and/or other treatments such as electrolysis, feminisation or masculinisation surgery and therapeutic supports.

Executive Summary

Introduction

In the last two decades, Ireland has slowly but steadily made significant advancement in the civil and legal rights of its LGBT citizens. As a direct consequence of these developments, Ireland has evolved from a society noted for being LGBTI oppressive to being considered internationally as a forerunner in ensuring the equal civil rights of LGBT people. Notwithstanding these most welcome changes, there are notable deficits in our knowledge surrounding the mental health and well-being of LGBTI people in Ireland, and in particular the extent to which experiences and mental health outcomes are similar or different across all LGBTI people. In addition, there is also an absence of comprehensive research on attitudes towards LGBTI people amongst the general population in Ireland, and as a consequence there is little discussion on the interrelationship between public attitudes and LGBTI people's lived experiences in school, college, work and other contexts. In an effort to understand the lives of LGBTI people in the Republic of Ireland and the factors that may impede or facilitate their mental health and well-being, this study, conducted prior to the May 2015 Marriage Equality referendum, comprised two distinct, concurrent modules: module 1 and module 2.

Module one explored the mental health and well-being experiences of LGBTI people in Ireland. Due to the extraordinary response rate received from the LGBTI population, this study is considered to be the largest study of LGBTI people in Ireland to date, the largest study of transgender people, and the first study with a sample of intersex people.

Module one's objectives were:

- To examine mental well-being (self-esteem, life satisfaction and happiness) and mental health issues (depression, anxiety, stress, substance misuse, self-harm and suicidality) among LGBTI people in Ireland, with specific emphasis on the adolescent and young adult cohort.
- To explore the impact of 'minority stress' on LGBTI mental health including experiences of coming out and experiences of discrimination in the context of school/college/work.

Module two assessed Irish public attitudes towards LGBT people.

Module two's objective was:

- To measure attitudes towards LGBT people in a nationally representative sample of the Irish public.

Module one: Design and Key Findings

Research methodology: Module one

Module one utilised a survey comprising 102 questions, which were a complementary mix of open and closed questions, and encapsulated a number of diverse topics including indicators of mental well-being, mental distress, experiences of school, college and work, and barriers to accessing mental health services. The survey was disseminated primarily via social media and supplementary online methods, with hard copies made available on request to potential participants without internet access.

Participant profile: Module one

In total, 2,264 people were included in the final sample of module one. Nearly two-fifths of the sample comprised gay males (38.6%) and just over a quarter were lesbian/gay females (26.5%). The next biggest group was bisexual participants (14.4%), the majority of whom were female. Over one tenth of the sample identified as transgender (12.3%), while 2% of the sample was made up of intersex participants. 6.3% of the sample identified as 'other' gender identity or sexual orientation. Age ranged between 14 and 71 years, with a mean age of 29.63 years. Almost 90% (89.4%; n=2,016) of participants identified their nationality as Irish. Nearly half of the participants (49.8%; n=1116) were from Dublin. Just over 80% of participants were working for payment or profit (47.6%; n=1,074) or were students/pupils (34.6%; n=780). More than half of the sample had completed third level education (55.9%; n=1,264), and almost 60% of the sample (57.7%; n=1,301) reported having 'no religion'. An overwhelming majority of participants in this study had told somebody that they were LGBTI, with only 3.1% disclosing that they had not told anybody. The mean age of knowing one's LGBTI identity in this study was 15 [most common 12], with the mean age of telling another person being 19 [most common 16]. For transgender participants, the mean age of knowing was 14 years of age, the mean age of telling was 20 years of age and the mean age of living in their preferred gender was 22 years of age.

Key findings from Module one: Mental health and well-being of LGBTI people

The findings from module one suggest that similar to the general population a large proportion of LGBTI participants (approximately 70%) are experiencing positive well-being. Across LGBTI groups and age groups, most mean scores for happiness and life satisfaction were above the midpoint of the scales. These are encouraging findings as

they indicate that a large proportion of the sample appraise their overall well-being in a positive light, which in turn may mean that they are experiencing many of the positive outcomes that high levels of well-being can induce.

While between 50-60% of the sample recorded no or very few indicators of depression, anxiety or stress on the DASS-scale, the findings still support the dominant narrative, both internationally and in Ireland, that a significant proportion of LGBTI people experience mental health difficulties. Across LGBTI groups between 12-35% of participants recorded scores indicating severe or extremely severe depression, anxiety, and stress. On all scales of DASS, the youngest age group (14-18 years) had the highest mean scores, followed by the 19-25 year olds. Rates of severe or extremely severe depression, anxiety and stress for the adolescent cohort (14-18 year) was four times higher than the rates reported for the 12-19 year old cohort in the *My World* survey of Irish adolescent and young people (Dooley and Fitzgerald 2012). The youngest age group (14-18 years) had significantly lower scores on satisfaction, happiness and self-esteem, followed by the 19-25 age group. Self-esteem scores were also lower than those reported in the *My World* survey. Alongside differences in mental health difficulties according to age, participants' DASS-scores were also mediated by LGBTI identity, clearly indicating that LGBTI people are not a homogenous group. Intersex had the highest mean scores for depression, anxiety and stress followed by transgender and bisexual participants. The mean scores on the satisfaction, happiness and self-esteem scales were also lowest among transgender and intersex participants.

In relation to self-harm, a lifetime history of self-harm was reported by a third (34%) of participants, which represents an increase on the 27% previously reported in the LGBT population in Ireland (Mayock *et al*. 2009). Nearly half of these (45.6%) reported that they had self-harmed within the past year, with nearly 60% relating their self-harm to their LGBTI identity and their struggle to be accepted by others and society. Over half (55.7%) of the sample aged 14-18 had a history of self-harm, with just over 75% of these having self-harmed in the previous year. Similar to other mental health issues, the findings in relation to self-harm again demonstrate that LGBTI people are not a homogeneous group, as bisexual (54.5%) and transgender participants (48.8%) were more likely to have self-harmed compared to gay males (19.5%). However, both lesbian/gay females and intersex participants also had relatively high levels of self-harm (37.4%, 42.1% respectively). A significant majority (63%) of participants who had self-harmed had thought about it for less than 24 hours.

Almost 60% of the sample had seriously thought of ending their own life, with approximately 45% having thought of doing so within the past year. 60% reported that their suicidal thoughts were at least somewhat related to their LGBTI identity. Of

those aged 14-18, over two-thirds (69.4%) had seriously thought of ending their own life, with over two thirds having considered ending their own life within the past year. A hierarchy of risk was also evident, with intersex (84.2%), transgender (75.6%) and bisexual (65.3%) participants being more likely to have considered ending their life compared to lesbian/gay females (56.4%) and gay males (52.4%). Of those who had seriously considered ending their own life, four in ten (39.9%) did not seek any help for the problems that led them to seriously consider ending their life.

Over one in five of the sample (21.4%) had seriously tried to take their own life. Of these, 26.3% had tried to take their life within the past year. Approximately two-thirds (66.8%) reported that their suicide attempt(s) was at least somewhat related to being LGBTI. Of those aged 14-18, nearly one third (31.9%) had seriously tried to take their own life, with over half (52.5%) having tried to do so within the last year. Of those aged 19-25, over a fifth (21.1%; n=110) had seriously tried to take their own life, with a quarter (25%; n=27) having tried to do so within the last year. Of the 407 participants who had tried to take their own life the mean age was 18.52 (SD=7.31), and the most common age was 15 years. Transgender (35.1%) and intersex participants (57.9%) were more likely to have attempted to take their own life compared to lesbian/gay females, gay males and bisexuals (17-24%). Of those who had seriously tried to take their own lives 30% did not seek help or support for their problems.

In relation to substance misuse, just over 40% of the participants' AUDIT scores indicated some level of alcohol problem. In terms of illegal drug-use, whilst 27% of the general population have reported using any illegal drugs in their lifetime (National Advisory Committee on Drugs 2011), just over half of the *LGBTIreland* study sample had taken drugs recreationally during their life (55.9%; n=1,095). In the general population the lifetime prevalence rate for any illegal drugs was lowest amongst the younger age cohort of 15-24 (27%) (National Advisory Committee on Drugs 2011), whereas, in this study, 49.9% of participants aged 14-25 had taken drugs recreationally.

Findings indicated that being bullied in school because of LGBTI identity exerted a strong influence on the onset of mental health difficulties for young people. Study participants (14-25 year olds) who experienced LGBTI bullying in school had significantly higher scores on the depression, anxiety, stress, and alcohol use scales indicating more problematic alcohol use. They also had significantly lower scores on the self-esteem scale. In addition they were more likely to self-harm, more likely to have seriously considered ending their life, and more likely to have attempted to take their own life than those who had not experienced LGBTI bullying in school. These findings are of concern as approximately a quarter of the 14-18 year old (23.6%) and 19-

25 year old (23.2%) participants reported missing or skipping school to avoid negative treatment related to being LGBTI.

Study findings suggest that LGBTI people continue to experience incidents of victimisation, discrimination and harassment outside of school: 75.2% reported that over their lifetime they had experienced being verbally hurt, with approximately one fifth of participants having experienced physical attacks due to being LGBTI. Gay male, transgender, and intersex participants appeared particularly at risk in this regard. Gay males reported the highest incidence of being physically attacked (29.3%), whilst transgender persons had comparatively high levels of having hurtful things written about them on social media (34.3%), high incidences of being threatened with being outed (40.6%), and the highest incidence of being attacked with a weapon (12.2%). Over a fifth of transgender people (22.1%) also reported being sexually attacked. Given the high incidences of harassment across the board it is not surprising that participants felt unsafe or very unsafe when showing public affection (53%) or holding hands with their partner (47.1%), with between 25% and 33% having some level of fear around being seen going to or leaving an LGBTI club or venue, reading an LGBTI publication in a public space, or checking an LGBTI website on a public computer. Approximately 60% of the transgender participants reported feeling unsafe to express their gender identity in public.

LGBTI people's experiences of college/university and work appear to be largely positive; participants' most common rating of LGBTI friendliness of work and college/university was 10 meaning 'completely LGBTI-friendly', which suggests that there have been many positive advances in colleges and universities, and workplace culture. Compared to both school and the workplace, college/university rated highest in terms of LGBTI friendliness, suggesting that college/university is a vastly improved experience for students who identity as LGBTI. The lowest incidence of bullying was also found for college/university (15.2% compared to 17.4% for workplace and 47.5% for school).

Despite LGBTI people's increased risk of mental health problems, the vast majority of participants identified a number of both systemic and psychosocial inhibitors to accessing mental health care. Whilst some of the barriers cited were specific to all people (lack of services, stigma, fear of being medicated), some LGBTI-specific barriers were cited, including fear that their sexual orientation or gender identity would be pathologised, and a lack of knowledge and skill among staff to respond to the needs of LGBTI people in a non-discriminatory fashion.

Participants were asked for their recommendations for future development in a number of areas. Interestingly, there was a consistency in the themes proffered by

participants across all groups and ages, and these included recommendations for: increased visibility and normalisation of LGBTI identities; enhanced education on, and awareness and positive affirmation of, LGBTI identities, including increasing awareness and visibility of LGBTI identities in schools; and enhancing protection and support for LGBTI identities. Recommendations explicitly reiterated the strong mediating role experiences of heteronormativity, rejection, victimisation, and harassment have on LGBTI people's feelings of societal acceptance, sense of belonging, mental health outcomes and willingness to publicly disclose LGBTI identity.

Module two: Design and Key Findings

Research methodology: Module two

Module two also consisted of a survey which incorporated 39 statements regarding attitudes towards LBGT people using Likert scales. The survey explored numerous topics including the Irish public's frequency of interaction with LGBT people, their belief system about being LGBT, their comfort with proximity to LGBT people, their attitudes towards sexual expression by LGB people, their acceptance to and tolerance of discrimination against LGBT people, their opinions regarding education about LGBT issues within school and the equality agenda. Module two's survey was administered via the telephone to a nationally representative sample by the market research company Red C. This survey did not explore frequency of interaction or attitudes towards intersex people.

Participant profile: Module two

In total, 1,008 telephone interviews were conducted. To ensure a nationally representative sample, quotas were set on age, gender, class and region. Module two's sample consisted of 51% (n=514) male participants and 49% (n=494) female participants. Ages ranged from 18 to 65 and over, with 11% (n=111) in the youngest age group (18-24 years) and 16% (n=161) in the oldest age group (65+ years). The participants were spread throughout the country: 54% (n=544) were in Dublin or the rest of Leinster, 28% (n=282) in Munster, and the remaining 18% (n=181) in Connacht/Ulster.

Key Findings from Module two: Public attitudes towards LGBT people

Importantly, the vast majority of the sample (87%-90%) did not believe it was okay to discriminate against LGBT people in services or employment, and there was also a high

level of non-acceptance around discrimination and bullying behaviour towards LGBT people. However, 15% of the sample thought that using LGBT slang words 'isn't really a big deal', 13% did not think that making fun of a young person in school because they are LGB is harmful, and 28% of participants felt that bullying is a normal part of growing up and school life. Whilst these views were in the minority, this finding is still of particular concern in light of findings from module one, and other research, which suggest that homophobic bullying in schools has considerable implications on the emotional and psychological well-being of young LGBT people.

The majority of participants demonstrated high levels of comfort in relation to working with LGB people (81%), being friends with LGB people (84%), and having their child taught by an LGB teacher (75%). Participants' comfort levels decrease around public displays of same-sex affection, with a greater percentage of participants indicating discomfort with a male couple kissing (39%) and a female couple kissing (30%) compared to a heterosexual couple (17%) kissing in public. This finding also resonated with findings from module one where over half of the LGBTI participants reported feeling unsafe or very unsafe showing affection with a same-sex partner in public or holding hands with a same-sex partner in public.

The study findings suggest that there may be misinformation in the public domain about sexual orientation and gender identity. Over a third of participants (34%) did not believe that one could know your sexual orientation at a young age like 12, which is at variance with module one's finding where the most common age of knowing was indeed 12 years of age. In addition, a small but significant proportion appear to still believe that being LGB is voluntary, transitory, and controllable, as 25% of participants believed that being LGB is a choice, something that someone can be convinced to become (17%), and that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment (27%). The delegitimising of bisexuality is also evident with 19% of participants believing that bisexual people are just confused about their sexual orientation.

Despite some participants' reservations in having their child taught by a transgender teacher (participants were 12% more comfortable with their child having a LGB teacher compared to a transgender teacher), the majority of participants still reported that they would support a family member who wanted a sex change (70%) and support transgender people's rights to legal recognition (74%).

Three-quarters (78%) of the sample believed that LGBT issues should be addressed in Relationships and Sexuality Education (RSE) within schools and that teachers should give positive messages about LGBT identities (75%). This is a particularly positive

finding in relation to module one of this study given that the need for reforms to the education system regarding increased awareness and visibility of LGBTI identities in schools is an issue that the LGBTI participants strongly and repeatedly identified.

One in three participants (32%) believed that equality has already been achieved for LGBT people and over half (57%) believed that being LGBT today is no longer really an issue, with people who rarely/never interacted with LGBT people being 9-11% more likely to agree that equality has been achieved for LGBT people and that being a LGBT person today is no longer really an issue.

Recommendations

Based on the findings of module one and module two the following seven strategies are recommended for achieving positive change for LGBTI people in Ireland:

- Reduce mental health risks and build resilience among LGBTI people
- Support the LGBTI community to flourish
- Protect and support LGBTI children and young people in schools
- Increase public understanding and change attitudes and behaviour
- Recognise the diverse needs within the LGBTI community
- Build the knowledge and skills of professionals and service providers
- Conduct further research and assess progress

Introduction

In the past 25 years, Ireland has witnessed significant legislative changes which, it is hoped, positively impact the lives of its Lesbian Gay Bisexual Transgender and Intersex (LGBTI) citizens. The earliest of these LGBTI progressive developments included: 1) the decriminalisation of homosexual acts between two consenting adult males aged 17 years or more in 1993; 2) the inclusion of sexual orientation and gender based discrimination in the Employment Equality Acts 1998-2008 and the Equal Status Acts 2000-2008; 3) the passing of the new Passport Act in 2008 allowing transgender people to receive passports in their preferred gender; and 4) the passing of the Civil Partnership Act in 2010 allowing same-sex couples to have their partnerships legally recognised for the first time. Since 2010, progression for LGBTI people has not abated as the described legal, societal, and legislative shifts accumulated to a momentous crescendo on the 22nd of May 2015 when the Irish people voted in a referendum to change the constitution to afford same-sex couples the rights of civil marriage, making Ireland the first country in the world to legalise same-sex marriage by public vote. Further, on the 15th July 2015, the Irish Government also passed the Gender Recognition Act, providing transgender people with full legal recognition of their preferred gender and allowing for the acquisition of a new birth certificate reflecting this change. More recently, in December 2015, the Equality (Miscellaneous Provisions) Bill 2013 amended the provisions of Section 37(1) of the Employment Equality Act making it illegal for religious-run institutions to discriminate against workers on the basis of their sexuality. As a direct consequence of these numerous and significant legislative developments, Ireland has marked its evolution from a society noted for being LGBTI oppressive to being considered internationally as a forerunner in ensuring the equal civil rights of LGBTI people.

While such progression at the bureaucratic level is important and laudable, there is relatively limited evidence available in Ireland from which to surmise whether attitudes amongst the general population towards LGBTI people, expressed on an everyday basis, are advancing at a commensurate pace. It must be acknowledged therefore that these legislative developments may not inevitably equate to improved everyday experiences for all LGBTI people and in all aspects of their lives. Notwithstanding the strength and resilience of LGBTI people, currently available research both internationally and in Ireland has consistently demonstrated that LGBTI people remain a particularly 'at risk' cohort of the population who not only experience elevated rates of mental health difficulties, but do so in part as a result of minority stress (i.e. direct and indirect forms of LGBTI specific discrimination and victimisation, internalised LGBTI identity shame, and stress associated with LGBTI identity concealment).

It is therefore imperative that there are continued efforts to understand the evolving lives of LGBTI people and the factors that may impede or facilitate their well-being,

particularly since there are notable knowledge deficits evident in the discourse surrounding LGBTI people and their unique experiences. For example, a vast amount of prior research has collated lesbian, gay, bisexual, transgender, and intersex people into one seemingly homogenous group.[1] This collation has, in many instances, promoted the perception that the issues and the extent to which they experience them are the same for and across all LGBTI people. However, emerging evidence suggests that the experiences of LGBTI people are very different to one another, not least with respect to their mental health and to public attitudes towards them. There is also a distinct absence of research conducted with intersex people in Ireland and internationally, resulting in a chasm of knowledge and understanding from which to develop adequate policy and practice responses to their needs. In addition, within many contexts, the discursive narrative surrounding LGBTI people almost exclusively focuses on their objective 'vulnerability' without adequate consideration and reflection of positive well-being and their ability to flourish. In a similar vein, permeating all of these limitations in prior research is the absence of LGBTI people's voices and perspectives on what strategies might advance change across various societal contexts. While this is slowly changing with the emergence of participatory and collaborative methodologies, it is vital that future research continues to ensure LGBTI people are to the forefront in identifying the issues and solutions most pertinent to them, ensuring that they play a significant role in the development of future policy and practice. In addition, in the absence of comprehensive research on attitudes amongst the general population in Ireland towards LGBTI people, there has consequently been little discussion of the interaction and interrelationship between public attitudes and LGBTI people's lived experiences across school, college, work and other contexts. Neither has there been any comprehensive discussion on public attitudes and receptive support for policy change within those contexts.

This study, conducted just prior to the marriage referendum, hoped to begin to address some of these knowledge deficits. It comprised two separate modules; one focusing on LGBTI people's overall well-being, their mental health and the factors/contexts informing them, and the second focusing on the general public's attitudes towards LGBT people.[2]

1 Due to this limitation with prior research, the acronym LGBTI is only used when referring to research which has included all cohorts of this population. Correspondingly, the terms LG, LGB, or LGBT are utilised throughout when referring to research which only examines particular groups.

2 The general public's knowledge and understanding of intersex people was perceived to be too limited to ensure reliable responses. Consequently, this module did not explore public attitudes towards intersex people, based on the recommendation of the Steering Group.

Module one consisted of a survey comprised of 102 questions on the various topics presented in the module objectives. This was distributed via social media and other online methods with the support of over 200 organisations and individuals. The survey questions were a complementary mix of open and closed questions to facilitate the garnering of both quantitative and qualitative data. In total, 2,264 people were included in the final analysis of the survey, making it the largest study to date of LGBTI people in Ireland, the largest study of transgender people and the first study that included intersex people. The objectives were:

- To examine mental well-being (self-esteem, life satisfaction and happiness) and mental health issues (depression, anxiety, stress, substance misuse, self-harm and suicidality) among LGBTI people in Ireland, with specific emphasis on the adolescent and young adult cohort.
- To explore the impact of 'minority stress' on LGBTI mental health including experiences of coming out and experiences of discrimination in the context of school/college/work.
- To identify, from the perspective of the LGBTI community, their priorities for future actions to enhance LGBTI affirmative policy, practice and culture.
- To compare the findings regarding LGBT[3] mental health in Ireland in 2014 with previous findings from Mayock *et al.*'s study (2009), with a specific emphasis on the adolescent and young adult cohort of LGBT people.

Module two's objective was:

- To measure attitudes towards LGBT people[4] in a nationally representative sample of the Irish public.

It also consisted of a survey, administered through a telephone interview, which incorporated 39 statements regarding attitudes towards LBGT people using Likert scales of 1 to 5 (1 meaning 'disagree strongly' and 5 meaning 'agree strongly'). In total, 1,008 telephone interviews were conducted with a nationally representative sample.

In this report, module one and module two are presented in chronological order. Module one is divided into nine chapters; the first deals with methodology and the profile of the participants (Chapter 1). Six chapters follow, each examining a particular theme derived from the topics addressed in the survey. These are: 1) LGBTI Well-being (Chapter 2); 2) LGBTI Mental Health (Chapter 3); 3) LGBTI School Years (Chapter 4); 4) LGBTI Experiences of College and University (Chapter 5); 5) LGBTI Experiences of Work (Chapter 6) and; 6) LGBTI Experiences of Mental Health Services (Chapter 7). A chapter

3 Intersex people were not identified as a group within Mayock *et al.*'s (2009) study.

4 This module did not explore public attitudes towards intersex people.

summarising key findings from across all six themes concludes module one (Chapter 8).

Module two is subsequently examined and consists of one chapter on its methodology and findings, and a discussion which links findings from module two to some of the module one findings (Chapter 9). Lastly, the key findings from both modules are identified and the future recommendations arising from both modules are outlined (Chapter 10).

Steering group

A Steering Group was set up to advise on the project. It included representatives of the funders (NOSP), commissioners (GLEN and BeLonGTo youth services) and members from a number of national organisations and Governmental departments: Department of Children and Youth Affairs (DCYA); Department of Health (DOH); Lesbians in Cork (LINC); Health Service Executive (HSE); Mental Health Commission (MHC); and the Transgender Equality Network Ireland (TENI).

CHAPTER 1

MODULE ONE: SURVEY OF THE HEALTH AND WELL-BEING OF LGBTI PEOPLE IN IRELAND

METHODOLOGY

Introduction

This chapter provides an overview of the methodology and methods employed in module one of the study. It includes information about the module's overall objectives and research design, data collection methods, recruitment of participants, sampling, and data analysis. Ethical considerations for the module are also addressed. The chapter concludes with an overview of the sample profile.

Objectives

The objectives of module one were:

1. To examine mental well-being (self-esteem, life satisfaction and happiness) and mental health issues (depression, anxiety, stress, substance misuse, self-harm and suicidality) among LGBTI people in Ireland, with specific emphasis on the adolescent and young adult cohort.
2. To explore the impact of 'minority stress' on LGBTI mental health including experiences of coming out and experiences of discrimination in the context of school/college/work.
3. To identify, from the perspective of the LGBTI community, their priorities for future actions to enhance LGBTI affirmative policy, practice and culture.
4. To compare the findings regarding LGBT mental health in Ireland in 2014 with previous findings from Mayock *et al.*'s study (2009), with a specific emphasis on the adolescent and young adult cohort of LGBT people.

Research design

The module employed a survey design that combined open and closed questions.

Inclusion criteria

The inclusion criteria for module one were: any person who identified as LGBTI; was 14 years of age or over, and living in the Republic of Ireland.

Data collection methods

Survey

Data for module one were collected using a survey that was designed by the research team and comprised of 102 questions[5]. The questions were derived from a range of sources. Some were previously developed and validated questions, tested scales and instruments, while other questions were developed by the research team. Previously developed questions were sourced from: TransPULSE survey (TransPULSE Project Canada 2009), the Central Statistics Office (CSO) Census 2011 Ireland (Central Statistics Office 2012), and the *Visible Lives* survey (Higgins *et al.* 2011). Measures that were used in the survey included:

- Rosenberg's Self-Esteem Scale (Rosenberg 1965)
- Alcohol Use Disorders Identification Test (AUDIT) (Babor *et al.* 2001)
- Depression, Anxiety and Stress Scale (DASS-21) (Lovibond and Lovibond 1995)
- Self-harm and suicidality from the Lifestyle and Coping Survey (Madge *et al.* 2008)
- Modified 15-item Coping Strategy Indicator (CSI-15) from the *My World Survey* (Dooley and Fitzgerald 2012) and the original Coping Strategy Indicator (Amirkhan 1990)

Permission for their use was obtained from all authors. The survey was designed as an anonymous, online survey using the SurveyMonkey tool (SurveyMonkey Inc.). To enable participation for those without internet access, a hard copy was also available on request.

Recruitment, sampling, and sample size

Survey

A multi-pronged recruitment strategy was employed to maximise the number of people that were informed of the module, and thus afforded the opportunity to participate. In both the *Supporting LGBT Lives* study (Mayock *et al.* 2009) and the *Visible Lives* study (Higgins *et al.* 2011), research teams had been successful in engaging with and informing local and national social, health, youth and LGBT organisations of the study. Therefore, a similar strategy was adopted for the present module. A range of organisations were contacted and sent information on module one. In total, over 200 organisations and individuals supported and promoted the module through social media and other online methods. Information posters were also sent to over 75 organisations

5 The full survey is available upon request from the Principal Investigator (AH).

nationwide, including LGBTI organisations, youth groups, mental health organisations, mental health in-patient units and hospitals, industrial and student unions, universities, and other community groups (See Appendix 1 for a full list of list of those who supported recruitment). These organisations were asked to post information about the module on their websites, Twitter and Facebook, and to email their mailing lists and post flyers in their offices. Posters were also distributed at LGBTI events and venues throughout the country. Furthermore, advertisements were broadcast on the radio publicising the module. In addition to the web address for the module, all advertising information included telephone and email details and invited people to request a postal version of the survey, an email version of the survey or to contact us if they wished to complete the survey through telephone interview. It is noteworthy that only 1 hard copy and 1 email version of the survey were returned; all other participants made use of the online survey.

Data analysis

Survey quantitative data

All quantitative survey data were entered into Microsoft Excel for cleaning and screening. In total, 2,644 people responded 'yes' to all 4 filter questions (14+ years of age, currently living in the ROI, identifying as LGBTI and agreeing to participate). Participants who provided limited or no further information past the 'Coming Out' section of the survey were removed (n=380). The final dataset included 2,264 participants. At this point, the dataset was transferred to IBM SPSS Statistics Version 21 for full analysis (IBM Corporation 2012). Data analysis included descriptive and bivariate statistics. The valid percentage is reported for each question i.e. the percent when missing data are excluded from the calculations. The significance level for statistical tests was set at $p<0.001$.

Survey qualitative data

All qualitative survey data were entered into Microsoft Excel. Content analysis of each question was conducted. Many of the responses were very well articulated and suggested that a lot of thought had been given to provide honest, rich, nuanced and individual answers. Each quote is accompanied by the respondent's self-identified gender and sexual orientation identity. While many themes were shared, the manner in which they were expressed demonstrated that people had developed individual perspectives on the questions. Some responses were lengthy, while other consisted of a single phrase or short comment.

Ethical considerations

Ethical approval for this module was received from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. While it is generally standard practice to obtain consent from parents/guardians of anyone less than 18 years of age prior to engaging in health research, parental consent was not sought in this module. There are persuasive reasons for this departure from common practice. Firstly, it is clear that many adolescents are not 'out' to their parents. Therefore, the act of presenting a consent form to parents for a survey focusing on the lives of LGBTI people was felt to be problematic as many adolescents would refuse to participate in a survey if parental knowledge and involvement was required (Flicker and Guta 2008). This would prevent the researchers from accessing a representative sample of young LGBTI people. Those who were 'out' may be over-represented as they would have less difficulty asking parents to sign a consent form. However, those who were not 'out', and because of their hidden sexuality may experience more psychological distress, would be under-represented and their experiences and needs would be less likely to be reflected in the research findings. This would effectively silence the voices of those that needed to be heard most.

Thus, it was argued that a waiver of parental consent would be justified to achieve suitable, unbiased samples. A precedent for this was found in the Federal Regulations of the US Department of Health and Human Services (DHHS 2009). They provide exemptions for acquiring parental consent in the case of some anonymous surveys or other research which could not be practically carried out without a waiver. In the present module, three main principles were adhered to in order to off-set the absence of parental consent for adolescent participation in the survey:

1. Securing anonymity: The proposed data collection tool was an anonymous online survey. Anonymous surveys are generally considered to fall within the realm of 'minimal risk research'.
2. Avoiding coercion: Adolescents self-selected for this module; therefore, they were not coerced or pressured to participate.
3. Low risk: The risks of participating in this survey were minimised to some degree by advertising the research through a range of local and national social, health, youth and LGBTI organisations. By partnering with agencies that have a prior relationship, no matter how tenuous, with the youth involved suggests that young people have a contact and pathway to seek assistance from should they require it (Flicker and Guta 2008).

In addition, the survey website and information sheets clearly stated the content of the survey. The website included the contact details for the research team, as well as an extensive list of contact details for LGBTI and mental health support services. It also included the following statement:

> *"The survey is about people's experiences of discrimination, mental and emotional well-being. It includes questions on anxiety, depression, self-harm, and substance misuse. If you think responding to these questions will cause upset, you may choose not to participate in the survey. If you decide not to participate, you can still access the information on support services by clicking on 'LGBT Support' on the left-hand side of this page."*

The study's website contained written information about the module. Written information sheets included information on the aims of the module, module procedures, potential risks and benefits, mechanisms to maintain confidentiality and anonymity, and the right to refuse to complete any part of the survey. Survey responses were given a code number and participants were advised not to write their name on the survey instrument.

No information cited in the report, e.g. biographical and geographical data, identifies the participants involved in the study. All data files were password protected and stored in accordance with the Data Protection (Amendment) Act 2003.

Sample profile

Sample Size

In total, 2,264 people were included in the final sample for the survey component of module one, the profile breakdown of which is provided (gender identity and sexual orientation; age; nationality and ethnicity; area living; employment, education and religion; relationships and children).

Gender Identity and Sexual Orientation

For the purpose of identifying potential differences between Lesbian, Gay, Bisexual, Transgender and Intersex participants, the participant's gender identity and sexual orientation was examined to enable coding into LGBTI categories. Nearly two-fifths of the sample comprised gay males (38.6%) and just over a quarter was lesbian/gay females (26.5%).[6] The next biggest group was bisexual participants (14.4%), the majority

6 As some women identified as lesbian and some as gay women, these groups were combined for the purpose of analysis and the term 'lesbian/gay female' used throughout the report.

of whom were female (76%, n=241). Over one tenth of the sample identified as transgender (12.3%),[7] while 2% of the sample was made up of intersex participants.[8] 6.3% of the sample identified as 'other' gender identity or sexual orientation (Table 1.1).

Table 1.1: Identity of the survey sample

	% (n)
Lesbian/gay female [a]	26.5% (600)
Gay male [b]	38.6% (873)
Bisexual [c]	14.4% (325)
Transgender [d]	12.3% (279)
Intersex [e]	2% (45)
Other identity	6.3% (142)
Total Sample	**N=2,264**
Total LGBTI sample	**N=2,122**

a Includes those who identified as female and lesbian/gay/queer
b Includes those who identified as male and gay/queer
c Includes those who identified as male or female and bisexual
d Includes those who identified as transgender with any sexual orientation
e Includes those who identified as intersex with any sexual orientation
NB. If participants identified as both transgender and intersex, they were coded into the intersex group for the purpose of analysis

Transgender participants comprised 12.3% (n=279) of the total sample, which represents the biggest sample of transgender people undertaken to date in Ireland. Just 4% (n=46) of the *Supporting LGBT Lives* (Mayock *et al.* 2009) sample and 7% (n=10) of the *Visible Lives* (Higgins *et al.* 2011) sample identified as transgender. Prior to this study, the largest transgender sample to date was 164 people in the *Speaking from the Margins* report (McNeil *et al.* 2013). In terms of sexual orientation, the transgender people in the

7 Participants were given a definition of 'transgender' and asked whether they identified as transgender or had a gender identity and/or expression that is different than the sex assigned to them at birth.

8 Participants were given a definition of 'intersex' and asked whether they identified as intersex or if they were born with reproductive sexual anatomy that does not fit the typical definitions of male or female.

sample described themselves as: bisexual (20.1%; n=56); queer (19.4%, n=54); lesbian (15.1%, n=42); gay (12.2%, n=34); heterosexual (10.8%, n=30); pansexual (7.2%; n=20) questioning/not sure (6.5%; n=18); other (5.4%, n=15) and asexual (3.6%; n=10). In total, 2.1% (n=45) of the sample identified as intersex. In terms of sexual orientation, the intersex people in the sample described themselves as: 26.7% (n=12) lesbian; 20.0% (n=9) bisexual; 13.3% (n=6) gay; 13.3% (n=6) pansexual; 6.7% (n=3) queer; 8.9% (n=4) heterosexual/straight; 8.9% (n=4) questioning/not sure; 2.2% (n=1) 'other'.

'Other Identity' participants

The 'other identity' category comprised participants who subscribed to another gender identity or sexual orientation outside of the LGBTI categories. 142 participants fell into this category. In terms of gender, those who identified as other included: females 71.8%; males 19%; and 'other gender identity' 9.2%. Those who identified as 'other gender identity' described themselves using terms such as: non-binary gender, demigirl; female-genderqueer; gender fluid; mostly female and male for legal purposes. In terms of sexual orientation, those who identified as "other" included: questioning/not sure 30.3%; other 27.5%; heterosexual/straight 7.7% and queer 2.8%. Additional terms used to describe sexual orientation by participants in this group included: aromantic grey-bisexual, homoromantic asexual; bisexual crossdresser; bi/pansexual; demisexual; demisexual pansexual; dyke and pansexual, while some participants questioned the validity of a label.

Age

In total, 2,257 participants provided their age. Ages ranged between 14 and 71 years (total range=57 years), with a mean age of 29.63 years (SD=1.87). The age profile of the sample was relatively young compared to the age profile of the national population (table 1.3).

Table 1.2: Age group of survey sample

Age Group (n=2,257)	% (n)
14-18 years	18.4% (416)
19-25 years	28.7% (648)
26-35 years	24.4% (551)
36-45 years	16.3% (367)
46+ years	12.2% (275)

Those aged 15-24 represent over two-fifths of the sample but comprise 16.1% of the national population; therefore the younger age group is over represented in this study (Table 1.3).

Table 1.3: Age group of survey sample compared to general population

	Age of study sample LGBTIreland (N=2,226)*	Age of population CSO (N=3,608,662)
15-24 years	42.6% (948)	16.1% (580,250)
25-44 years	43.5% (969)	40.2% (1,450,140)
45-64 years	13.3% (295)	28.9% (1,042,879)
65 years and over	.6% (14)	14.8% (535,393)

*Percentages are only calculated for those aged 15+. This is because the CSO population figures only include people 15 years and over.

Nationality and ethnicity

Almost 90% (89.4%; n=2,016) of participants identified their nationality as Irish. The remaining 10.6% (n=239) identified their nationality as 'Other' (representing more than 40 other nationalities, such as American, Australian, Brazilian, Canadian, Chinese, Chilean, English, South African, Norwegian, Swedish, Danish, Spanish, Serbian, French, Filipino, Polish, Romanian, Russian, Thai, Turkish and Welsh), including 1.2%

(n=26) who were dual citizens of Ireland and another country (American, Australian, Scottish, South African).

Almost 90% (87.6%; n=1,979) of participants identified their ethnicity as White Irish (Table 1.4). More than 30 other ethnicities were recorded, such as Arabic, American, African, Asian, British Irish/Chinese, Filipino, Hispanic, Latino, and Scottish.

Table 1.4: Ethnicity of survey sample

Ethnicity (n=2,259)	% (n)
White (Irish)	87.6% (1,979)
White (Irish Traveller)	.6% (13)
White (Non-Irish; any other White background)	8.8% (199)
Black or Black Irish (African; any other Black background)	.2% (4)
Asian or Asian Irish (Chinese; any other Asian background)	1.0% (22)
Other, including mixed background	1.9% (42)

Compared to the general population, the nationality and ethnicity of the survey sample is reflective of the national profile (Appendix 2).

Where are participants living?

Participants represented all of the counties of the Republic of Ireland. Nearly half (49.6%; n=1116) were living in Dublin. The next largest groups, in descending order, were living in Cork (10.7%; n=239), Galway (4.9%; n=110), Kildare (3.7%; n=83), and Wicklow (3.1%; n=70). In comparison to CSO statistics there was an over representation of people from Dublin. In 2012, 27.7% of the overall population lived in Dublin, 11.3% lived in Cork, 5.5% lived in Galway, and 4.6% lived in Kildare (Central Statistics Office [CSO] 2012). (See Appendix 3 for further breakdown).

Nearly 60% of participants lived either in a city (27.9%; n=630) or a suburb of a city (30.1%: n=680). Smaller proportions lived in a town (18.6%; n=419), village (7.8%; n=176) or rural/country area (15.7%; n=354). Of the 2,229 to provide information, participants reported living in the Republic of Ireland between 1 and 70 years, with a mean number of years living in the Republic of Ireland of 25.65 (SD = 11.89).

Almost 40% (39.6%; n=895) of participants reported living with their parents or guardians and 14.4% (n=325) lived with friends or housemates. Another 15% (14.7%; n=333) lived alone. Just over 20% (22.2%; n=501) lived with their same-sex partner either with (3.8%; n=86) or without children (18.4%; n=415). While just over 3% lived with their opposite sex partner either with (1.4%; n=31) or without children (1.9%; n=44) (Table 1.5). Other living situations included living with LGBT identified housemates, living with an ex-same-sex partner, living with their own with children, direct provision hostel, sharing an apartment with a heterosexual married couple, foster care, and student residences.

Table 1.5: Living situation of survey sample

Living situation (n=2,259)	% (n)
I live with my parent(s) or guardian(s)	39.6% (895)
I live with my same-sex partner, civil partner, or spouse with no child(ren)	18.4% (415)
I live alone	14.7% (333)
I live with friends or housemates	14.4% (325)
I live with family members other than my parents/ guardians	3.2% (73)
I live with my same-sex partner, civil partner, or spouse with child(ren)	3.8% (86)
I live with my opposite sex partner/spouse with no child(ren)	1.9% (44)
I live with my opposite sex partner/spouse with child(ren)	1.4% (31)
I live in supported accommodation/residential care	.1% (2)
Other	2.4% (55)

Employment, education, and religion

Just over 80% of participants were working for payment or profit (47.6%; n=1,074) or were students/pupils (34.6%; n=780). Another 2.3% (n=51) were on a Community Employment Scheme, Job Bridge, Back to Work Scheme, or Internship, while 2.8%

(n=64) were looking for their first regular job. Just over 1% (1.3%; n=30) were looking after home or family, with some acting as carers. Almost 9% of the sample were unemployed (8.5%; n = 192) and another .6% (n=14) unable to work due to permanent sickness or disability. Just over 1% (1.4%; n=31) were retired. The number of people working (48.3%; n=1,072) and the number of people unemployed (8.6%; n=191) in this study was relatively similar to national statistics (working 50.1%; unemployed 10.8%). However, there were three times as many students or pupils in this study (33.7%; n=747) when compared to national statistics (11.3%).[9]

More than half of the sample had completed third level education (55.9%; n=1,264), and just over one-quarter (26.7%; n=604) had completed upper secondary level education. Under 3% had completed primary education (1.9%; n=44) or less (.3%; n=6). Overall, the study sample had higher levels of education completed compared to the general population. Within this study, nearly 60% (57.2%; n=1,294) had completed education higher than upper secondary level compared to 45.6% of the general population. Furthermore, just 2.2% (n=50) of participants had completed primary education or less compared to 16.0% of the general population.

Almost 60% of the sample (57.7%; n=1,301) reported having 'no religion'. Nearly three in ten participants reported being Roman Catholic (28.9%; n=653) and just 2.6% (n=59) as being from the Church of Ireland. A further 10.8% (n=243) reported having an 'other' religion, including Atheist, Agnostic, Buddhist, Methodist, Non-practicing, Episcopal, Evangelist, Lutheran, Hindu, Humanist, Humanist Existentialist, Islamic, Pagan, Presbyterian Quaker, Taoist, Unitarian and Wiccan. The number of people who identified as Roman Catholic in this study (28.9%: n=653) was significantly less than national population figures (85.5%). The number of people who stated they have 'no religion' in this study (57.7%; n=1,301) was more than 10 times greater than national population figures (6.0%). See Appendix 4 and 5 for more detail on the employment status, educational level, and religion of survey sample and for comparison with CSO data.

Relationships

Participants were asked about their current relationship status. Just over 50% (54.1%; 1,222) were single; some of these were dating (16.0%; n=361), while others were not (38.1%; n=861). Another 44.2% (n=999) were in a relationship. This included 41.2% (n=931) in a monogamous relationship, 2.4% (n=54) in a non-monogamous/open relationship, and .6% (n=14) in a polyamorous relationship (Table 1.6).

9 This analysis included only those aged 15+ to allow for a comparison to be made with CSO employment data

About one in ten participants (10.1%; n=228) were in a civil partnership with someone of the same sex. A further 2.5% (n=57) were married to someone of the opposite sex and 1.5% (n=34) were married to someone of the same sex (Table 1.6). National population estimates are that 41.7% (n=1,505,035) of the population are single, 47.3% (n=1,708,604) are married, 3.2% (n=116,194) are separated, 2.4% (n=87,770) are divorced, and 5.3% (n=191,059) are widowed.

Table 1.6: Relationship status and civil status of survey sample

Relationship status (n=2,258)	**% (n)**
Single and not dating	38.1% (861)
Single and dating	16.0% (361)
In a monogamous relationship	41.2% (931)
In a non-monogamous (open) relationship	2.4% (54)
In a polyamorous (multiple people) relationship	.6% (14)
Other	1.6% (37)
Civil status (n=2,258)	
Not married/Not in a civil partnership	85.9% (1,939)
I am in a civil partnership with someone of the same sex	10.1% (228)
I am married to someone of the opposite sex	2.5% (57)
I am married to someone of the same sex	1.5% (34)

Children

Of the 2,258 participants to answer on children, almost 10% (9.8%; n=221) reported that they are or had been a parent. Participants had between 1 and 6 children. Of the parents in the sample, 80.1% (n=177) were biological parents and 19.0% (n=42) were non-biological parents. The remainder of parental types can be seen in table 1.7. 'Other' written information provided around parental types included: '2 biological and 2 non-biological', 'child was my partner's from a previous relationship', 'Donor Dad', 'had a girl but she passed away', 'I am a step mother (my partner's son)', 'lost pregnancy', and 'We have 2 children. One is biologically mine and the other is biologically my partner's'. Just over 40% of parents identified as lesbian/gay female followed by approximately 20% who identified as transgender. In addition, 58% of parents were in monogamous relationships (See Appendix 6).

Table 1.7: Parental type of parents in survey sample

Parental type (n=221)*	% (n)
I am a biological parent.	80.1% (177)
I am a non-biological parent.	19.0% (42)
I am an adoptive parent.	3.2% (7)
I am a foster parent.	2.3% (5)
Other	1.8% (4)

*Participants could choose multiple response categories.

Limitations and strengths

When interpreting the findings, the following study limitations require consideration. Firstly, module one findings are based on a non-probability sample of LGBTI people. Therefore, it is impossible to determine how statistically representative the survey sample of 2,264 is in terms of age, education, socioeconomic status and other demographic variables. Secondly, participants self-identified as LGBTI people and self-selected to participate in the survey. In other words, they actively volunteered to participate in the research, spent between 20-30 minutes completing the questionnaire and provided expansive responses to open-ended questions. This potentially biases the sample towards people who were interested in the survey, motivated to make their voices heard and may have been more secure in their sexual orientation and gender identity. Only a small minority of participants were not 'out' to someone, therefore, it is possible that those who are 'out' may have more favourable (or different) outcomes on a number of measures. Thirdly, the profile of people who participated in the survey suggests that they were well-educated and mainly between the ages of 15-24; the survey sample over-represented people living in Dublin, who comprised almost 50% of the sample but represent approximately 28% of the national population.

The sample under-represents certain groups, including: those from a Black or Black Irish background; people aged 45-64, but particularly those over 65; and people with lower levels of education. It must also be acknowledged that the recruitment strategy may have resulted in people with reading difficulties and people not familiar with technology being unable to participate.

In terms of achieving objective four, comparing the findings with earlier Irish studies, some of the measures used in this study are different from those in Mayock *et al*'s. (2009) *Supporting LGBT Lives* study; therefore, direct comparisons cannot be made.

One of the strengths of module one is the size of the survey sample. In total, 2,264 people were included in the final sample for the survey component of module one. According to the most recent census in 2011, the total Irish population is 4,588,252 (Central Statistics Office 2012). If roughly 10% of the population is LGBTI[10], this makes a target population of 458,825. The minimum sample size to achieve a confidence level of 95% (+/- 3%) is 1,065 meaning that the obtained sample is more than twice the required size, which adds to the robustness of the module. The sample of 2,264 participants denotes this study as the largest study to date of LGBTI people in Ireland. In addition, it is the largest study of transgender people and the first study that included intersex people in Ireland. Furthermore, this study achieved greater representation of lesbian/gay female participants, in comparison to other studies where the ratio of gay men to lesbian females was usually nearly 3:1, this study had a 1.5:1 ratio.

10 In 2002, The Equality Authority adopted a figure of 10% for the *Implementing Equality for Lesbians, Gays and Bisexuals* report (The Equality Authority 2002). More recently in the *My World Study* 8% identified as LGB and a further 3% were unsure (89% identified as heterosexual) (Dooley and Fitzgerald 2012).

CHAPTER 2

FINDINGS: LGBTI WELLBEING

Introduction

Historically, well-being was often defined as merely the absence of pathology. However, while there is now a growing consensus that "well-being is about thriving and flourishing rather than simply avoiding illness" (Prilleltensky and Prilleltensky 2006: 106), a universal definition of well-being remains elusive (Brown and Westaway 2011; McGillivray and Clarke 2006). Nevertheless, amongst the evidently diverse concepts of well-being, there is some agreement that the objective and subjective components informing it are complex and multidimensional (Ryff 1989; Kahneman and Deaton 2010). Subjective components of well-being are considered particularly heterogeneous and comprise an individual's appraisals about various dimensions of one's life such as life satisfaction, autonomy, mastery, social connectedness, and personal security (Diener 2012; Narayan *et al*. 2000; Ryff and Keyes 1995). In the case of LGBTI people, such appraisals of their well-being may be strongly mediated by many LGBTI distinct factors including their sense of pride in their LGBTI identity, their sense of belonging in the LGBTI community, their coming out experience, and/or their exposure to LGBTI discrimination and harassment. For example, some research evidence suggests that publicly disclosing LGBT status is an important part of identity development;[11] facilitating the eventual formation of an authentic, stable, positive and LGBT affirmative self-identity (Ragins 2004), which in turn cultivates many physical and mental health benefits deemed pertinent to high levels of well-being (Pennebaker and Chung 2011). However, concurrent research has also indicated that such physical and mental health benefits are neither inevitable nor universally experienced; rather they may only apply to autonomy supportive contexts in which LGBT people feel accepted and secure (Legate *et al*. 2012). Conversely, coming out in contexts which are controlling or oppressive are associated with costs to well-being (D'Augelli 2006), including higher stress and mental health difficulties due to the pressured inducement of LGBT identity concealment (Miller and Major 2000).

An additional negative outcome of coming out within oppressive contexts includes high exposure to harassment, discrimination and victimisation of LGBTI people. Specifically, sexual and physical violence targeting sexual minorities is seen as a global problem (Alden and Parker 2005; Rothman *et al*. 2011) and equally, transphobic hate crime has been proven to be prevalent across Europe, the UK and Ireland (McBride and Hansson 2010; McIlroy 2009; Turner *et al*. 2009; Whittle *et al*. 2007). Such a prolific culture of homophobia, biphobia, and transphobia can lead to internalised

11 The acronym LGBTI is only used when referring to research which has included all cohorts of this population. Correspondingly, the term LGBT is utilised throughout when referring to research which only examines particular groups.

heterosexism and shame about one's own LGBT identity (Feinstein *et al*. 2012a, 2012b; Szymanski 2006). Consequently, the association between experiences of harassment and victimisation with poor physical and mental wellbeing is now readily accepted. Minority stress theory in particular points to exposure to discrimination, stigma and prejudice as strong determinants informing poor mental and physical outcomes for LGBT people (Meyer 1995). However, poor physical and mental health outcomes are not inevitable as the employment of coping strategies have been proven to produce a strong mediating effect. It is consistently reported that sexual and gender minority individuals engage in maladaptive coping strategies, which can powerfully decrease their psychological and physical well-being, more often than their heterosexual peers (Feldman and Meyer 2007; Meyer *et al*. 2001; Rosario *et al*. 2009; Siever 1994). Conversely however, emerging research is contesting such postulations by highlighting that, despite the described challenges to an LGBT person's wellbeing, LGBT people can demonstrate resilience and often utilise adaptive coping resources to enhance their well-being (Riggle *et al*. 2008).

In light of this research evidence demonstrating the relationship between LGBTI well-being and mediating variables, such as coming out as an LGBTI person, experiences of harassment and victimisation, and sense of safety and coping strategies, the focus of this chapter is on these mediating variables in the lives of LGBTI people in Ireland. Firstly, the results of participants' appraisals of subjective well-being variables such as self-esteem, happiness, and life satisfaction are presented. Subsequently, participants' experiences of and opinions on factors which are understood to influence subjective well-being are explored including: 1) their feelings about their LGBTI identity; 2) their experiences of coming out and being out; 3) living in preferred gender; 4) their experiences of discrimination, harassment and subsequent sense of safety; and lastly 5) the coping strategies they employ in response to these challenges to their well-being.

Self-esteem, happiness, and life satisfaction

Self-esteem

To measure self-esteem participants were asked how much they agreed or disagreed with a series of 10 statements which comprise the Rosenberg Self-Esteem Scale (Rosenberg 1965). Responses were scored from one to four, with higher scores indicating greater self-esteem. Participants were then given a total score based on their responses. The mean score for self-esteem for the total sample was 28.48 (SD=6.8), with a range of 10-40. Intersex, transgender and bisexual participants had statistically significantly lower mean self-esteem scores compared to gay males and lesbian/gay females [$F(4,1927)=33.407$, $p=.000$] (See table 2.1). The youngest age group (14-18 year) had statistically significant lower mean self-esteem scores (M=24.29, SD=6.08) followed

by the 19-25 year olds (M=26.83, SD=6.65), and then the 26-35 year olds (M=29.25) [F(4,1924)=83.236, p=.000] (Table 2.1). There were no significant differences between the older two age groups who both had similarly higher mean self-esteem scores compared to the other age groups.

Table 2.1: Mean Rosenberg self-esteem scores

	ALL LGBTI	L	G	B	T	I
All Ages	28.48	29.03	29.89	26.66	25.47	23.78
14-18	24.29	23.64	26.68	24.17	22.43	19.82
19-25	26.83	25.75	28.75	26.49	23.88	20.86

Life satisfaction and happiness

Participants were asked, 'All things considered, how satisfied are you with your life as a whole nowadays?' on a scale of zero meaning 'extremely dissatisfied' to 10 meaning 'extremely satisfied'. The mean life satisfaction rating given by participants was 6.66 (SD=2.22; n=2,017), with a range of 0 to 10 (Table 2.2). The most common score was a 7. Both of these scores are slightly above the midway point for the scale. Less than 25% of participants rated their life satisfaction at 5 or less.

Participants were also asked, 'Taking all things together, how happy would you say you are?' on a scale of zero meaning 'extremely unhappy' to 10 meaning 'extremely happy'. The mean happiness rating given by participants was 6.62 (SD=2.25; n=2,014), with a range of 0 to 10 (Table 2.2). The most common score was a 7. Both of these mean and common scores are slightly above the midway point for the scale. Less than 25% of participants rated their happiness a 5 or less.

Both satisfaction and happiness scores increased by age. The youngest age group (14-18 years) had significantly lower scores, followed by the 19-25 age group. The mean scores for both satisfaction and happiness were lowest among transgender and intersex participants, not only across the sample as a whole but also among the youngest age groups (14-18 and 19-25), while gay males had the highest scores. The mean satisfaction and happiness scores for those who identified as bisexual were lower than both gay males and lesbian/gay females and higher than the transgender and intersex groups. However, in the age groups 14-18 and 19-25, bisexuals had higher satisfaction and happiness scores than lesbian/gay females.

Table 2.2: Satisfaction and happiness scores by LGBTI group

SATISFACTION							
		ALL LGBTI	**L**	**G**	**B**	**T**	**I**
Mean score	**All ages**	6.66 (n=2017)	6.87 (n=571)	6.98 (n=843)	6.41 (n=304)	5.62 (n=260)	5.38 (n=39)
	14-18	5.85 (n=347)	5.68 (n=66)	6.62 (n=101)	5.97 (n=97))	5.01 (n=72)	4.09 (n=11)
	19-25	6.51 (n=562)	6.36 (n=132)	6.93 (n=237)	6.61 (n=107)	5.36 (n=77)	6.22 (n=9)
Mode	**All ages**	7	8	8	7	7	8
HAPPINESS							
		ALL LGBTI	**L**	**G**	**B**	**T**	**I**
Mean score	**All ages**	6.62 (n=2015)	6.81 (n=569)	6.96 (n=843)	6.35 (n=304)	5.67 (n=26)	5.05 (n=39)
	14-18	5.66 (n=346)	5.35 (n=66)	6.49 (n=100)	5.81 (n=97)	4.89 (n=72)	3.82 (n=11)
	19-25	6.42 (n=562)	6.19 (n=132)	6.88 (n=237)	6.5 (n=107)	5.39 (n=77)	5.67 (n=9)
Mode	**All ages**	7	8	8	7	7	3/8

Factors informing LGBTI wellbeing

Participants were asked the question 'What about being LGBTI makes you happy or proud?'. Of the 2,264 participants in the sample, 57.7% (n=1,308) answered this question identifying a number of issues that were categorised into: social aspects, personal aspects, LGBTI rights movement and questioning the question (Table 2.3).

Table 2.3: Themes and subthemes related to 'What about being LGBTI makes you happy or proud?' (N=1,867)

Social aspects 41% (n=761)	**Personal aspects 31% (n=575)**	**LGBTI rights movement 19% (n=346)**	**Questioning the question 10% (n=185)**
Inclusion in LGBTI community and support received (n=293)	Identity accepted by oneself (n=348)	Involvement in LGBTI rights movement (n=219)	LGBTI identity considered irrelevant (n=150)
Partner (n=119)	Glad to be different (n=97)	Fighting spirit (n=69)	Unhappiness/ ambiguous feelings(n=35)
Identity accepted by others (n=95)	Own growth and development (n=69)	Progress in LGBTI cause (n=58)	
Friends (n=81)	Freedom (n=61)		
Love (n=40)			
Coming out (n=35)			
Family (n=35)			
Being out (n=34)			
Helping others (n=29)			

Social aspects

The role of the LGBTI community figured prominently, with happiness and pride being derived from a sense of inclusion, belonging, and support from engagement with that community. The LGBTI community was mentioned as a source of practical social support and friendship, but also in a more general sense of community or moral support deriving from its existence and activism. Sometimes the diverse character of the LGBTI community was highlighted as something that made participants happy. A number of participants mentioned helping others and tied this in with trying to change negative attitudes towards LGBTI people.

I'm proud of how the LGBTI community supports each other, of the colour, love, noise, sass. (Bisexual female, 22)

The fact that we can come together as a community when we need to and all our personal problems with each other can be put aside for a bigger cause. (Gay male, 28)

Love was also mentioned as a source of happiness. Often, both loving others and being loved were mentioned. Bisexual participants sometimes highlighted the advantages of their freedom of choice in this respect (although as we will see, many of them were also conflicted about this).

I'm happy to be able be with someone I love instead of being forced to be with someone that I could never truly love. (Bisexual male, 23)

I'm proud to be different. As a bisexual, I feel I was gifted with twice the love straight people have. I have the ability to love both sexes and I feel that is a beautiful thing. (Bisexual female, 19)

Partners, family, and friends were also mentioned as a source of happiness. Sometimes, the acceptance of a partner by family or the community was highlighted. For participants who were parents, children were mentioned as a source of happiness and pride. The general importance of acceptance by others or by society at large was also referred to by many participants. While acceptance of self was mentioned much more often than acceptance by others, they were sometimes mentioned together.

Being accepted by those I love for being the person I am. (Lesbian/gay female, 30)

There was a lingering sense within some comments that many participants felt that once they had accepted themselves, all else became a secondary issue. Some emphasised that they had stopped being concerned about what other people thought of them.

That I no longer care what others think and I'm free to be me now it took a few years to get here but the journey was worth it. (Lesbian/gay female, 55)

The role of coming out as a source of happiness and pride was also mentioned by many. Its importance was often highlighted as part of accepting oneself.

> *Being accepted, being loved, being myself... once I stopped all the denial, all the hiding, all the self-doubts. I became so much happier. I wish I had done this a long time ago! (Bisexual female, 25)*

Personal aspects

The most common personal aspect mentioned was of having accepted or being proud of one's own identity as LGBTI. As is clear from the quotes below, this acceptance was described as a highly individual and varied experience. A few young participants expressed a desire to reach this acceptance of themselves in the future, while others seemed to have already found themselves and were now eager to express their identity more freely. Often accepting one's LGBTI identity included a reference to personal growth or having had to overcome challenges in order to achieve this state of identity acceptance. The latter was expressed very succinctly by one of the participants: *"I fought the war inside and won, nothing less". (Gay male, 16)*

> *I am very proud and happy to have become the person I was always meant to be. It took a lot of struggle and sacrifice, money, time and soul searching to become the woman I am today. Sometimes I can't believe I actually made it. (Transgender, female, heterosexual, 41)*

> *I'm proud of the journey I've made personally in going from hating myself for my sexuality to accepting and approving of myself. If I wasn't LGBTQI I don't know if I would have learnt such self-acceptance. (Intersex, gay)*

Furthermore, many participants related their happiness and pride to the enjoyment of being different. Sometimes a sense of freedom in not having to fit into the constraints of traditional norms was mentioned.

> *You are less shackled, in that, as someone who is 'different' to the 'norm', you are much more open and accepting of diversity - you embrace diversity. (Lesbian/gay female, 28)*

LGBTI rights movement

While the social aspect was dominated by references to the LGBTI community, references to the LGBTI rights movement also figured prominently in the responses. Many participants referred to the LGBTI rights movement in a variety of ways as something that they related to and felt proud and/or happy about. Sometimes this was expressed with a reference to progress made throughout the years to advocate for LGBTI rights and favourable legislation. Some participants mentioned that they were happy to be LGBTI in Ireland rather than elsewhere in the world. If this was mentioned, it tended to include a reference to the progress in the degree of acceptance of LGBTI in Ireland in recent times. Very few mentioned favouring living elsewhere. Some participants emphasised that they were still hoping for more progress in Ireland on this front in the future.

> *The positive changes that have occurred in so much of the Western World in the past 50 years. The LGBTI community have made enormous political progress due to well organised strategies and groups. The Pride movement has been hugely successful and a very positive strategy to pursue. I am proud of all the LGBTI people who are not afraid to come out and be themselves, even in the face of hostility and prejudice. (Gay male, 37)*

> *I love that in Irish society there is greater acceptance. I feel like my generation has grown up with the change and I have seen attitudes among society as a whole take a positive lift. (Gay male, 35)*

Frequent mention of elements of a 'fighting spirit' included in this suggests that many of the participants enjoy an activist perspective.

> *It makes me proud to be LGBTI because we are able to achieve so much and we are fighting so hard to get what we want and it is working. This continuous work of progress is amazing and I am so happy to be involved with a community with such passion, hope and happiness. (Bisexual female, 27)*

Furthermore, some participants highlighted that being LGBTI had given them a better appreciation of what it is like when you are not part of the mainstream in society. This made them more empathetic towards other minorities; a realisation they valued highly.

> *My experience as a transgender man has allowed me to have a unique perspective in life. I have a greater sense of empathy and understanding for difference. I value each person's individual journey and know that equality and rights are something all humans deserve. (Transgender male, questioning/not sure, 66)*

The colourful aspect of LGBTI friendships was emphasised by some. Festivities such as 'Pride Parade' were often included as an example of this. In contrast, several responses highlighted the happiness of leading a highly 'normal' and less demonstrative life.

> *Being LGBTI gives me access to a subculture and a community which I wouldn't have experienced otherwise. I love the potential openness and queerness of this community, and the idea that there are no restrictions, barriers or labels to being oneself. (Gay male, 31)*

> *I am proud that I can show that I am a good example of just how normal and capable gay people are. (Lesbian/gay female, 27)*

LGBTI identity considered irrelevant to pride and happiness

A considerable segment of the participants highlighted that they felt that being LGBTI was unrelated to their happiness or not something to be proud of. Well-articulated, principled responses expressing sociological and political thought were also included.

> *Nothing makes me proud to be gay. I just am. I don't see people proud to be straight, do you? (Gay male, 29)*

> *Just being myself. I don't feel particularly proud. It's not about being different, it's about being who you are. I don't want to feel different in a way that would create the feeling of THEM and US. I would like to see diversity being accepted by all regardless what group they belong to, not separating the groups on the basis of any ethnic, racial, sexual or gender characteristics. (Gay male, 49)*

Unhappiness

Some participants suggested that they had very little to be proud or happy about. A small number of participants elaborated on the reasons for their expressed unhappiness, indicating that the difficulties they were experiencing around being LGBTI made it very difficult to be happy or proud. Two very direct expressions of this sentiment were: *"I don't feel proud, I feel ashamed" (Bisexual female, 14)* and *"Nothing. I would rather be straight" (Intersex, gay, 38)* while others expressed their feelings in a more neutral way, with one participant noting, *"Nothing really, I don't want to be different or thought of as special" (Bisexual male, 19).*

The impression also emerged that it is more difficult to be happy and LGBTI in rural Ireland. Other mixed reactions involved elements of secrecy, fear or stress.

> *Very little! Being in the closet and afraid of retribution, I find myself hiding who I am and want to be as a result of LGBTI stigma, societal constraints (particularly in rural Ireland). (Gay male, 44)*

Also several participants responded with a simple: *'Nothing' (Gay male, 34; gay male, 33; transgender, Lesbian/gay, 40)*, *'Nothing really' (Lesbian/gay female, 18)*, *'Not much at the moment' (Bisexual female, 23)*, and *'Not much in rural Ireland' (Transgender, Lesbian/gay, 35)*. There were several people who responded with *'n/a'*, which could conceivably be interpreted in the same way, but since we cannot be sure, they were not included here.

Ambiguous feelings

Complex responses, including dissonant aspects and ambiguous feelings were not uncommon. In particular, many bisexual participants expressed ambiguous responses. Other ambiguous responses emphasised pride at being out, but also a sense of fear around it.

> *The fact that I am different (bi) is the very reason that I am proud and not proud. (Bisexual female, 21)*

> *I am happy with who I am, and I am happy that I came out but I dunno if I am proud of it. I think a lot of people dislike the LGBT community and it kind of scares me. (Lesbian/gay female, 25)*

Finally, a few particularly comprehensive quotes that incorporate many elements mentioned in the above:

> *I survived my own demons about being gay. I survived the demons that were so prevalent when I was growing up in Dublin in the 80's and the 90's when I first went to gay places. I survive today as I surround myself with people who see me for the person I am, in all my LGBTI-ness and all my me-ness, and I survive today by talking and objecting and educating the people I share this country with about the need, right and expectation that being LGBTI is just another way, an equal way and a wonderfully different way. I'm proud of the life I have lived so far, with all the bumps, the lows and the highs. I'm proud that I feel hopeful too, hopeful for everyone - that will we learn to live together! (Gay male, 33)*

I'm not sure if it makes me happy or proud. My goal is to live unfettered and without shame, and I'm working on both of those things. The LGBTQIA community has helped me massively in coming to accept myself and normalise who I am when previously I'd only felt like a massive freak. I feel like I have places I can go and people I can talk to, who accept me without question, which I've never had before and is utterly priceless. I have built my own family, to whom I'm very grateful, happy and proud to know. (Transgender, pansexual, 20)

Coming out and being out as LGBTI

First Knew/First Told

Survey participants were asked how old they were when they first knew they were LGBTI. Of the 2,085 participants to answer, the mean age of knowing was 14.72 years (SD=5.73), with a range between 0 and 55 years reported. The most common age for knowing for the total sample was 12 years. Half of the participants realised they were LGBTI by 14 years of age and 75% realised by 17 years of age or younger.

Survey participants were also asked how old they were when they first told someone they were LGBTI. The mean age of participants to tell someone they were LGBTI was 19.63 years (SD=6.38; n=1,844), with a range between 4 and 63 years. The most common age of telling someone for the total sample was 16 years of age (Table 2.4). Those aged 19-25 most commonly told someone of their LGBTI identity at age 16 while for those aged 14-18, the common age to tell someone was slightly younger, at 14 or 15 years of age (Table 2.5).

People who identified as intersex had the youngest mean age of awareness (M=12, SD=12.03). This was followed by gay males (M=13.5; SD=4.39; n=865) and transgender participants (M=13.9; SD=7.21; n=271). These groups were younger compared to both lesbian/gay females, who had the oldest mean age of awareness (M=16.8; SD=6.31; n=586), and bisexuals (M=15.4; SD=5.36; n=318). Lesbian/gay females were also slightly older than most groups when they first told someone about their LGBTI identity. Both transgender and intersex participants reported commonly telling someone at the age of 14/15, which was slightly younger compared to the other LGBTI groups (Table 2.4).

Table 2.4: Age of first knowing and first telling of LGBTI identity by LGBTI group

FIRST KNEW						
	ALL LGBTI	**L**	**G**	**B**	**T**	**I**
Mean age	14.7 (n=2,085)	16.8 (n=586)	13.5 (n=865)	15.4 (n=318)	13.9 (n=271)	12 (n=45)
Most Common age (Mode)	12	16	12	14	12/14	14
FIRST TOLD						
	ALL LGBTI	**L**	**G**	**B**	**T**	**I**
Mean age	19.6 (n=1,844)	20.8 (n=529)	19.2 (n=778)	18.6 (n=270)	19.5 (n=231)	21.3 (n=36)
Most Common age (Mode)	16	17	16	16	14	15

The age of awareness was statistically significantly lower for the younger age groups (14-18, 19-25) compared to the older age groups [F(4, 2075)=43.377, p=.000]. Significant differences were identified between all age groups with regard to age of telling someone about their LGBTI identity; the age of telling someone being significantly lower for younger people in the sample compared to older people [F(4, 1839)=224.028, p=.000]. It is notable that the gap between the ages of knowing and telling is much smaller for the 14-18 age group compared to all other age groups. Though the most common age of awareness was 12/13 years across all age groups, it was more common for older age groups to tell someone about their identity in their late teens and early adulthood (Table 2.5).

Table 2.5: Age of first knowing and first telling of LGBTI identity by Age group

Age of *knowing* LGBTI identity by age group (n=2080)				
14-18 years	**19-25 years**	**26-35 years**	**36-45 years**	**46+ years**
M=12.67 SD=2.22 Mode=13 Range=3-17 (n = 352)	M = 13.67 SD = 3.61 Mode = 12 Range = 3-25 (n = 596)	M = 14.98 SD = 5.09 Mode = 12 Range = 3-33 (n = 525)	M = 15.87 SD = 7.54 Mode = 12 Range = 3-42 (n = 346)	M = 17.91 SD = 8.86 Mode = 12 Range = 0-55 (n = 261)
Age of *telling* LGBTI identity by age group (n=1839)				
14-18 years	**19-25 years**	**26-35 years**	**36-45 years**	**46+ years**
M=14.68 SD=1.57 Mode=14/15 Range= 10-18 (n = 289)	M = 17.2 SD = 2.7 Mode = 16 Range = 11-25 (n = 522)	M = 19.83 SD = 4.34 Mode = 18 Range = 7-34 (n = 481)	M = 23.05 SD = 6.52 Mode = 21 Range = 4-42 (n = 326)	M = 26.53 SD = 10.2 Mode = 17 Range = 10-63 (n = 221)

Many participants also took the time to write in further information about the age at which they realised they were LGBTI. Many described 'always' knowing or realising even when they were very young that they were 'different' but were not able to verbalise that difference at the time. Others described a process of 'questioning' before fully realising that they were LGBTI.

Have you told anyone about your LGBTI identity?

Approximately 3.1% (65/2121) of participants had not told anyone they were LGBTI. Of these participants, people identified themselves as: 23 bisexual, 21 gay male, 11 transgender, 6 lesbian/gay female and 4 intersex. A significantly greater proportion of bisexuals (7.1%) and intersex participants (8.9%) had not told anyone about their LGBTI identity compared to the other groups (1-4%) [$x^2(4)=33.382$, p=.000]. The youngest age group of participants (14-18 years) were statistically significantly least likely to have told someone (7%; n=25) compared to the other age groups (1-4%) [$x^2(4)=30.793$, p=.000], which is perhaps unsurprising as the mean age of coming out for the study was 19.63 years. Of those aged 14-18 who had not told anyone (n=25), 10 identified as gay male, 10 as bisexual, 4 as lesbian/gay female and 1 as intersex.

Participants were asked whether they had told different categories of people that they were LGBTI, including family members, work colleagues, and people in school and the community. The largest number of participants were out to their mothers, sister(s), friends, brother(s), and father. Further details are presented in table 2.6.

Table 2.6: Have you told any of the following that you are LGBTI?

	All/Yes	Some	None/No
Mother (n=1,895)	78.7% (1,492)	-	21.3% (403)
Father (n=1,744)	70.2% (1,224)	-	29.8% (520)
Guardians (n=646)	51.2% (331)	3.4% (22)	45.4% (293)
Friends (n=2,030)	74.8% (1,520)	23.4% (476)	1.8% (37)
Brother(s) (n=1,515)	71.7% (1,087)	4.9% (74)	23.4% (354)
Sister(s) (n=1,496)	75.5% (1,129)	4.9% (73)	19.7% (294)
Other relative(s) (n=1,952)	47.8% (933)	23.9% (466)	28.3% (553)
Work colleague(s) (n=1,706)	53.3% (909)	25% (426)	21.7% (371)
School mate(s) (n=1,456)	54.1% (903)	32.9% (550)	13.0% (217)
Teacher(s)/Lecturer(s) (n=1,456)	37.6% (548)	19.9% (290)	42.4% (618)
People within your local community (neighbours) (n=1,861)	33.7% (627)	26.5% (494)	39.8% (740)

Transgender: Living in preferred gender

Nearly half of transgender participants (48%; n=129) reported currently living in their felt/preferred gender full-time and 30.5% (n=82) reported living in their felt/preferred gender part-time. This means that one in five (21.6%; n=58) were not living in their felt/preferred gender. The transgender participants currently living in their felt/preferred

gender either part-time or full-time (78.5%, n=211) were asked at what age they began living in their felt/preferred gender. The responses (n=174) ranged from 0 years to 67, with a mean age of 22.12 years (SD=11.1). For those 25 and under, 17 years was the mean age and also the most common age at which they began to live in their felt/preferred gender. Some participants provided text to explain their situation, indicating that they were 'always aware', 'aware since birth' and 'not sure' as awareness was a gradual process.

Coming out: 'What has helped you in coming out to people as LGBTI?'

1,834 participants responded to the question on what helped them to come out as LGBTI. Responses to this question centred on factors, triggers, and circumstances that helped or resulted in participants coming out to others. Most participants appeared to have arrived at the decision to come out consciously, however, there were also those who referred to coming out as an 'accident', as an impromptu decision or one that had been forced by their identity being discovered, being 'outed', or being asked directly about their sexual orientation. In terms of factors that helped or supported people to come out, a number of themes emerged which were categorised along three main dimensions: social, personal, and practical factors (Table 2.7).

Table 2.7: Themes and subthemes related to what helped people to come out as LGBTI (N=2,470)

Social aspects 75% (n=1,864)	**Personal aspects 13% (n=320)**	**Practical aspects 12% (n=286)**
Knowing that people would be supportive and accepting (n=772) Finding LGBTI friends and allies (n=355) Support and acceptance of friends (n=333) Support and acceptance of family (n=223) Changing attitudes in Irish society (n=101) Increased visibility of LGBTI people (n=80)	Developing self-awareness and self-acceptance (n=320)	Impact of internet/media (n=127) Role of life events or experiences (n=109) Strategies for coming out (n=29) Gaining education on LGBTI identities (n=21)

Social aspects

Participants' comments related to social factors that helped them to come out included: the role of support and acceptance; LGBTI friends and allies; and the changing landscape for LGBTI people in Ireland. Participants identified support and acceptance (n=772), including friends, family and other people, as helping them to come out. Participants commented on finding it easier to come out to people who they knew would be supportive or accepting of their identity. For many participants, knowing in advance how people feel about LGBTI people, whether they are supportive of marriage equality, whether they are homophobic, biphobic or transphobic, whether they have an understanding of LGBTI issues and know LGBTI people, helped them to reach a decision about whether to come out. Trust was identified as instrumental in deciding whether to come out to a particular person. In addition, being close to the person, knowing each other well and feeling comfortable with them also facilitated disclosure.

> *I feel more comfortable talking about my sexuality when I know what people's attitudes are. (Lesbian/gay female, 43)*

> *I told one or two people that I trusted in the beginning to see how they would react and when their reaction was positive, it helped me to feel more comfortable with my sexuality. (Gay male, 51)*

Many people spoke of a growing self-confidence during the coming out process as a result of other people's acceptance. When participants encountered support and acceptance from others after coming out to them, this buoyed their confidence to tell other people. Positive reactions not only reinforced comfort with oneself and encouraged coming out to other people, it also enabled participants to build up a network and to feel supported in the process of coming out. Participants reported that it helped when people had an indifferent reaction to coming out, such as people being indifferent, not caring about it, not making a big deal of it, not passing judgement and not treating them any differently.

> *It helped to take it one person at a time, keeping the fingers crossed each reaction was a positive one. The more I told, the less importance I placed on their opinion as I became more comfortable with who I am. (Gay male, 34)*

It was easier for people (n=223) to come out when they felt secure in the knowledge that their family would accept and love them regardless of how they identify and that they would be treated as nothing had changed. A family environment characterised

by openness, care, love, support, and open-minded and liberal attitudes, instilled confidence in participants that coming out would be greeted positively. Participants reported that it made it easier for them to come out when families communicated acceptance though talking positively about LGBTI issues or when assumptions of heterosexuality were not made and there was no pressure to conform.

> *Having parents and friends who are open-minded and have reaffirmed to me many times that they love me no matter what others think. (Bisexual female, 20)*

Having other family members who identified as LGBTI also helped some participants to come out. They could confide in that person, and use the family's acceptance of them as an indication of the likely reaction to their own coming out: *"What made me finally decide to come out to my mum was when I found out that one of my uncles is gay and in a homosexual relationship" (Transgender, Lesbian/gay, 14)*. In addition, finding an ally within the family circle helped people to come out as they could count on that person's support, who could tell other family members and advocate on their behalf.

> *My mother was always extremely supportive of equality before I came out and so I knew she would be fine with it and she also had talked my father into seeing it as ok as well. (Gay male, 15)*

Participants (n=333) reported that it was easier to come out when they had friends whom they knew would accept them. Some of the participants had friends who identified as LGBTI and had gone through coming out, while others had friends who were openly questioning their own identity. Participants felt comfortable disclosing their identity to these people as they felt their friends could understand them and they were able to provide encouragement and support.

> *Having a close friend going through something similar and being able to talk about it with him made it easier to gain confidence and come out to others. (Bisexual male, 27)*

Having friends who openly demonstrated support for and understanding of LGBTI identities and issues was also reported as helpful. For example, friends who embraced LGBTI people within their social circle, who displayed positive attitudes towards LGBTI people and demonstrated an absence of homophobic or transphobic language and behaviour. All these factors indicated that they could trust their friend to come out to and feel assured of their acceptance. Participants described how they received positive reactions from friends and how friends were a great source of support in helping participants to accept themselves.

Getting great support and no judgement from any of my friends made it much easier to come out. (Lesbian/gay female, 39)

Participants (n=355) reported finding it easier to come out when they were able to find LGBTI people through support groups, clubs, college societies, online and so on. It was important to participants to be able to talk to people who they could identify with, who could understand and relate to their feelings and experiences, who provided examples of feeling comfortable with their identity and who were living openly and proudly, who could give advice about coming out to family and friends, and with whom they could feel acceptance and a sense of community. Such experiences enhanced participants' self-confidence and ease with their identity and provided a source of inspiration to come out to others.

Knowing other people who have gone through coming out as LGBTI and having people to talk to who actually understand. (Lesbian/gay female, 19)

Finding LGBTI people and connecting with LGBTI support services and groups reduced the sense of isolation and loneliness that some people experienced and increased their ease with their identity. Being part of a community, finding acceptance within that community and getting the opportunity to celebrate ones' identity through events, such as the Pride Parade, was also identified by participants as important. Many people reported finding allies within the wider community, be it the counsellor or teacher at school, the Garda or the local youth worker.

Meeting other LGBTI people who you can identify with, who have gone through similar feelings and experiences and to see people who are comfortable with who they are; all of this makes you realize that you are not the only person and gives you some strength and hope. (Lesbian/gay female 29)

The level of support for LGBTI issues in participants' educational and employment environment was also a factor in deciding to come out. A small number of participants reported finding inclusiveness in their school environment where LGBT posters were displayed, LGBT support groups were established and where workshops and discussions around LGBTI issues were run. For many participants, the transition to college coincided with a transformation in their support networks. The college environment was perceived as being more LGBTI-friendly, open and inclusive and there

was an opportunity to meet people through LGBTI societies and clubs. Pink training[12] was noted by several participants as enhancing their self-confidence.

> *Attending USI Pink Training helped me to become more comfortable and more confident in coming out. (Lesbian/gay female, 21)*

> *For me to come out, having LGBTI related resources in both third level institutions [Pink Training] and within the community helped a lot. (Transgender, queer, 25).*

Similarly workplaces that demonstrate support for LGBTI through having a LGBT staff network and trade union LGBT groups, and where there is a culture of openness and acceptance of LGBTI identities, encouraged people to come out: *"At work the presence of an LGBT group has been important in being out to colleagues". (Gay male, 30)*

Changing attitudes within Irish society towards LGBTI people were also identified as a factor. Participants (n=101) noted that there was a greater awareness and acceptance of the LGBTI community, and more acceptance of diversity in general. Irish society was viewed as more progressive and liberal and less influenced by Roman Catholic Church doctrine. It was felt that this resulted in less prejudice and reduced the stigma attached to LGBTI identities, as well as reduced incidence of harassment and victimisation. Significant developments cited as evidence of this change included: the decriminalisation of homosexuality; the introduction of anti-discrimination legislation and equality legislation; civil partnership for same-sex couples; and a growing LGBTI-rights movement.

> *The atmosphere in society has changed and made it far easier to come out over the course of my life. The almost complete normalisation of other sexual identities has helped enormously. (Gay male, 30)*

The increasing visibility of LGBTI people in everyday life, and the presence of positive role models in the public eye, were identified as making it easier to come out (n=80). Many participants felt that coming out had been helped by more media coverage of LGBTI issues, such as homophobia and marriage equality, coming under the spotlight in recent times. It was also felt that the greater visibility of LGBTI people in the media, the presence of high profile LGBTI people in public life and the increase in representation of LGBTI people on TV, in films and literature, had provided role models with whom participants could identify. This also served to forge a greater

12 Pink Training is a weekend of workshops organised by USI (Union of Students Ireland) aimed at students interested in learning more about their gender identity and sexuality.

understanding and awareness of the LGBTI community among the general public.

> *Representation in the media was huge for me. I would have worked everything out a lot later if I never encountered any LGBT+ characters. Reading about other LGBT+ people and their identities and experiences. (Transgender, queer, 20)*

> *Coverage of LGBT matters in the press and positive portrayals of LGBT folk in the media have helped. (Transgender, queer, 25)*

Personal aspects

Over 300 participants (n=320) commented on how becoming more self-aware of one's identity resulted in greater willingness to disclose. For some people, the first step in the coming out process was to learn to accept their LGBTI identity and then to become more comfortable and confident in themselves and their ability to express it to others. Participants spoke of realising and learning that their gender identity or sexual orientation was not 'wrong' and was nothing to be ashamed of. For a large number of participants, coming out was a journey towards realising and accepting *'I am who I am'*, and that it is not something that is amenable to change. It was realising that everyone has a right to be who they are, and learning to see it as something to be proud of. In some cases, recognising and challenging the presence of internalised stigma helped people to come out, although the deeply ingrained nature of it was acknowledged as difficult to overcome. Some people mentioned talking therapies as having aided their self-awareness and acceptance, which in turn helped them to come out.

> *For me it took some years to be comfortable with myself and my sexual identity. Acceptance was the key; when I accepted that being gay is part of who I am and not "something wrong with me" I became more confident and self-assured. (Lesbian/gay female, 35)*

> *The inner confidence that being trans is ok. (Transgender, bisexual, 42)*

In other cases, the process of coming out itself instilled more confidence in participants as they became more comfortable with themselves. The first disclosure was described by participants as the most difficult; thereafter, they reported that the process became easier as they became more practiced at doing it and garnered more support as time went on: *"It was hard for my first, but with the support that I have gotten, I have been able to tell more". (Gay male, 14)*

A positive sense of self in terms self-worth, self-esteem, self-confidence were all mentioned as attributes that made it easier to come out. People mentioned an array of feelings which contributed to them coming out. This included feeling safer, feeling prouder, feeling stronger and courageous, feeling less fearful, being happy in their lives and feeling happy with their decision to come out. For some people, self-confidence stemmed from the realisation that identifying as LGBTI represented just one facet of them as a person and did not subsume their identity. Neither did it change who they are as a person or dictate who they should be or how they should behave.

> *Confidence in myself. Knowing that I am the same person I always was, except better because I have explored my sexuality and not been afraid to do so. (Female, 23)*

A lot of people cited the desire to be happy, to be *'true to myself'* and to live a fulfilled life with the possibility of having a relationship, as one of the factors that helped them to reach a decision to come out. The need and desire to be *'true to myself'*, *'to be myself'*, to be open and honest in interactions with others and to live authentically was the driving force behind many participants' coming out. Aligned with this was the stress and exhaustion that many people reported experiencing as a result of hiding their true identity. The knowledge that hiding or living a lie is a harder option, and may be more detrimental to a person motivated some people to come out.

> *I decided my goal in life was to be happy and if I didn't accept who I was and what I was I could never achieve that goal. (Gay male, 20)*

Factors related to getting older appeared to impact positively on some participants' sense of self-acceptance and, therefore, coming out. This was articulated in terms of not giving as much weight to other people's opinions as one got older, feeling more comfortable with oneself with age, and being acutely aware of time passing by: *"I got older and no longer cared what people thought" (Lesbian/gay female 51).*

Self-acceptance was also associated with reclaiming power and taking away the need for other people's acceptance. Participants commented about coming to the realisation that they are responsible for their own happiness, and acknowledging that there may be people who are unwilling to accept how they identify, and learning to live with that. Participants described not being afraid of adverse reactions and feeling comfortable enough with themselves to the point where they could disregard negative responses to their identity. Thus, they developed a variety of responses to negative opinions or reactions, such as discounting people's negative opinions, breaking contact with people who held negative opinions, and not letting negative opinions prevent them

from being who they are. Some participants' comments reflected a defiant attitude towards people who are not accepting of their identity. This attitude helped them not to yield to other people's expectations of them and to persevere in being out even when it was not accepted by their family or society.

> *My attitude is that I am who I am. If people can't accept me for who I am, then they aren't worth knowing. (Lesbian/gay female, 22)*

Practical aspects

A number of practical aspects helped participants come out. These include the impact of media/internet, the role of life events and experiences, gaining education on LGBTI identities, and developing strategies for coming out. The internet and media were identified (n=127) as useful resources for people to explore their sexuality and to access information on LGBTI identities. The online blogging site Tumblr, in particular, was cited by a number of participants as a useful resource for information about sexuality. The internet also provided people with advice about approaches to coming out which they could then utilise in their own lives. People were also able to access others' experiences of identifying as LGBTI and coming out through YouTube videos and '*It Gets Better*' project videos, and to draw hope, inspiration and advice from these shared experiences. In addition to providing information, the internet was also a means of connecting with other LGBTI people and building online networks of friends for support and advice.

> *Mostly the information available on the internet and connecting with other queer people online. (Lesbian/gay female, 24)*

> *Hearing people's stories and experiences on YouTube was invaluable to me. YouTube was also extremely helpful to see people living their lives happily while out of the closet. (Gay male, 19)*

Many participants (n=109) mentioned specific life events or experiences that enabled or compelled them to come out, including moving away from home and gaining financial independence. Some of these were positive life events, such as falling in love, entering into a civil partnership, having children, or transitioning gender. For some participants having a partner, and the desire to make their love for another person known, prompted them to come out. In addition, having another person to lean on for support who was also in the process of coming out was also cited as a factor which helped participants to come out. One participant expressed the view that

having a partner makes it real for family members who may otherwise find it difficult to accept the person's identity. Another participant felt that people's attitudes are more accepting when the discussion is not focused on LGBTI identity per se but more common and relatable themes, such as relationships and love. Furthermore, a few participants commented that having a partner made it easier to communicate one's sexual orientation in a more understated way than having to be explicit.

> *Always easier when I have a partner, it's just easier to slip it in there and then say 'she'! (Transgender female, heterosexual, 54)*

For others, it was a negative event, such as having a near fatal road traffic accident or a response to a trauma, that led them to come out. Some participants' decision to come out was triggered by reaching a crisis point in their lives where they felt that their health and well-being was being negatively impacted by hiding their identity and reaching a point where they felt they could no longer live a lie.

> *It was a live or die situation. I couldn't live a lie any longer. I wanted to be free. (Gay male, 46)*

Some participants experienced moving away from home or to urban cities, either in Ireland or abroad, as liberating as they felt able to be more open and that there was greater acceptance of and support for LGBTI in these places. For others, going to college was significant because it was felt that there was a greater openness about sexual/gender identity in the college environment and they had access to LGBTI supports, resources and peers.

> *Living in an urban area like Dublin has helped. Would feel less comfortable being out in the country and would feel more isolated. (Gay male, 30)*

A small number of participants took financial independence and job security into account when deciding to come out. They felt that they could risk losing the support of their family or those around them because they had achieved a level of independence and were no longer reliant on other people.

> *My independence (financial, etc.) meant I felt safe to tell them without fear of any reprisal. They likely wouldn't have "cut me off" but I wasn't willing to take that chance. (Gay male, 24)*

For some participants (n=21), education on LBGTI identities and issues made it easier to come out. They reasoned that education enabled them to gain a better understanding

of how they identified, leading to greater confidence to tell other people. It was also felt that there was a wealth of resources and information available to enable the people around them to educate themselves to better understand LGBTI identities. Participants described being exposed to LGBTI issues through educational programmes on TV, through magazine articles and through their studies. One participant mentioned studying about diversity, while another felt that doing a project on discrimination and homophobia within school facilitated them to come out. The school environment was also mentioned in the context of raising awareness of LGBTI identities by displaying posters, running workshops and discussing sexual orientation.

> *Learning about LGBT issues and different LGBT experiences so that I could have a meaningful conversation where I didn't feel uncomfortable at all. (Lesbian/gay female, 22)*

Some participants (n=29) spoke of the way in which they approached coming out to others. For some, it was a concerted and contrived effort to adopt a casual approach and to come out in a way which portrayed confidence and did not conform to heteronormative assumptions. Some participants felt that how they approached coming out affected the way in which people responded; therefore, these participants reported learning to adopt strategies which maximised their own comfort and ease with telling people, while attempting to manage people's responses and elicit positive or non-problematic reactions.

> *I found that it became easier when I learned how to casually drop it into conversation rather than make it a big announcement. If I act as though I assume people already know and I expect them to be ok with it, it takes the pressure off both me and them because they aren't put on the spot and they don't feel that they are expected to say the right thing. (Bisexual female, 27)*

Some participants found it easier to come out to people via email, by writing a letter or sending a text rather than face-to-face.

> *"Taking time to draft an email that informed recipients of my status, what changes they could eventually expect and the appropriate pronouns and name to use made it easier for me to tell family and friends." (Transgender male, 24).*

Facebook was also a medium through which people could express their LGBTI identity. Others found it easier if people asked them about their orientation as opposed to bringing up the subject themselves.

Nine people stated that they had come out with the aid of alcohol and one person under the influence of drugs.

> *"All the people I've told, it's been in a relaxed social situation with alcohol involved. I think that makes it easier because people are more relaxed and open to hearing what you've got to say." (Lesbian/gay female, 23)*

Other Views

Although the survey did not specifically ask participants to describe their feelings around the coming out process, a small number of people expressed the view that they did not feel that they experienced a coming out in identifying and being openly LGBTI. This was attributed to the fact that their identity was not something that caused any inner turmoil about themselves or how people may respond. It also appeared to stem from a principled view of not wanting to collude with heteronormative assumptions of sexuality or to imply 'abnormality' by coming out as well as not wishing to be defined and labelled by others according to ones' sexual orientation.

> *I didn't come out the way many people do, I wasn't ashamed about my sexual orientation, and coming out would make it seem like I thought it was abnormal. (Transgender, pansexual, 20)*

A small portion of people also reported finding the process of coming out very easy. This was attributed to a natural self-confidence and inner strength, the fact that people around them had assumed that they were LGBTI, and that they readily experienced self-acceptance and acceptance and support from others. In contrast, a number of people reported finding the process of coming out very difficult due to ingrained internalised homophobia, being in conservative environments and living in rural areas where they felt there was little or no access to support. There were also a small portion of people who simply stated that nothing helped them to come out.

Coming out: 'If you have not told anyone you are LGBTI, what are some of the reasons for not telling?'

In total, 84 participants answered the question on reasons they had not come out. This represented 83.2% of the sample who were not out (n=101). Analysis of the comments resulted in the following 6 themes (Table 2.8).

Table 2.8: Reasons participants had not come out (n=91)

Fear of rejection and discrimination	Not sure of sexual orientation	Not something I need to declare	Not knowing how to raise conversation and disclose	Anxiety that their voice and orientation would be discounted	Not fully comfortable with self
48% (n=44)	14% (n=13)	13% (n=12)	10% (n=9)	9% (n=8)	5% (n=5)

The most common reason people identified for not coming out was fear (n=44): fear of rejection by family and friends; fear of being perceived and treated differently; fear of being subjected to varying degrees of harassment; and fear of being told that they are too young to know their sexual orientation. Within this category, fear of being judged and rejected by family was the most common reason for not coming out. Some participants commented on their awareness of existing negative attitudes within the family and, as a consequence, were reluctant to disclose. Others mentioned how patterns of communication within the family that demonstrated heterosexual assumption blocked them from coming out. Similar to the fear of telling family, participants were also fearful of telling friends for fear of rejection and fear of being treated differently. Others were concerned that they would be subjected to various degrees of intimidation ranging from 'teasing or slagging' from friends, to name calling, bullying and intimidation. Some of the participants were also afraid of losing friends and social networks.

> *My family wouldn't accept me...I have been in conversations when they often slag people off for being LGBT. (Female, Questioning/Not sure, 17)*

> *I would lose friends. I know that many of them are homophobic and I see no real benefit to coming out at this age. Just causes hassle...I wouldn't be able to handle the slagging at this age. (Gay male, 16)*

In addition to fears about how family and friends would react to disclosure, there were also fears about the impact of social stigma and negative societal attitudes on how they would be perceived and treated by people more generally.

> *The stigma I suppose. I know society and as much as they say they're okay with LGBT people they still make cruel jokes behind their back. I've witnessed this before. I think big part of it is me being very wary of how people perceive me. (Male, Questioning/Not Sure, 19)*

Two participants, who appeared to be married, mentioned specific issues. One person was afraid of abuse from their husband and the second person mentioned fear within the travelling community and fear for how their children might be treated if they disclosed.

The second most common reason cited (n=13) was a lack of certainty around their LGBTI identity with some participants writing that they were 'still questioning' their identity. Although the comments were brief, it did appear that participants were of the view that they had to be 100% sure of their identity before disclosing. Participants did not appear to consider that disclosing and discussing might be a helpful part of the process. Indeed, one participant felt that disclosing would put pressure on them to stick to that identity.

> *I'm unsure. Too much pressure to stick with a label. Rather not discuss it with people. (Female, Questioning/Not Sure, 18)*

The third most common reason mentioned (n=12) was a personal belief that disclosing sexual orientation was not necessary, as it was a private and personal issue that should not concern others. Two people put their non-disclosure down to the fact they are private people, while for another the 'issue had not arisen'. One person's reason for not wishing to disclose centred on them being happy and not wanting to disrupt that.

> *Just don't feel the need to tell anyone. I don't hide it; nobody's ever asked. (Bisexual female, 20)*

The fourth most common reason participants said they didn't disclose (n=9) was to do with communication skills, timing, and not wanting to hurt or make others feel uncomfortable. Participants who commented within this theme mentioned that they lacked the skills to raise the topic or were unable to create a context that would enable them to disclose: *"There is never the right moment, although it sounds cliché, it's true" (Lesbian/gay female, 15)*. Three other participants mentioned that when the timing was right disclosure would be something that would happen in the normal course of conversation as opposed to creating a 'formal' coming out process.

Linked to the fear of rejection by family and friends was the fear that their voice would be discounted or questioned. Participants who commented (n=8) were concerned that family and friends would either tell them they were too young to know their sexual orientation or discount their sexual orientation, especially bisexuality, because of lack of knowledge or a belief that it does not exist. For people who identified as bisexual,

the fear of their sexual orientation being subject to ridicule or being dismissed as non-existent was particularly evident.

> *Social stigma surrounding being bisexual make it difficult, people saying things like 'oh you're just confused' or 'you're just greedy and indecisive'. (Bisexual female, 22)*

For a small number of people (n=5), the desire to disclose and have a confidante to discuss their sexuality with was important, yet they also stressed the need to feel more comfortable with themselves and their identity before being ready and able to open up to others.

> *Hmm, I only recently came out to my parents. It'll probably take more time to adjust and be comfortable of who I am before coming out to more people. (Gay male, 21)*

Coming out: 'What would make it easier to come out?'

In total, 788 participants who were out and 22 participants who were not out provided information about 'What would make it easier to come out'? This represents 36.5% of the sample of participants who were out (n=2,160), and 21.8% of the sample who were not out (n=101).

These participants provided more than 1,000 individual recommendations, which were categorised into three major headings: supports; society-wide changes; and the coming out experience. Each major theme had a number of sub-themes, described in table 2.9.

Table 2.9: Themes and subthemes related to 'What would make it easier to come out?' (N=1,007)

Supports 51.1% (n=514)	**Society-wide changes 40.3% (n=406)**	**Coming out experience 8.6% (n=87)**
Visibility (n=163) Education (n=119) Support services and resources (n=72) Social supports (n=63) Legal protections (n=56) School (n=32) Workplace (n=9)	More accepting attitudes (n=204) Normalisation of LGBTI identities (n=88) Increasing awareness and understanding (n=79) Increasing LGBTI positive behaviour (n=35)	Not making heteronormative assumptions (n=29) Guidance in the process (15) Less fear of a negative reaction (n=14) Knowing the person is accepting (n=11) Comfort with self (n=9) Better reactions to coming out (n=7) Moving away (2)

Supports

Many participants commented on the types of supports in various areas of society that would make it easier to come out as LGBTI. More than 150 participants felt that an increased visibility and presence of LGBTI people would make it easier to come out. Many participants discussed the positive feedback loop that would occur with an increased visibility of out people; the more LGBTI people who were out, the more LGBTI people would be likely to come out. Therefore, they felt LGBTI people themselves had a role to play in making it easier for others to come out. In addition, it was felt that an increased presence of LGBTI people within society and the community would make it easier for friends, family, and other people to react positively when LGBTI people came out. It was also felt that more positive LGBTI role models in the community and media would help LGBTI people in coming out.

> *Greater awareness of LGBTI coming out makes it easier for others to do so. Visibility is vital to the coming out process and the more people come out the easier and more "normal" LGBTI becomes. (Lesbian/gay female, 44)*

> *Having positive role models in the media, sports, and entertainment industries. (Gay male, 28)*

Many participants discussed how they felt an increased media presence of LGBTI people's lives, diversity, and relationships, would impact positively on people coming out. They were of the view that it would help to normalise people's views of LGBTI people and increase acceptance. Some participants spoke specifically of the need for more positive media portrayals of various LGBTI sub-groups to improve society's views towards LGBTI people and combat stereotypes.

Over 100 participants mentioned that education would help LGBTI people in coming out. Participants talked about the need for education of the public feeling this would lead to a greater understanding of LGBTI people. They were of the view that a better informed public would lead to more positive attitudes to, and greater acceptance of LGBTI people. Participants also mentioned the need for education in specific areas, including bisexuality and transgender people.

> *For people who aren't LGBTI, I think having information about who we are helps tremendously. It gives others the information we need them to know, so they can understand. (Lesbian/gay female, 22)*

Many participants mentioned how a greater existence of support services and resources, including information, would make it easier for LGBTI people to come out. The need for more supports for young people, particularly in schools and rural areas, was highlighted.

> *Greater school support for LGBTI students would make it easier to come out as our rural school had none. (Gay male, 24)*

Many participants described how better support from family, particularly parents, would make it easier to come out. A few participants felt that there was a need for more services and supports for family of LGBTI people. They felt that if family and friends were better informed about LGBTI issues, they would be more understanding and accepting when the LGBTI family member came out.

> *It would be great if my parents where more educated so they could accept me, that way I wouldn't be as scared to come out to them. (Lesbian/gay female, 16)*

Some participants mentioned how a more supportive and inclusive culture within the LGBTI community was needed. Several felt that the LGBTI community in Ireland was 'made up of cliques' that pushed out those who did not 'fit' in. Several bisexual and transgender participants mentioned that they had difficulties integrating into the LGBTI community.

> *If the LGBT community were a bit more inclusive and without a clique. (Transgender female, Lesbian/gay, 34)*

More than 30 participants wrote that school environments needed to provide a more welcoming and inclusive environment for a diversity of students. In a great many comments, participants wrote about how better education (or any at all) around LGBTI identities within school would make it easier for LGBTI people to come out. Many were of the view that education of students from a young age, and education within schools, would go a long way in normalising LGBTI identity for those who are non-LGBTI. A handful of participants commented on the need for the school system to become less intertwined with religion in order to create an environment of inclusivity. Several participants also mentioned the need for campaigns and strategy to tackle LGBTI bullying within school.

> *I think more/better/any representation of LGBT people in the education system would make it easier to come out, as what we're exposed to in school and around peers is pretty influential. We need to be more open in schools, normalise discussions on sexuality and relationships. Even discourse and information on straight relationships is poor. (Lesbian/gay female, 17)*

Several participants discussed how it would be easier to come out as LGBTI if it was accepted by their work place.

> *More workplace awareness would make it easier at work. (Gay male, 23)*

Society-wide changes

Many participants commented on the need for society-wide change in order to make it easier for LGBTI people to come out.

Several people referred specifically to the need for more open-mindedness and less judgmental attitudes within society towards LGBTI people: *"If LGBTI people were more accepted in Ireland, it would be easier" (Gay male, 21)*. A few participants commented how heteronormative attitudes needed to end. In addition, people stressed the importance of deconstructing the heterosexual norm and challenging stereotypes that have developed around how LGBTI people look and present, which make it more challenging to come out as LGBTI, such as this quote from a young woman who was not out.

> *I hate the stereotypes presented about what a lesbian should look or act like because I am not a typical lesbian in that sense. I have long hair and like to wear dresses and I feel people would think I don't look enough like a lesbian. I hate that before someone comes out, it is assumed that they are straight! I wish that before you decide and really know whether you are gay or straight, people should not assume you are one or the other, but simply wait for each person to confirm how they feel about their sexuality. (Lesbian/gay female, 15)*

Many also referenced the existence of stigma, homophobia, biphobia, and transphobia within society. Participants felt that stigma towards LGBTI people continues to exist, making it harder for them to come out.

> *What would make it easier would be if there wasn't a horrible stigma attached and the belief that if you identify as LGBTI, there is something wrong with you. (Lesbian/gay female, 19)*

A noticeable percentage of responses related to attitudes towards bisexuality. Bisexual participants were particularly critical of the stigma, stereotyping, and biphobia that exist towards bisexual people within society.

> *Less stigma attached to bisexuality. Bi girls are "experimenting" or just curious. Bi guys are seen as just making excuses before they come out "fully". (Bisexual female, 18)*

> *It would be easier to come out to my family if there were less negative stereotypes around bisexuality. (Bisexual female, 17)*

Many participants commented that LGBTI identities needed to become more normalised in society. A few participants also described how this normalisation process needed to begin at a young age with all children and hoped that in the future LGBTI identities would become completely normalised, so that the entire coming out process became unnecessary. Many compared it to the fact that non-LGBTI people never have to 'come out' and say they are heterosexual, cisgender people; it is just assumed. Some were of the view that if their LGBTI identity became more normalised, other people would realise it is just one part of their identity and not the sum total of it.

> *People being accepting and not making a big deal about it. Being more casual about it and treating it like it's normal. (Female, Pansexual, 17)*

In terms of awareness and understanding, participants felt that if more people knew about LGBTI people, their identities, and their issues, it would make things easier. They felt this would increase people's acceptance of LGBTI people and reduce the need for having to explain their identity. Many participants felt that increasing the dialogue and discussion around LGBTI identities would help in this understanding: *"Wider understanding of LGBTI identities would make it easier to come out; ignorance of others has been my biggest hurdle to coming out" (Transgender, bisexual, 21)*. A noticeable group of participants particularly raised the issue for more understanding around bisexuality and transgender people.

Participants described how the continued existence of negative behaviours towards LGBTI people makes it harder for people to come out. Some described fears related to anti-LGBTI behaviour, such as abuse or harassment that makes it more difficult to come out. For many participants, the use of negative language and discussion around LGBTI people is something that makes it harder to come out.

> *It would be easier to come out to others if I knew that I would not face discrimination or harassment. (Lesbian/gay female, 29)*

A couple of participants suggested how LGBTI-positive behaviour and affirmation would make coming out easier: *"Having visual markers that suggested and confirmed LGBTQ friendliness". (Gay male, 28)*

Coming out experience

The third major theme relates to the coming out experience itself. For those who were not out, the most common theme was the need for guidance from other LGBTI people who had gone through a similar process and the opportunity to meet and talk to peers who were in a similar situation.

> *What would make it easier was if I could get to know some other LGBT people/person who I could talk to and be myself around. (Gay male, 18)*

Many participants wrote that coming out is easier when there is no assumption made that they are straight. Similarly, several participants felt that being asked about their identity would make it easier to come out as LGBTI.

> *People not automatically assuming that you're straight unless you tell them otherwise. (Bisexual female, 23)*

Some participants felt that it would be easier to come out if there was less fear or worry around a negative reaction: *"It would be easier if there wasn't so much fear and uncertainty involved" (Transgender, non-binary, pansexual, 16).*

Two people, who were not out, were of the view that as they got older and moved to college it would be easier to come out, as moving away would give some protection from 'potential rejection' from family and friends. Several participants felt that it is easier to come out when they know beforehand that the person is accepting of LGBTI people. Some participants mentioned gauging other people's levels of acceptance by raising a discussion about an issue affecting LGBTI people to see how they would react. This then provided a signal as to whether it was safe or unsafe to come out.

> *It's always easier when you know someone is LGBT-friendly because you don't have to worry about the reaction. That would be the main thing that would make things easier. (Lesbian/gay female, 25)*

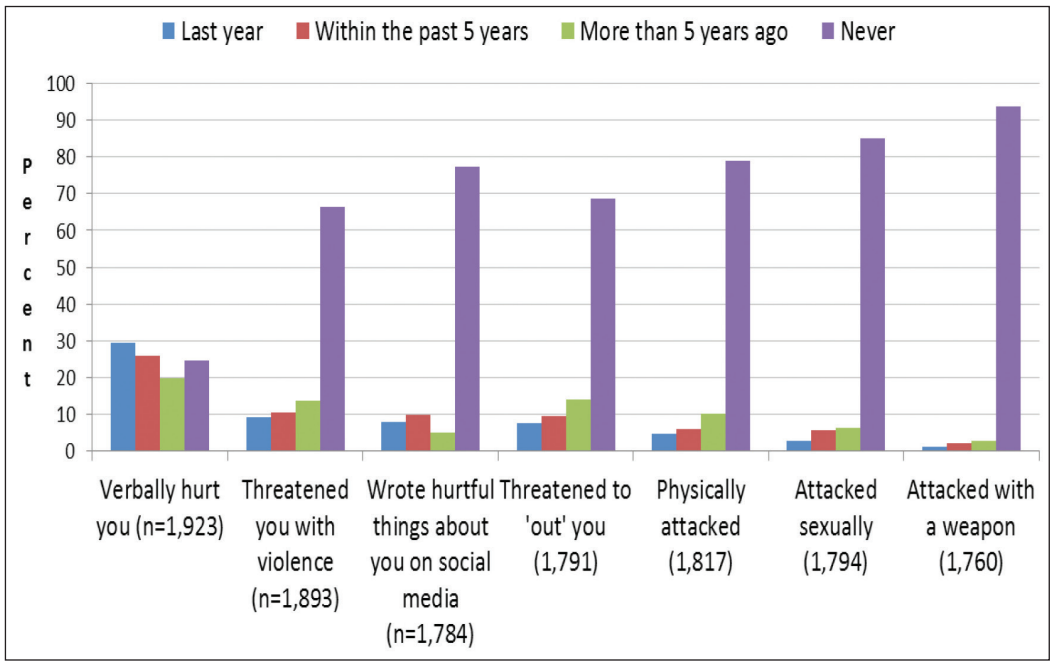
A handful of participants commented that personal comfort and acceptance with their LGBTI identity was the only thing that would make it easier to come out, noting that the passage of time facilitates increased acceptance, which in turn would ease the process of coming out.

Experiences of harassment and violence and sense of safety as an LGBTI person in Ireland

Experiences of harassment and violence

Participants were asked about their experiences of harassment and violence in other aspects of their life (besides school, college/university, or work) because they are LGBTI. By far, the most frequently reported negative experience was being verbally hurt due to being LGBTI, with 75.2% (n=1,447) of participants having experienced this at some point in their life, with 29.4% (n=565) of the events having occurred within the past year. Up to a third of participants had experienced the following verbal harassment or threats due to being LGBTI within their lifetime: threatened with physical violence (33.6%; n=616), had someone threaten to 'out' them as LGBTI (31.2%; n=559), or had hurtful things written about them on social media (22.8%; n=406). Just over one fifth of participants had experienced some form of physical attack due to being LGBTI within their lifetime: punched, hit, or physically attacked (21.1%; n=384), attacked sexually (14.9%; n=268), or attacked with a weapon (6.3%; n=111) (See figure 2.1).

Figure 2.1: Experiences of harassment and violence

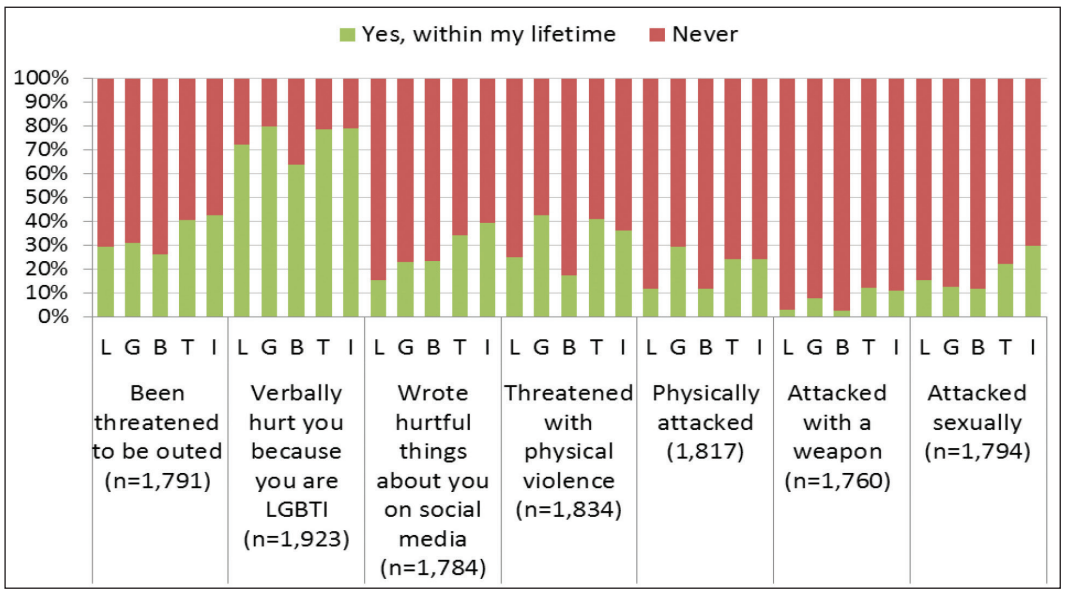


CHAPTER 2

As there were differences in experiences of violence and harassment by LGBTI group, Pearson chi-square tests were conducted to see if these were statistically significant. Statistically significant differences were found for each of the 7 experiences of harassment and violence (See figure 2.2).

- A higher proportion of gay males (79.9%) transgender (78.7%) and intersex (78.9%) participants reported being verbally hurt compared to those who identified as bisexual (63.7%) and those who identified as lesbian/gay female (72.3%).
- Transgender and intersex participants reported higher levels of having hurtful things written about them on social media (34.3%, 39.5% respectively) compared to bisexuals (23.4%), gay males (23.1%) and lesbian/gay females (15.4%); and higher incidences of being threatened with being outed (40.6%; 42.4% respectively) compared to gay males (30.8%), lesbian/gay females (29.2%), and bisexuals (26.3%).
- Over 40% of gay males (42.4%) and transgender participants (40.9%) reported being threatened with violence, followed by intersex participants (36.1%), with lower levels reported by both bisexuals (17.5%) and lesbian/gay females (25%).
- Gay males reported the highest incidence of being physically attacked (29.3%) followed by intersex and transgender participants (24.3%, 24.2%), with lower incidences reported by lesbian/gay females and bisexuals (11.8%, 11.9%).
- Transgender and intersex participants reported higher levels of being attacked with a weapon (12.2%, 10.8%) followed by gay males (7.8%).
- Over a fifth of transgender and intersex participants reported being sexually attacked (22.1%; 29.7%) with a lower incidence reported by the other LGBTI groups (12-15%).

Figure 2.2: Experiences of harassment and violence by LGBTI group



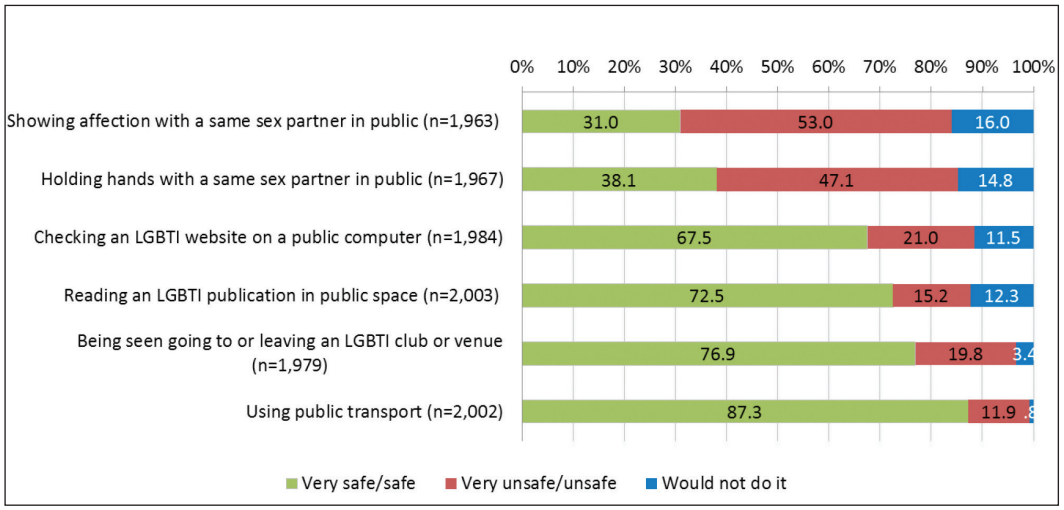
As there were differences in experience of violence and harassment by age group, Pearson chi-square tests test were conducted to see if differences were statistically significant. Statistically significant differences were found for: someone threatened to 'out' you, verbally hurt you, wrote hurtful things about you on social media and threatened you with physical violence. No statistically significant results were found for: physically attacked, attacked sexually, and attacked with a weapon.

- The younger age groups reported higher incidences of being threatened with being outed (14-18: 36.8%; 19-25: 33.5%) compared to the older age groups (36-45: 26.1%; 46+:27.6%).
- In terms of being verbally hurt, the responses followed a trend with the youngest age group (14-18 years: 66.1%) and the older age group (46+ years: 67.5%) reporting the lowest rates of incidence, with the rates increasing towards the middle of the age range (19-45 years: 77%-80%).
- Perhaps unsurprisingly, the younger age groups (14-25 years: 31%-32%) experienced the highest rates of hurtful things being written about them on social media, compared to 17.1% for those aged 26-35 years, 14.6% for those aged 36-45 years, and just 8.9% for those aged 46+ years.
- In terms of being threatened with physical violence, the youngest age group (14-18 years) reported the lowest incidence (24.2%). All of those 19+ years of age reported an incidence between 32% and 38%.

Sense of safety as an LGBTI person in Ireland

Participants were asked how safe they would feel in six situations. Participants felt most unsafe showing affection with a same-sex partner in public or holding hands with a same-sex partner in public. Over half of the participants (53%;= n=1,040) reporting feeling unsafe or very unsafe showing affection and 16% (n=315) reporting they would not do it. Similarly 47.1% (n=927) reported feeling unsafe or very unsafe holding hands with a same sex couple in public and 14.8% (n=291) reported that they would not do it. Between 67% and 76% of participants felt safe or very safe doing the following activities: being seen going to or leaving an LGBTI club or venue (76.9%; n=1,521), reading an LGBTI publication in a public space (72.5%; n=1,452); or checking an LGBTI website on a public computer (67.5%; n=1,339). However, between 25% and 33% had some level of fear around these activities, with approximately 12% of participants reporting that they would not read an LGBTI publication in a public space (12.3%; n=246) or check an LGBTI website on a public computer (11.5%; n=.228). Participants reported that they felt most safe using public transport (87.3%; n=1,747) (See figure 2.3).

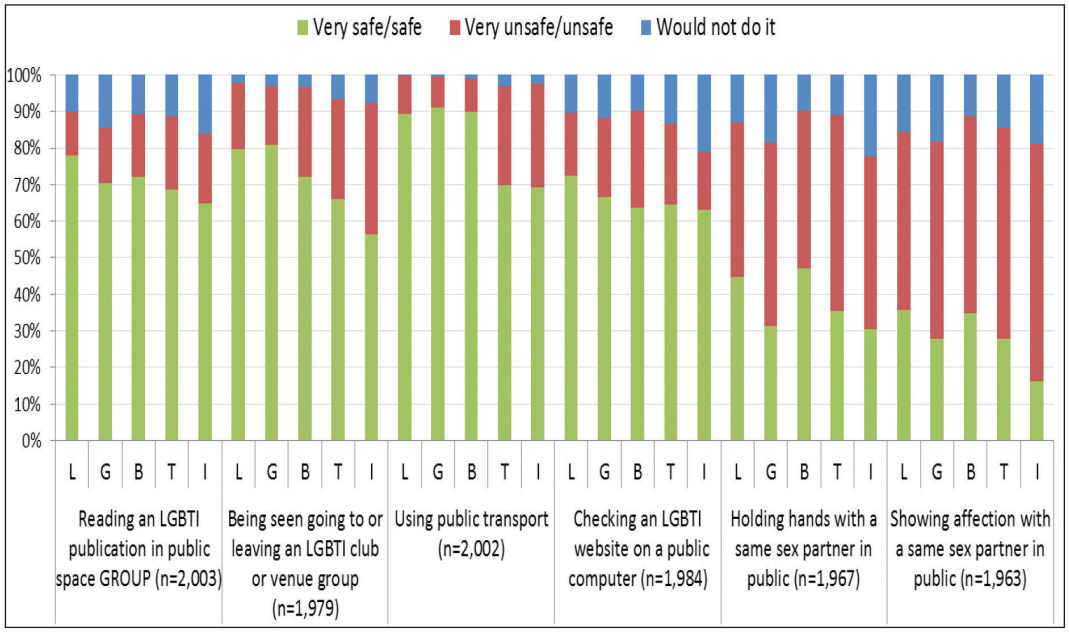
Figure 2.3: Sense of safety as an LGBTI person in Ireland



A Pearson chi-square test revealed that there were statistically significant differences in feelings of safety by LGBTI group for the variables: reading an LGBTI publication in a public space, being seen going to or leaving an LGBTI club or venue, checking an LGBTI website on a public computer, holding hands with a same-sex partner in public, and showing affection with a same-sex partner in public (Figure 2.4). The 'using public transport' variable could not be calculated as expected cell counts were too small.

- Nearly four fifths (78.1%) of lesbian/gay females reported feeling very safe/safe reading an LGBTI publication in public compared to between 65-72% for all other LGBTI groups with the lowest being 64.9% for those who identified as intersex.
- Intersex, transgender and bisexual participants were more likely to feel very unsafe/unsafe (25-36%) being seen going to or leaving an LGBTI club or venue, compared to gay males (16.1%) and lesbian/gay females (18.1%).
- A higher proportion of bisexual people (26.7%) reported feeling very unsafe/ unsafe checking an LGBTI website on a public computer compared to the other LGBTI groups (15-22%) while a greater proportion of the intersex group reported that they would not do it (21.1%) compared to the other groups (10-13%).
- Gay male (50.1%) and transgender participants (53.3%) were more likely to report feeling unsafe/very unsafe holding hands in public compared to lesbian/gay female (42.3%) and bisexual participants (43.3%). Higher proportions of lesbian/ gay females and bisexuals felt safe showing affection with a same-sex partner in public.

Figure 2.4: Sense of safety by LGBTI group



There were also statistically significant differences in feelings of safety by age group for the variables: reading an LGBTI publication in a public space, being seen going to or leaving an LGBTI club or venue, checking an LGBTI website on a public computer, holding hands with a same-sex partner in public, and showing affection with a same-sex partner in public. The 'using public transport' variable could not be calculated as expected cell counts were too small.

- Those aged 14-25 years (23%-29%) were more likely to report they would feel unsafe/very unsafe checking an LGBTI website on a public computer compared to those aged 26+ years (14%-19%).
- Those aged 14-25 years (17%-21%) were more likely to report they would feel unsafe/very unsafe reading an LGBTI publication in a public space compared to those aged 26+ years (12%-15%).
- Those aged 14-18 years were far more likely to say they would feel unsafe/very unsafe being seen going to or leaving an LGBTI club or venue. Approximately 10% of those aged 14-18 years 'would not do it' compared to 4.5% of those aged 19-25 years, and between 1%-2% of those aged 26 and over.
- In terms of holding hands or showing affection with a same-sex partner, the older a participant the more likely they were to report that they 'would not do it'. Over a fifth of those aged 46+ reported that they would not hold hands with a same-sex partner in public or show affection (21.1%; 22.2%) compared to around a tenth of those aged 14-18 (9.5%; 11.6%).

Transgender feeling of safety, and experiences of harassment and violence

In addition to the above questions, all of the people in the 'transgender' group were asked about a number of other transgender specific experiences. While 41.6% (n=94) of transgender participants had never experienced someone purposely using the wrong pronoun when talking about their gender, 58.4% (n=132) had experienced this, with the majority (38.9%; n=88) reporting having experienced it within the past year. Just 4.4% (n=10) experienced this more than 5 years ago. Transgender participants were also asked how safe they would feel expressing their gender identity in public. While 40.3% (n=100) reported they would feel safe or very safe, nearly half (48%; n=119) would feel unsafe or very unsafe and 11.7% (n=29) would not express their gender identity in public.

What one thing would help you feel safer as an LGBTI person in Ireland?

In total, 1,346 people made 1,504 responses in relation to the question on, 'What one thing would help you feel safer as an LGBTI person in Ireland?' This represents 59.5% of the total dataset of 2,264 participants. Five major themes emerged: legal protection and other security; societal attitudes; education of public; visibility; and freedom from negative attention (See table 2.10).

Table 2.10: Themes related to improving safety for LGBTI people (N=1,397)

Legal protections and other security	Societal attitudes	Education of public	Visibility	Freedom from negative attention
42% (n=583)	24% (n=332)	12% (n=174)	12% (n=163)	10% (n=145)

Legal protections and other security

Nearly 600 participants made recommendations for enhancing the protection and security of LGBTI people in Ireland in order to help them feel safer. These responses were broken down into three categories: legal protections (n=278), Garda protections (n=121), and supports (n=184). Nearly 300 recommendations were made about the ways in which changes in legislation could help LGBTI people feel safer in Ireland. Nearly 100 people wrote that full legal equality and protection by law would help them to feel the safest within Ireland.

Being legally recognised as an equal citizen to non-LGBTI people. (Lesbian/gay female, 40)

Participants appeared to be aware of existing laws around hate crimes, and made over 100 recommendations regarding the need for more stringent enforcement of these laws to protect the safety and well-being of LGBTI people in Ireland. Many wrote how hate crimes needed to be identified as such and prosecuted to the full extent of the law. Many participants also wrote that hate crimes should carry harsher penalties and longer sentences. Several participants felt there should be a 'zero tolerance' stance towards hate crimes and other anti-LGBTI behaviour, including LGBTI bullying and use of negative language related to LGBTI people.

Harsher sentences for ALL infringements of personal and professional integrity in respect to sexual orientation gender identity and/or expression. (Lesbian/gay female, 42)

Many participants commented that the An Garda Siochána should be more pro-active in their policing related to anti-LGBTI criminal activity. Several participants noted that officers needed to take crimes against LGBTI people more seriously and many participants suggested that the Gardaí need more training in how to respond effectively and appropriately to anti-LGBTI crimes.

Gardaí being trained to properly respond to LGBTIQ and, in particular, trans issues. (Transgender, bisexual, 17)

More than 40 participants felt that an increased Gardaí presence would impact positively on their feelings of safety as an LGBTI person. A few participants expressed the view that more LGBTI Gardaí would impact positively on LGBTI safety in Ireland. Several participants also felt that the Gardaí should be more visible in their support of LGBTI people.

A stronger police presence around LGBTI venues. (Transgender male, bisexual, 44)

More LGBTI Gardaí. (Transgender, Lesbian/gay, 32)

Participants made almost 200 recommendations about supports (besides increased enforcement of laws and Garda protections) that would assist them in feeling safe as an LGBTI person in Ireland. More than 60 people suggested that raising public awareness of LGBTI people and their relationships would lead to increased public understanding and reduce the likelihood of abuse, harassment, or victimisation.

> *More public awareness of the queer community in Ireland in the general media, to emphasize the positives of the community, while also showing people the lesser known divisions of the community to the general public. (Transgender, queer, 20)*

In addition, several participants argued that raising awareness of the consequences of anti-LGBTI behaviour/crime would help in changing negative and anti-social behaviour. Other participants felt that stigmatizing anti-LGBTI behaviour and crime would support them in feeling safer as an LGBTI person in Ireland. Nearly 30 of these people thought that awareness campaigns would be an effective tool for both discouraging anti-LGBTI behaviour and also positively portraying LGBTI people and couples.

> *Socially stigmatising homo/bi/transphobia to the degree that it's something someone would just never think to do, even when they were angry and wanted to insult someone. (Gay male, 24)*

Several participants stated that greater support for LGBTI issues at Government level would help them feel safer. Nearly 20 participants felt that if people within the community would stand up for, or intervene on behalf of, LGBTI people they would feel safer.

> *More support from the Government and Irish institutions. I believe there are many in support of LGBTI people yet refuse to be vocally supportive. More support from people in 'power' would make others less likely to be openly against it (which would hopefully reduce violence/prejudice towards the LGBTI community). (Gay male, 27)*

Over 30 participants reported that the creation of 'safe spaces' for LGBTI people would help them feel safer. Several participants also suggested that non-LGBTI specific services could indicate their inclusivity with statements of positive affirmation, such as displaying a sign or rainbow flag. A few participants wrote how the availability of safe and supportive services would improve feelings of safety for LGBTI people in Ireland. They suggested a variety of services, including gender neutral toilets, LGBTI-safe transport, support groups, and safer methods for reporting crimes.

> *It's about creating spaces with like-minded people, because there will always be looks or misunderstanding from the general public. So more places and events supportive to LGBTI to meet and express themselves. (Bisexual female, 34)*

Several participants recommended strategies and security measure that they felt would help LGBTI people to feel safer. These included protecting oneself with a weapon or self-defence skills, avoiding certain areas, or staying in a group.

> *For the most part, I feel very safe in Ireland but there are places and times where it can feel very unsafe - just have to be clever about where you go, when and how to avoid any potential confrontations. (Lesbian/gay female, 24)*

Change societal attitudes

Over 300 participants felt that attitudes within society needed to change in order for them to feel safer as an LGBTI person in Ireland. Several participants were of the view that people within Irish society needed to be more accepting of public displays of affection (PDAs) in order for LGBTI people to feel safe showing affection publicly. While some felt PDAs were viewed as unacceptable for all members of Irish society, others felt the unacceptability only related to same-sex couples.

> *A better attitude towards public displays of affection in Ireland. It's fine for guys and girls to be mauling each other on the street, but it's not acceptable for a same sex couple to do it. (Bisexual female, 32)*

Just over 50 participants argued that attitudes towards LGBTI people needed to become more 'normalised', in this way it was felt they would be accepted as 'normal' and their feelings of safety would improve. Many participants discussed this generally in terms of the need for increased societal 'acceptance', 'understanding', and 'tolerance' towards LGBTI people. Other participants felt that negative feelings towards LGBTI people, including homophobia and transphobia, needed to be eradicated in order for them to feel safer.

> *Normalise it. Stop hetero normalisation in Irish culture. Stop making hetero the "default" or "right" thing. (Questioning/Not Sure male, 18)*

Some participants believed that religion was the source of some of these negative attitudes. Several participants stated that a reduction in the influence of the Roman Catholic Church on attitudes towards LGBTI would improve their feelings of safety.

> *Lessening the position of the Catholic church in the country would be something. Taking the patronage of schools away from the church. We live in a rural part of the country surrounded by catholic schools and our family goes against the ethos of these schools, apparently (Lesbian/gay female, 29)*

> *Remove the influence of the Catholic church from all public institutions, aside from ones that are specifically there for religious purpose. (Bisexual, Female, 18)*

Nearly 200 participants stated that improved public education related to LGBTI people and issues would positively impact on their feelings of safety. It was felt that more education would lead to a greater understanding of LGBTI people, reducing ignorance and fear, thus impacting positively on their acceptance and safety within society. Many participants expressed the view that education related to LGBTI issues should begin at a young age.

> *Better education and visibility of LGBTI issues to combat harassment borne of fear and ignorance. (Lesbian/gay female, 31)*

Several participants felt that education related to transgender people in particular needed to be improved in order for them to feel safe.

> *Educating the public about what it means to be transgender so that there is no confusion and then that way we can be treated with respect." (Transgender, bisexual, 26)*

Increase visibility

163 recommendations were made around increasing positive visibility of LGBTI people and LGBTI-related issues in order to promote feelings of safety for LGBTI people. Many participants felt that there should be more visibility of LGBTI people in Irish life. Some participants discussed how more visible LGBTI people in power would also help to increase visibility and feelings of acceptance and safety. More than 50 participants felt that an increased visibility of same-sex couples would help increase acceptance of same-sex relationships and affection, thus promoting greater feelings of safety.

> *Having openly LGBT people in positions of power - e.g. Taoiseach, government ministers, presidents, heads of large Irish corporations, etc. (Lesbian/gay female, 61)*

It would be helpful if LGBTI people were visible and 'out' regularly in their everyday life, with couples regularly holding hands (if that's what they like to do) and expressing affection in the same way as heterosexual couples often do. In this way, LGBTI love would become normalised in everyday life and it would be evident that there is nothing strange/deviant about it. (Lesbian/gay female, 38)

It was felt that the media had a role to play in portraying positive representations of LGBTI people and characters. A few participants reported that there was a need for more transgender visibility within the media. Other participants recommended that the media give better reporting of and coverage to anti-LGBTI crimes. A few participants believed that the media should not be allowed to give such a strong voice to those who are anti-LGBTI.

An increased presence of LGBT issues on Irish media and more LGBT characters in Irish TV programs. This would help people become more comfortable with the idea. (Gay male, 21)

Greater reporting, exposure, and punishment of LGBT hate crimes. It is almost never reported on to the wider public, so some people think they can act with impunity. (Gay male, 21)

Freedom from negative attention

Nearly 150 recommendations were made about the need to remove the fear or threat of judgment, harassment, or violence in society towards LGBTI people. Several participants reported that they would simply like the freedom to express themselves and feel safe: *"That I don't have to think before I do" (Gay male, 32)*. Many participants described how they wanted to be able to go out and be themselves without a fear or threat of negative comments, abuse or violence. They did not want to have to 'check themselves' and their behaviour. In many cases, participants reported they would feel safer if there was not a pervasive, looming, undercurrent that they were unsafe. This caused them to feel worry, tension, and anxiety around going out, especially as a same-sex couple.

Less threat of potential violence. (Gay male, 23)

Always watching your back is not good! (Lesbian/gay female, 25)

Almost 20 comments reflected that participants would feel safer if people did not '*stare at them*' as much, particularly when they were out with their same-sex partner. Several participants felt they would feel safer if people would '*mind their own business*': *"In an ideal world if everyone looked after themselves rather that other people's business" (Lesbian/gay female, 44).*

> *Freedom to hold my partner's hand and not be stared at. (Bisexual female, 40)*

> *If people stopped staring at me because of my gender. (Transgender, heterosexual, 20)*

Others described how they would feel safer if they did not have to face actual negative events related to being LGBTI. For most, this was verbal harassment or taunting.

> *Less public harassment, asking if I'm a man or a woman. (Transgender male, bisexual, 26)*

> *If heterosexual [people] didn't make sexual advances to me and my girlfriend when they realize we are lesbians. (Lesbian/gay female, 34)*

A few participants reported that they would feel safer if they knew that crimes against LGBTI people were not still occurring.

> *If the statistics of LGBT people being attacked, assaulted etc. decreased, verbal abuse on the street decreased etc., we would feel safer. (Transgender male, heterosexual, 20)*

Other views

Of the participants who responded to this question, 40 people said they did not know or were not sure what would help them feel safer as an LGBTI person in Ireland. Fourteen people said that nothing could be done to help them feel safer as an LGBTI person in Ireland, while 20 people said nothing could be done as they already felt safe. Four people felt that safety could be improved by a change within the LGBTI community itself.

The LGBT community need to establish more cross community links to build trust and understanding with ordinary folks. Ultimately, this is the best way of further undoing the taboo and building real bonds between all kinds of people. (Gay male, 45)

Seventeen participants felt that they would feel safer if they could have more confidence and be comfortable with themselves. Examples of comments within this category included: *"More confidence to be who I am rather than always striving to 'fit in'" (Lesbian/gay female, 28)* and *"Belief in yourself" (Lesbian/gay female, 40).*

Coping strategies

A modified version of the Coping Strategies Indicator (Amirkhan 1990) was used to assess the coping strategies of the sample. The modified scale was based on that used by Dooley and Fitzgerald in the *My World* Survey (Dooley and Fitzgerald 2012). It included 15 statements in total, with three sub-scales around the different coping strategies: avoidant, planned, and support-focused. The avoidant scale included six statements, the planned scale had five, and the support-focused scale had four statements. The avoidant strategies emphasised avoidant-focused ways of coping, such as avoiding the problem by spending time alone, watching TV, or pretending there is no problem. Planned strategies focused on strategies such as goal setting and making plans. Support-focused strategies included relying on friends for advice and support. Statements on the scale were scored from 1 'never' to 6 'always'. Table 2.11 shows the scores on each of the coping scales for both the sample and the younger age groups, broken down by LGBTI identity.

Table 2.11: Coping strategies of the survey sample

AVOIDANT STRATEGIES: MEAN (N)						
	ALL LGBTI	**L**	**G**	**B**	**T**	**I**
All Ages	17.22 (n=1,756)	16.56 (n=489)	16.23 (n=745)	18.74 (n=266)	19.23 (n=220)	23.25 (n=36)
14-18	20.56 (n=291)	21.91 (n=53)	18.5 (n=84)	21.18 (n=85)	20.64 (n=67)	25 (n=11)
19-25	18.43 (n=482)	18.82 (n=113)	17.17 (n=206)	18.24 (n=88)	21.12 (n=67)	24.75 (n=8)
PLANNED STRATEGIES: MEAN (N)						
	ALL LGBTI	**L**	**G**	**B**	**T**	**I**
All Ages	17.17 (n=1,838)	17.52 (n=511)	17.52 (n=775)	16.95 (n=278)	15.89 (n=239)	14.83 (n=35)
14-18	15.15 (n=316)	14.59 (n=58)	16.07 (n=91)	15.44 (n=89)	14.55 (n=67)	11.82 (n=11)
19-25	16.79 (n=503)	16.10 (n=120)	17.37 (n=210)	17.17 (n=94)	16.14 (n=71)	13.5 (n=8)
SUPPORT FOCUSED STRATEGIES: MEAN (N)						
	ALL LGBTI	**L**	**G**	**B**	**T**	**I**
All Ages	12.92 (n=1,851)	13.31 (n=516)	13.26 (n=783)	12.62 (n=276)	11.8 (n=239)	10.03 (n=37)
14-18	12.06 (n=321)	12.76 (n=58)	12.11 (n=94)	11.6 (n=91)	12.49 (n=67)	9.18 (n=11)
19-25	12.8 (n=503)	12.32 (n=119)	13.5 (n=213)	12.54 (n=91)	12.22 (n=72)	9.63 (n=8)

Intersex participants had the highest mean scores on the avoidant scale, followed by transgender participants, and the lowest mean scores for planned and support-focused coping strategies, again followed by transgender participants, suggesting that these participants employ more negative coping strategies compared to the other LGBTI groups. In terms of age, the youngest age group (14-18) had the highest scores overall for avoidant coping, followed by the 19-25 year olds and the 26-35 year olds, indicating that the younger participants tended to use more avoidant coping strategies compared to older participants. The younger age groups (14-18, 19-25) had the lowest scores for

planned coping strategies and lower scores than those aged 26-45 for support-focused coping strategies.

Discussion

The findings of this study suggest that similar to the general population (CSO 2015; OECD 2013), a large proportion of LGBTI participants (approximately 70%) are experiencing positive well-being in terms of happiness and life satisfaction. On both the happiness and life satisfaction scales, the majority of participants scored above the midway point on the scales with less than 25% of the sample rating their levels of happiness and life satisfaction below point 5 on the scales. In addition, pride in their LGBTI identity, the LGBT community and the LGBT rights movement was reported in the qualitative responses. These are encouraging findings as they indicate that a large proportion of the sample appraise their overall well-being in a positive light, which in turn may mean that they are also experiencing many of the positive outcomes that high levels of well-being can induce including effective learning, productivity and creativity, good relationships, pro-social behaviour, and good health and life expectancy (Chida and Steptoe 2008; Diener *et al*. 2010; Dolan *et al*. 2008; Huppert 2009; Lyubomirsky *et al*. 2005). Factors which may have positively informed participants' appraisals of their well-being included acceptance of their own LGBTI identity, public disclosure of their LGBTI identity and support from the LGBT community.

An overwhelming majority of participants in this study had told somebody that they were LGBTI, with only 3.1% disclosing that they had not told anybody. This is reflective of Mayock *et al*.'s (2009) finding that 96% of survey participants were 'out' to at least one person in their lives. Participants had most commonly disclosed to parents, friends and siblings; a finding which again reflects Mayock *et al*. (2009) wherein 2/3 of the survey participants were out to family members and friends but less than half were out to people in other social contexts such as workplaces, school/college. Given that public disclosure of one's LGBTI identity is associated with a vast number of positive well-being outcomes such as a greater sense of authenticity (Vaughan and Waehler 2010), higher self-esteem (Halpin and Allen 2004; Jordan and Deluty 1998), lower anxiety (Jordan and Deluty 1998; Lehavot and Simoni 2011), fewer depressive symptoms (Ayala and Coleman 2000; Lehavot and Simoni 2011; Lewis *et al*. 2001), less overall psychological distress (Morris *et al*. 2001), and greater positive affect (Halpin and Allen 2004; Jordan and Deluty 1998), these are extremely encouraging findings.

It also seems that the great majority of LGBTI people are not only publicly disclosing their sexual orientation and gender identity, but that they also appear to be doing so at a young age; predominantly during the years of adolescence. The mean age of knowing one's LGBTI identity in this study was 15 [most common 12], with the mean

age of telling another person being 19 [most common 16]. This means that for most participants there was at least a 4 year gap, sometimes more, between self-identifying and telling. These findings are nearly identical to the findings from Mayock *et al.*'s (2009) study in which the mean age of knowing was 14 [most common 12] and the mean age of telling was 21 [most common 17]. Both of these figures are however much lower than those in the *Visible Lives* study in which the mean age of knowing was 20 and mean age of telling was 31 (Higgins *et al.* 2011). Conversely, the age range of the participants in *Visible lives* was 55 to 80 years, whereas the age range in Mayock *et al.*'s (2009) study was 14-73 and the age range in this *LGBTIreland* study is 14-71.

Study findings indicate that the ages of knowing and coming out are not the same across, and between, the LGBTI communities. For transgender participants the mean age of knowing was 14 years of age, which is higher than that reported in other studies, where the average age varied between 3 years and 10 years (Nagoshi 2015; Kennedy & Hellen 2010; McBride 2013; Grossman & D'Augelli 2006; Factor & Rothblum 2008). While the majority of transgender participants (75.5%) reported currently living in their felt/preferred gender either full-time (48%) or part-time (30.5%), there was a 6 year gap between their mean age of knowing (14 years old) and their mean age of telling (20 years old), and a two-year gap between disclosure and living in their preferred gender (22 years old).

In keeping with international and Irish research, findings indicate that LGBT youth are self-identifying as LGBT and coming out at younger ages than previous generations (Mayock *et al.* 2009; Higgins *et al.* 2011; Calzo *et al.* 2011; Kennedy and Hellen 2010). Given that the process of coming out can be extremely difficult (Meyer 1995; Troiden 1989), not least because of the pertinent risk of rejection from family and friends (Mayock *et al.* 2009; Ray 2006), this finding perhaps indicates a perceived increase in levels of acceptance of LGBTI identities within participants' circle of family, friends, and wider community networks. In fact, 75% of participants noted that it was social aspects, such as knowing that friends, family and wider society would be supportive and accepting, that facilitated the disclosure of their LGBTI identity. In contrast, an absence of support and fear of rejection by family and friends, including fear of being perceived and treated differently; fear of being subjected to varying degrees of harassment; and fear of being told that they are too young to know their sexual orientation, were the reasons given by participants who had not yet come out, for not disclosing their LGBTI identity.

Whilst it is extremely positive that nearly all of the participants were out to at least one person, the study findings also indicate that LGBTI people continue to be exposed to victimisation and discrimination. The vast majority of participants (75.2%) reported that over their lifetime they had experienced being verbally hurt, with approximately 20% of participants having experienced physical attacks due to being LGBTI. Such reported incidences of harassment are slightly lower than reported in Mayock *et al*. (2009) wherein 80.4% and 42.5% of LGBT participants reported being verbally or physically assaulted respectively. Despite this apparent reduction, the reported incidences of verbal and physical assaults are indicative of the hostile behaviour many LGBT people are still regularly exposed to. Gay male, transgender, and intersex participants appeared particularly at risk in this regard. Gay males reported the highest incidence of being physically attacked (29.3%), whilst transgender persons had comparatively high levels of having hurtful things written about them on social media (34.3%), high incidences of being threatened with being outed (40.6%), and the highest incidence of being attacked with a weapon (12.2%). Over a fifth of transgender people (22.1%) also reported being attacked sexually. The transgender participants' reports thus reflect the fact that transphobic hate crime has been proven to be prevalent across Europe, the UK and Ireland (McBride and Hansson 2010; McIlroy 2009; Turner *et al*. 2009; Whittle et al. 2007). In Ireland, TENI reported that between March 2013 and October 2013 there were thirty two reported incidents of transphobic violence; the majority of which involved verbal abuse or insults (88%), threats of violence (28%), and physical violence (19%) (TENI 2014). Similar to their transgender counterparts, intersex participants in *LGBTIreland* reported comparatively high levels of having hurtful things written about them on social media (39.5%), being threatened with being outed (42.4%), being threatened with violence (36.1%), and being physically attacked (24.3%). Over a fifth of intersex participants (29.7%) also reported being sexually attacked. Despite the dearth of research available with which to compare and validate these findings on intersex people's experiences of harassment, it may be postulated that such hostile behaviour towards intersex people may be informed, at least in part, by the arguably limited public knowledge and understanding of, and familiarity with, intersex identities.

Whilst gay male, transgender and intersex participants appeared to experience comparatively higher rates of verbal, physical and sexual harassment than their bisexual and lesbian/gay female counterparts, bisexual and lesbian/gay females still experienced significant levels of victimisation. A quarter of lesbian/gay females experienced threats of violence, in addition to also being threatened with being outed (29.2%), and being physically attacked (11.8%). Over a quarter of bisexual people had

been threatened with being outed alongside being threatened with violence (17.5%), and being physically attacked (11.9%). Given the high incidences of harassment across the board it is not surprising that, in order to prevent such traumatic experiences, LGBT people reportedly conceal their sexual orientation and/or gender identity, and adjust their behaviour in public spaces (Dermer *et al*. 2010). Although participants reported feeling most safe using public transport (87.3%), when it came to displays of public affection participants felt unsafe or very unsafe when showing public affection (53%) or holding hands with their partner (47.1%). Accordingly, a proportion of participants reported that they would not show affection to, (16%) or hold hands (14.8%) with their partner in public. Likewise, FRA (2013) reported that 50% of their survey participants avoided certain places or locations for fear of being assaulted, threatened or harassed. Gay men and transgender people, who in *LGBTIreland* experienced some of the highest levels of harassment, were considered to be more likely to adapt their behaviour in this way (FRA 2013); often avoiding being open about being LGBT on public transport, on street or other places, and in public premises or buildings (FRA 2013). Higgins *et al*. (2011) similarly reported that although the majority of LGBT survey participants felt safe walking alone in their neighbourhood after dark and felt safe in their homes after dark, only 23% were comfortable holding hands in public with same-sex partners and 22% felt safe showing affection with same-sex partners in public. International research suggests that, despite this constant threat, the majority of LGBTI people do not tend to report their experiences of verbal and physical harassment to authorities because they feel police would do nothing about it, or because they fear homophobic or transphobic reactions from the police (McIlroy 2009; FRA 2013). In TENI's (2014) study of transphobic hate crimes, 56% of participants reported that they did not report the incident/crime to the police. Likewise, in FRA's (2013) study, only 22% reported violence to the police, with this reduced to 6% when dealing with harassment, and in the Metro Youth Chances (2014) study only 21% of those who had endured some form of sexual abuse received any help or support (Metro Youth Chances 2014). Due to this lack of reporting, research suggests that the statistics for the number of hate crimes are inaccurate (Tucker and Potocky-Tripoli 2006; McIlroy 2009; Guasp *et al*. 2013) and as a result the problem of sexual and gender harassment is currently severely underestimated.

In order to reduce the high incidence of victimisation and discrimination, participants proffered a number of recommendations including, the introduction of stronger legal protections for LGBTI people and further initiatives to normalise and increase visibility of LGBTI identities. Interestingly, participants' recommendations in this regard overlapped with their suggestions as to 'what would make it easier to come out', which also included frequent references to the need for increased visibility, normalisation and acceptance of LGBTI identities, in addition to further legal protections, support

services, and public awareness and education. This overlap of recommendations explicitly reiterates the strong mediating role which experiences of heteronormativity, rejection, victimisation, and harassment may have on LGBTI people's feelings of societal acceptance and sense of belonging, and in turn on their willingness to publicly disclose their LGBTI identity. It is therefore argued that concerted efforts to redress the high incidence of LGBTI harassment and victimisation will promote a societal culture conducive to public disclosure of LGBTI identities and positive LGBTI affirming experiences.

In relation to self-esteem, the findings suggest that the mean score (mean=28.48, SD=6.8) for the total sample is just slightly lower than the international norms based on 53 countries (mean=30.85; SD=4.82) reported by Schmitt & Allik (2005). Similarly the mean scores for the younger LGBTI participants (14-18 years: mean=24.29; 19-25 years: mean=26.83) are also lower than the mean of 27.3 reported for the 13-17 years olds in NiGabhainn and Mullan's (2003) Irish study, and considerably lower than the scores for a sample of 12 to 25 year old Irish young people (mean= 28.4; SD=5.7) in Dooley and Fitzgerald's (2012) study.

Findings also suggest that the majority of LGBTI people's coping strategies are also a cause for concern. All cohorts of the LGBTI sample demonstrated high mean scores on avoidant coping strategies, but bisexual (18.74), transgender (19.23) and intersex (23.25) participants' mean scores were particularly elevated in comparison to their lesbian/gay female (16.56) and gay male (16.23) counterparts. Further, the youngest age group in the sample (14-18 years old) also displayed a very high mean score of avoidant coping (20.56). While research indicates that younger people in general have poorer coping mechanisms than older people (Diehl *et al*. 2014), the mean score for avoidant coping in *LGBTIreland* exceeds the scores reported in the *My World* survey. In *My World* the mean (m) scores for the adolescent cohort were as follows; 14-15 years (M=15.5), 16-17 years (M=16.2), and 18-19 years (M=17.2) (Dooley and Fitzgerald 2012). Such findings reiterate the dominant narrative of prior research which suggests that the utilisation of avoidant coping strategies is more prolific in the LGBT population in comparison to the general population (Feldman and Meyer 2007; Meyer *et al*. 2001; Rosario *et al*. 2009; Siever 1994). The postulated outcome of employing avoidant coping strategies is decreased levels of physical and psychological well-being (Miquelon and Vallerand 2008; Szymanksi 2009) including the onset or exacerbation of mental health difficulties (Dermer *et al*. 2010; Talley and Betancourt 2011). Given this evidence, and the rates of mental health difficulties and self-harm identified in this study (discussed in Chapter three), it is critical that well-being initiatives with a strong emphasis on raising awareness and education on positive coping strategies be instigated and tailored to

the distinct needs of the LGBTI community. In this light, it may be beneficial to learn from and incorporate the experiences and knowledge of the older gay male and lesbian/gay female communities who, in this study, scored the lowest mean score in avoidant coping strategies and the highest mean score in the adaptive coping strategies of planned and support focused coping and who, in prior research, have been identified as displaying increased resilience to challenges to their well-being (Riggle *et al*. 2008; Higgins *et al*. 2011). Of the numerous resilience building factors which previous studies have identified, including: social support; LGBT community connectedness; high level of 'outness'; low levels of internalised homophobia; being in steady relationship; self-acceptance; avoiding and/or exiting hostile environments; and affirmation of sexual identity (Kwon 2013; Dentato *et al*. 2014; Follins *et al*. 2014; Asakura and Craig 2014; Wong 2015; Shilo *et al*. 2015; Foster *et al*. 2015; Beasley *et al*. 2015; Higgins *et al*. 2011), social support among LGBTI people themselves is consistently cited as one of the most influential factors in strengthening resilience within the LGBTI community (Russell and Richards 2003; Vincke and Heeringen 2002; Kaminski 2000). Social support was also cited by participants in this study as one of the primary variables informing their levels of happiness and pride about being LGBTI. Participants noted that they derived a sense of inclusion, belonging and support from actively being involved in the LGBTI community. It may therefore be warranted that further initiatives addressing LGBTI people's well-being consider this established source of support as key to developing increased utilisation of adaptive coping strategies and consequently strengthening LGBTI resilience to the many challenges people may endure.

FINDINGS: LGBTI MENTAL HEALTH

Introduction

Internationally, LGBT people have been consistently identified as a population who experience elevated rates of mental health difficulties comparative to the general population. Whilst many of the early studies suffer from methodological limitations, Cochran & Mays (2009) suggest that even recent, more methodologically rigorous studies convincingly indicate that LGBT populations experience increased risk of developing mental health difficulties (Tjepkema 2008; Corliss *et al*. 2008; Ziyadeh *et al*. 2007; Burgard *et al*. 2005; Drabble *et al*. 2005; Fergusson *et al*. 2005; Cochran & Mays 2000; Cochran 2003, 2007; Garofalo *et al*. 1999; Gilman *et al*. 2001; Remafedi *et al*. 1998; Robin *et al*. 2002; Russell and Joyner 2001; Sandfort *et al*. 2001, 2006; Skegg *et al*. 2003; Wichstrom and Hegna 2003). The findings of these studies support King *et al*.'s (2008) meta-analysis which revealed that, compared with heterosexual people, the prevalence of depression and anxiety disorders (over a period of 12 months or a lifetime) was at least 1.5 times higher in individuals who are LGB (RR range 1.54–2.58); that the incidence of suicide attempts was double in LGB people (pooled risk ratio (RR) for lifetime risk 2.47, 95% CI 1.87–3.28); and that dependence on alcohol and other substances over 12 months was also 1.5 times higher in the LGB population (King *et al*. 2008).

Contemporary research studies, published post King *et al*.'s (2008) meta-analysis, have also, to varying extents and consistency, continuously reiterated the heightened rates of mental health difficulties (Bolton and Sareen 2011; Chakraborty *et al*. 2011), substance use disorders (Kecojevic *et al*. 2012; McCabe *et al*. 2013; Mereish and Bradford 2014), and suicide attempts in LGBT individuals (Haas *et al*. 2011; Kann *et al*. 2011; Lewis 2009; Marshal *et al*. 2011; Ramsay and Tremblay 2012). Further to this body of work, a small but steadily growing number of studies which explore the rates of Non-Suicidal Self Injury (NSSI) in the sexual minority community reflect the trend of the previously described research. Batejan *et al*.'s (2015) meta-analysis of 11 published and 4 unpublished studies describing the statistical associations between sexual orientation and NSSI, which together comprised of 7,147 sexual minority and 61,701 heterosexual participants, indicated that the odds of engaging in Non-Suicidal Self Injury are approximately three times greater for sexual minorities as compared to heterosexual participants.

In light of this international context, this chapter explores the module findings relating to participants' mental health. First, changes in participants' mental health in

the past five years are examined. Next, data on participants' scores on the Depression, Anxiety, and Stress Scale (DASS) are presented. Following this, both quantitative and qualitative findings related to self-harm, suicidal thoughts, and suicide attempts are presented. Experiences of help seeking are also explored. Finally, participants' use and misuse of alcohol and other recreational drugs is examined.

Changes to mental health in past five years and factors that have impacted on mental health

Participants were asked to think about the past five years and say whether they thought their mental health had worsened, stayed the same, or improved. Of the 1,870 participants who responded to this question, half (50.9%; n=952) felt their mental health had improved, while about one-quarter (25.4%; n=475) felt it had worsened. The remaining 23.7% (n=443) felt it had stayed the same.

Chi-square tests were conducted to determine whether there were any significant differences in changes in mental health in the past five years by LGBTI group and age group. Significant differences were found for both variables.

- Transgender (32.9%; n=80) and intersex participants (42.1%; n=16) were more likely than gay males (21.7%; n=171), lesbian/gay females (24.4%; n=127) and bisexuals (28.8%; n=81) to report that their mental health had worsened in the past five years.
- Participants aged 14-18 years (48%; n=154) were more likely to report that their mental health had worsened in the past 5 years compared to the other age groups (19-25: 25.4%; 26-35: 18.8%; 36-45: 19.9%; 46+: 15.7%).

Participants were asked whether a list of factors had an impact on their mental health in the past 5 years. Overall, more than 40% of the participants who responded were of the view that the listed factors had a positive impact on their mental health (Table 3.1). The factors most frequently deemed to have a positive impact were seeing more LGBTI people in the media and on TV (89.2%; n=1,487); making new LGBTI friends (88.8%; n=1,485) and coming out as LGBTI to friends (86.2%; n=1,296). Other factors with a positive impact related to changes in Irish law, such as changes in legislation related to gender identity (82.7%; n=884) and the Civil Partnership Bill[13] (82.5%; n=1,365), as well as joining an LGBTI group (82%; n=760). Factors that were rated most negatively related to calling a non-LGBTI helpline (12.4%; n=31) and engaging with mental health services (12%; n=93). Coming out as LGBTI to family members also had a negative impact on mental health for 10.7% (n=137) of the participants who responded. Of the 137

13 The survey took place prior to the Marriage Equality Referendum.

participants who reported that coming out to family members had a negative impact on their mental health, they identified as: 43 transgender; 35 gay male; 34 lesbian/gay female; 19 bisexual and 6 intersex. Of the 93 participants who reported that engaging with the mental health services had a negative impact on their mental health, they identified as: 28 lesbian/gay female; 21 as transgender; 20 as gay males; 18 as bisexual and 6 as intersex.

Table 3.1: Factors that have impacted on mental health of the survey sample

	Positive impact	Negative impact	No impact at all
Seeing more LGBTI people in the media and on TV (n=1,667)	89.2% (n=1487)	3% (n=50)	7.8% (n=130)
Making new LGBTI friends (n=1,673)	88.8% (n=1485)	1.5% (n=25)	9.7% (n=163)
Coming out as LGBTI to friends (n=1,503)	86.2% (n=1296)	2.4% (n=36)	11.4% (n=171)
Changes in legislation related to gender identity like the Gender Recognition Bill (n=1,136)	82.7% (n=884)	2.5% (n=27)	14.8% (n=158)
Changes in law like the Civil Partnership Bill (n=1,644)	82.5% (n=1,365)	3.4% (n=56)	14.1% (n=232)
Joining an LGBTI group (n=971)	82% (n=760)	4.4% (n=41)	13.6.% (n=126)
Transitioning to my preferred gender (n=206)	77.7% (n=160)	4.4% (n=9)	18% (n=37)
Using a general (not LGBTI-specific) support group or service (n=517)	73.3% (n=379)	7% (n=36)	19.7% (n=102)
Coming out as LGBTI to family members (n=1,283)	73.3% (n=941)	10.7% (n=137)	16.0% (n=205)
Visiting an LGBTI centre (n=634)	72.4% (n=459)	3.5% (n=22)	24.1% (n=153)
Engaging with the mental health services (n=773)	70.5% (n=545)	12% (n=93)	17.5% (n=135)

	Positive impact	Negative impact	No impact at all
Joining an LGBTI youth group (n=318)	68.9% (n=219)	5% (n=16)	26.1% (n=83)
Calling an LBGTI helpline (n=212)	55.2% (n=117)	5.7% (n=12)	39.2% (n=83)
Calling a non-LGBTI helpline (n=249)	48.6% (n=121)	12.4% (n=31)	39% (n=97)
Family joining an LGBTI support group or service (n=134)	42.5% (n=57)	6% (n=8)	51.5% (n=69)

Depression, anxiety, and stress

Participants were asked a series of 21 questions as part of the Depression, Anxiety, and Stress Scale (DASS-21) (Lovibond and Lovibond 1995). The scale has three sub-scales comprised of seven items for each dimension: depression, anxiety, and stress. Responses for each item were scored from zero to three and ranged from 'did not apply to me at all' to 'applied to me very much, or most of the time'. The items for each sub-scale were added and participants were given a total score. Because the DASS 21 is a short form version of the DASS (the Long Form has 42 items), the final score of each item (Depression, Anxiety and Stress) was multiplied by two (x2) in line with Lovibond and Lovibond's (1995) recommendation to allow comparisons to be made with the DASS 42. Scores on each of the sub-scales range from a minimum of 0 to a maximum of 42, with higher scores reflecting higher levels of distress. Scores are categorised into five groups: normal, mild, moderate, severe and extremely severe. This categorisation provides an indicator of the severity of the negative emotions of Depression, Anxiety and Stress. Interpretation of severity is based on cut-off points, with higher scores indicating greater levels of distress; for example 'mild' means that the person is above the population mean, but still well below the typical severity of people seeking help (See Table 3.2 for cut-off points).

Table 3.2: Scoring of the DASS-42

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

The mean score for the depression scale was 11.55 (SD = 11.51), which falls within the mild depression category. Just over half the sample (53.2%; n=991) had normal scores on the depression scale, meaning that the remaining 46.8% (n=872) had scores indicating some level of depression. Approximately one in ten (11%; n=204) participants had scores within the mild depression category and a further 15.9% (n=296) scored within the moderate depression category. Just over 20% of the scores fell within the categories of either severe (7.1%; n=132) or extremely severe (12.9%; n=240) depression (Table 3.3).

The mean score for the anxiety scale was 8.8 (SD=9.81), which falls in the category of mild anxiety. Just over 58% of the sample (58.3%; n=1,097) had scores falling within the normal anxiety category. A further 10.5% (n=198) and 8.7% (n=163) had scores in the mild and moderate anxiety categories respectively. Over 20% had scores that were within either the severe (7%; n=131) or extremely severe (15.6%; n=294) anxiety categories (Table 3.3).

The mean score for the stress scale was 13.3 (SD=10.4), falling within the normal stress category and over 60% (64.5%; n=1,202) of participants had scores within this category. About one in five participants were experiencing either mild (9.1%; n=170) or moderate (11.2%; n=208) stress levels. Just over 15% had scores indicating either severe (9.3%; n=174) or extremely severe (5.9%; n =109) stress (Table 3.3).

Table 3.3: DASS-42 scores of the survey sample

Scale (n)	Mean (SD)	Range	Normal	Mild or Moderate	Severe or Extremely Severe
Depression (n=1,863)	11.55 (11.51)	0-42	53.2% (991)	26.9% (500)	20% (372)
Anxiety (n=1,883)	8.8 (9.81)	0-42	58.3% (1,097)	19.2% (361)	22.6% (425)
Stress (n=1,863)	13.3 (10.4)	0-42	64.5% (1,202)	20.3% (378)	15.2% (283)

Gay males had the lowest mean scores of all the LGBTI groups for depression, anxiety and stress, followed next by lesbian/gay females. Intersex participants had the highest scores on each of the scales, followed by transgender participants and bisexual participants who had the second and third highest scores respectively (see figures 3.1 and 3.2).

Figure 3.1: DASS-42 mean scores across LGBTI groups

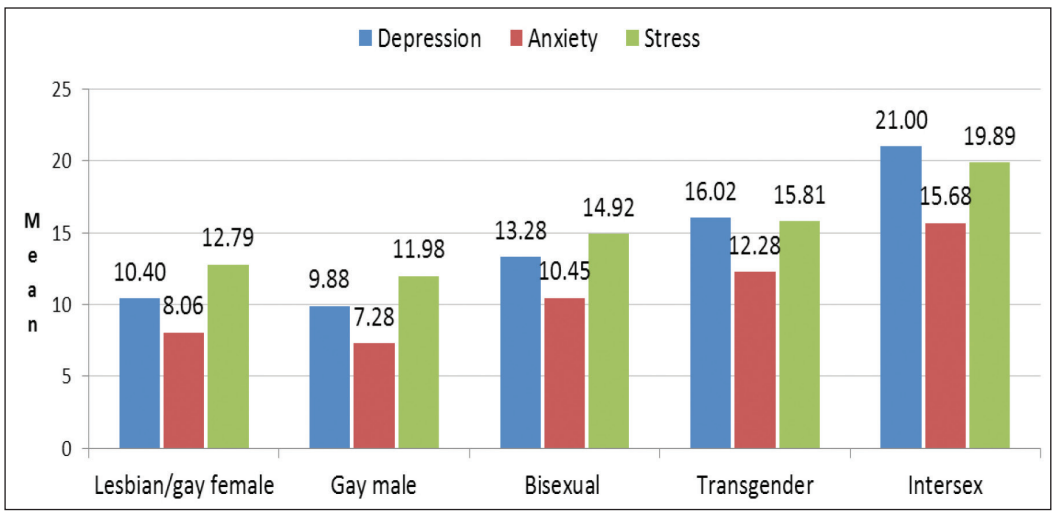
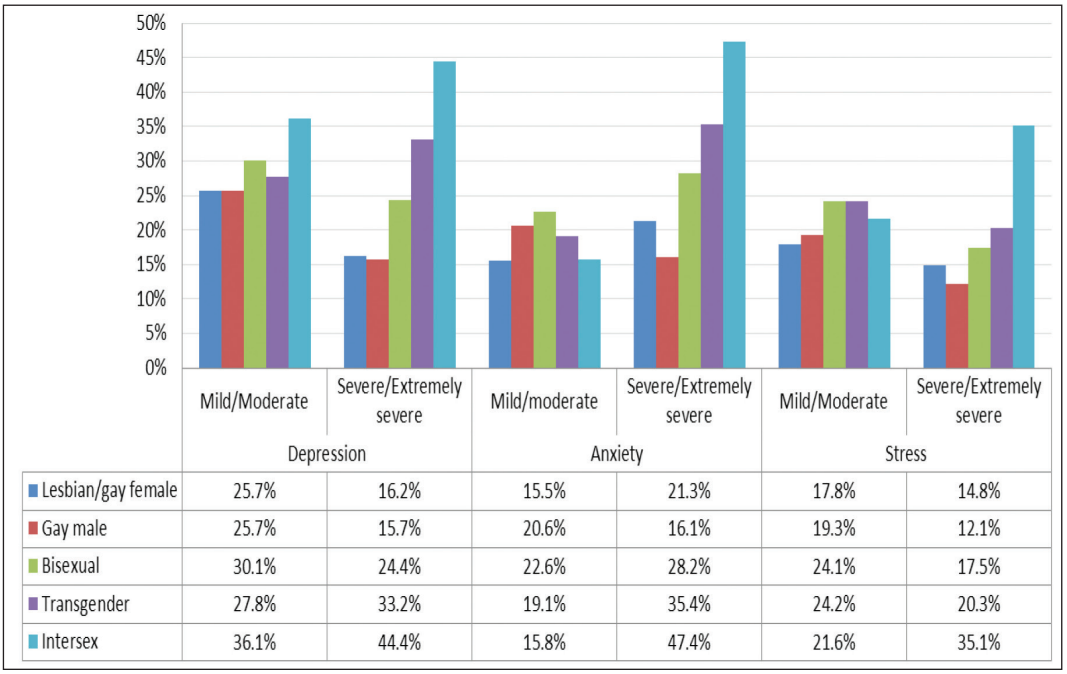


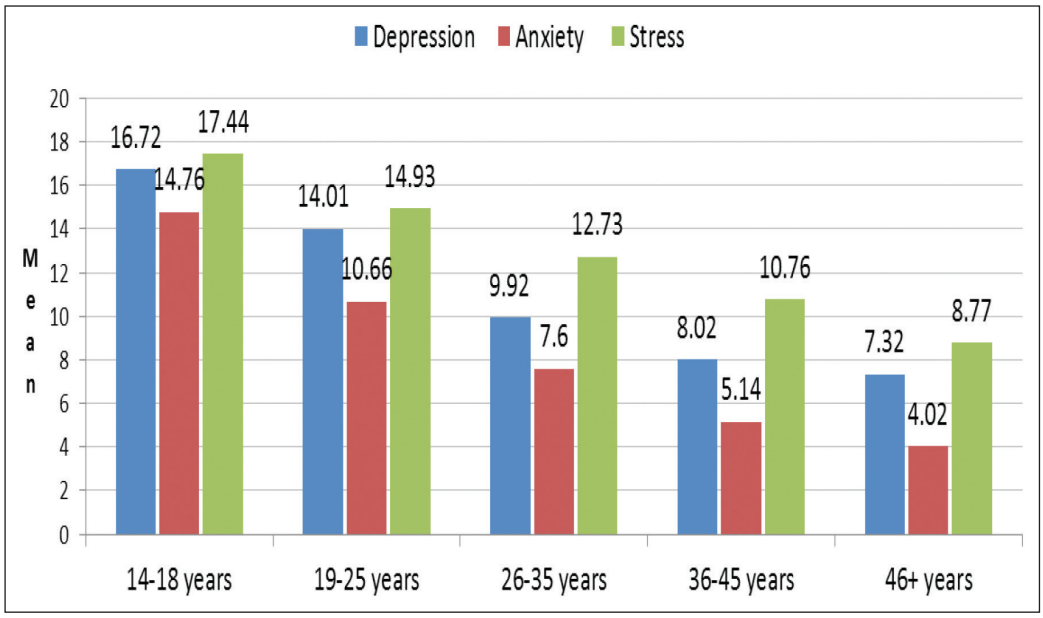
Figure 3.2: Proportion of participants with mild/moderate or severe/extremely severe DASS scores by LGBTI group



	Depression		Anxiety		Stress	
	Mild/Moderate	Severe/Extremely severe	Mild/moderate	Severe/Extremely severe	Mild/Moderate	Severe/Extremely severe
Lesbian/gay female	25.7%	16.2%	15.5%	21.3%	17.8%	14.8%
Gay male	25.7%	15.7%	20.6%	16.1%	19.3%	12.1%
Bisexual	30.1%	24.4%	22.6%	28.2%	24.1%	17.5%
Transgender	27.8%	33.2%	19.1%	35.4%	24.2%	20.3%
Intersex	36.1%	44.4%	15.8%	47.4%	21.6%	35.1%

On all scales, the youngest age group (14-18 years) had the highest scores, followed by the 19-25 year olds and the 26-35 year olds. This indicates that the highest levels of indicators of depression, anxiety, and stress were among those aged 35 and younger in the sample. Those aged 14-18 and 19-25 had mean scores outside of the normal range for depression, anxiety and stress (Figure 3.3).

Figure 3.3: DASS-42 mean scores across age groups



In the sample, 34% of 14-18 year olds (adolescents) were classified as being within normal levels on depression scale. Approximately 11% were in the mild range, 20% in the moderate and 35% in the severe (11%) or extremely severe (24%). Similar to the breakdown on the depression scale, 31% of the adolescents were found to be in the normal range on anxiety scale. One tenth (10%) were in the mild range, 15% in the moderate and 43% in the severe (13%) or extremely severe (31%) range. In relation to stress, 44% of 14-18 year olds were classified as being within the normal levels, with 12% in the mild range, 21% in the moderate, 15% in the severe category and 9% in the extremely severe category. For the 19-25 aged group small differences were evident; a greater number of participants were within the normal range for all three variables and there was a reduction in the number who came within the severe or extremely severe range for all three variables (Table 3.4).

Table 3.4: DASS-42 scores of those aged 14-25

DEPRESSION					
	Normal	**Mild**	**Moderate**	**Severe**	**Extremely severe**
14-18 (n=318)	34.3% (109)	11.3% (936)	19.8% (63)	10.7% (34)	23.9% (76)
19-25 (n=511)	42.9% (219)	13.5% (69)	15.9% (81)	9.8% (50)	18.0% (92)
14-25 (n=829)	39.6% (328)	12.7% (105)	17.4% (144)	10.1% (84)	20.3% (168)
ANXIETY					
	Normal	**Mild**	**Moderate**	**Severe**	**Extremely severe**
14-18 (n=322)	30.7% (99)	10.9% (35)	14.9% (48)	12.7% (41)	30.7% (99)
19-25 (n=520)	51.2% (266)	11% (57)	8.3% (43)	8.3% (43)	21.3% (111)
14-25 (n=842)	43.3% (365)	10.9% (92)	10.8% (91)	10% (84)	24.9% (21)
STRESS					
	Normal	**Mild**	**Moderate**	**Severe**	**Extremely severe**
14-18 (n=316)	44.0% (139)	12% (38)	20.6% (65)	14.6% (46)	8.9% (28)
19-25 (n=519)	57% (296)	10% (52)	12.7% (66)	12.7% (66)	7.5% (39)
14-25 (n=835)	52.1% (435)	10.8% (90)	15.7% (131)	13.4% (112)	8% (67)

Self-harm, suicidal thoughts, suicide attempts, and help seeking

Self-harm

Participants were asked whether they had ever deliberately harmed themselves in a way that was not intended as a means to take their own life. They were then asked to provide a description of their most recent self-harm incident. Descriptions of self-harm were coded according to the standardised definition adapted for use in this study which viewed self-harm as an 'intentional act' with a non-fatal outcome.

Episodes of self-harm were categorised as 'yes', 'not meeting criteria', or 'no description given'. Those in the 'not meeting criteria' category comprised those who reported self-harm but whose description did not match the coding criteria (e.g. if self-harm was clearly non-intentional). If a participant reported self-harm, but did not describe the act they were categorised as 'no information given'. Using this criteria, it was found that 34.1% (n=656) of the sample had self-harmed in their lifetime. Nearly half of these (45.6%; n=298) reported that they had self-harmed within the past year. Over half of the sample aged 14-18 had self-harmed (55.7%; n=186) with 76.9% of those (n=143) having done so in the last year. Just under half of the sample aged 19-25 had self-harmed (43.3%; n=228) with 46.2% of those (n=105) having done so in the last year (See table 3.5).

Of those who had self-harmed, 628 provided information about when they first harmed themselves. The average age was 15.75 years (SD=4.75), with a range from 4 to 51 years. The most common age was 15 years. Approximately 90% (90.9%; n=588) had self-harmed more than once and nearly 60% (57.2%; n=370) reported that they self-harmed six times or more.

Table 3.5: Self-harm: Rate, recency and age

		ALL LGBTI	L	G	B	T	I
Ever Self-harmed	**All Ages**	34.1% (n=656)	37.4% (n=202)	19.5% (n=157)	54.5% (n=159)	48.8% (n=122)	42.1% (n=16)
	14-18	55.7% (n=186)	61.3% (n=38)	32% (n=31)	66% (n=62)	67.1% (n=47)	72.7% (n=8)
	19-25	43.3% (n=228)	52.4% (n=65)	26.7% (n=59)	59% (n=59)	54.1% (n=40)	62.5% (n=5)
Self-harmed in the last year	**All Ages**	45.6% (n=298)	40.1% (n=81)	35% (n=55)	47.5% (n=75)	60.3% (n=73)	87.5% (n=14)
	14-18	76.9% (n=143)	78.9% (n=30)	71% (n=22)	74.2% (n=46)	78.7% (n=37)	100% (n=8)
	19-25	46.2% (n=105)	44.6% (n=29)	35.6% (n=21)	42.4% (n=25)	66.7% (n=26)	80% (n=4)
Age first self-harmed	**Sample**	M=15.75 Mode=15 (n=628)	M=15.60 Mode=15 (n=187)	M=17.79 Mode= 14 (n=153)	M=14.89 Mode= 14 (n=153)	M=14.71 Mode= 14 (n=119)	M=14.31 Mode= 15 (n=16)

Chi-square tests were run to test whether there were any differences in rates of self-harm by LGBTI group and age group. Statistically significant differences were found for both variables:

- Both bisexual (54.5%) and transgender participants (48.8%) were more likely to have self-harmed compared to gay males (19.5%). Both lesbian/gay females and intersex participants also had relatively high levels of self-harm (37.4%, 42.1% respectively).
- The youngest age group (14-18 years: 55.7%) self-harmed at a rate of more than six times that of the oldest age group (46+ years: 8.9%). It was also found that the youngest age group was more likely to have self-harmed most recently (See table 3.6).

Table 3.6: Last self-harm incident by age group

	Less than a month ago	Between a month and a year ago	Between a year and five years ago	More than five years ago
All ages (n=657)	15.4% (n=101)	30.1% (n=197)	24.6% (n=161)	29.8% (n=195)
14-18 years (n=186)	31.2% (n=8)	45.7% (n=85)	22.0% (n=41)	1.1% (n=2)
19-25 years (n=227)	13.2% (n=30)	33.0% (n=75)	30.4% (n=69)	23.3% (n=53)
26-35 years (n=160)	5.6% (n=9)	18.8% (n=30)	24.4% (n=39)	51.2% (n=82)
36-45 years (n=59)	5.1% (n=3)	8.5% (n=5)	13.6% (n=8)	72.9% (n=43)
46+ years (n=21)	4.8% (n=1)	9.5% (n=2)	14.3% (n=3)	71.4%(n=15)

Method of self-harm

Based on the operational definition utilised in this study, self-harm was coded into relevant categories including self-cutting, overdose, self-battery etc. By far the most common method of self-harm was cutting, which was reported by over three-quarters of participants (75.9%, n=498). This was followed by overdose (12.7%; n= 83), self-battery (10.7%; n= 70), and burning (6.6 %; n=43). A minority self-harmed using other methods including significant alcohol misuse (2.6%; n=17) and attempted hanging (1.1%; n=7) (Table 3.7). 25 participants (3.8%) identified self-harm which was classified as 'other' and consisted mainly of acts such as skin pinching, biting and hair pulling.

Table 3.7: Methods of self-harm in the survey sample

Method of self-harm	Yes
Self-cutting (n=656)	75.9% (498)
Overdose (n=656)	12.7% (83)
Self-battery (n=656)	10.7% (70)
Burning (n=656)	6.6% (43)
Alcohol (n=656)	2.6% (17)
Hanging (n=656)	1.1% (7)
Recreational drug (n=656)	0.5% (3)
Suffocation (n=656)	0.2% (1)
Non-ingestible substance (n=656)	0.2% (1)
Other (n=656)	3.8% (25)

Impulsivity is a common feature of self-harm, particularly in young people. To explore the role of impulsivity in this study, participants were asked how long before the self-harm act had they started to think about it (Table 3.8). Over two-fifths of participants who self-harmed thought about it for less than one hour (44.9%; n=292). Almost one-fifth thought about harming themselves for less than one day (18.9%; n=123). These results show that the significant majority of participants who harmed themselves had thought about it for less than 24 hours suggesting that impulsivity is indeed a factor.

Table 3.8: Time elapsed between self-harming thought and action

How long before you tried to harm yourself on that occasion had you started to think about doing it? (n=650)	
Less than an hour	44.9% (292)
More than an hour but less than a day	18.9% (123)
More than a day but less than a week	13.4% (87)
More than a week but less than a month	7.8% (51)
A month or more	15% (97)

The motivation behind self-harm

The motivation behind self-harm was elicited in this study by asking participants to describe in their own words why they tried to harm themselves. Common descriptions which emerged from this data indicated motivations such as release of tension, feeling pain, wanting to feel 'something else', a desire for control, a way to seek help, a means of escape and feeling worthless. Many participants identified that they self-harmed as they had seen friends/family doing it and thought it might help. For about 60% of participants, their self-harm was to some degree related to their LGBTI identity and this was a recurring issue in the open-ended comments regarding motivation to self-harm.

LGBTI identity

A common driving factor behind self-harm in this study was factors relating to people's experiences as an LGBTI person. In the survey, 59.9% (n=389) related their self-harm to their LGBTI identity and their struggle to be accepted by others and society (Table 3.9).

Table 3.9: Relation of self-harm to LGBTI identity of the survey sample

How much of your self-harm is/was related to being LGBTI? (n=650)	
Very much related	14.5% (94)
Very related	12.8% (83)
Somewhat related	32.6% (212)
Not very related	20.5% (133)
Not at all related	19.7% (128)

For many participants, their self-harm was related to the anticipated or actual negative reaction from family and/or friends which caused significant distress.

> *Family had been my life and my parents were my best friends. I was abandoned after I came out and it destroyed my identity. I really struggled to resolve it and at the time it kind of broke my mind. (Gay male, 28)*

> *I was having nervous thoughts about whether I was going to come out to my parents or not. And the thought of it got too much and I decided to cut myself to get some sort of release from those thoughts. I still haven't come out to them. (Gay male, 20)*

One very poignant account describes how a mother's disparaging words about gay people were deeply wounding to her daughter and her mental health, which led her to self-harm.

> *I self-harmed on this occasion because myself and my mam were watching Coronation Street and there was a gay couple on screen, she began to tut and roll her eyes, I knew why, but I asked what was the matter anyway and she said something along the lines of "the gays are everywhere these days, they're getting married now and everything, when will people realise that it is not normal and it never will be normal", I was forced to make my excuses and leave the room, it hurt me in a way that I am unable to describe because little does she know that she just ripped apart the person she brought into the world. So out of guilt, fear, and feeling ashamed I self-harmed because I needed a pain I could control, I blamed myself for turning out like this and I tore myself apart. I will never ever forget what she said that night. (Lesbian/gay female, 17)*

Homophobic behaviours in school and wider society were also identified as being linked to self-harm.

> *I was ashamed and angry, because other people and the media use horrid words and people in the school always use "fag" as an insult on one another and it made me feel all wrong. (Transgender, bisexual, 16)*

> *The first occasion occurred after someone in my year followed me to the bathroom and accused me of "feeling him up" to a teacher and the second occurred after 6th year students wrote faggot in permanent marker on my cheek. The cutting I do anytime I feel like I am better off dead. (Gay male, 15)*

For others, the struggle to understand what they were feeling, and to understand their sexuality caused them distress.

> *Struggling a lot with my sexuality and at times my gender identity. It was more the confusion I felt about what specific label I was, as opposed to being LGBTI. (Bisexual female, 23)*

> *I took the [names tablets] after my first experience with another guy. I was disgusted with myself. I punched myself over my sexual feelings, I'd get angry with myself and take my anger out on myself and so I'd punch myself. (Gay male, 23)*

Release of tension

As a consequence of stress and anxiety in their lives, many participants described self-harming as a means to reduce the tension they felt. Self-harm was viewed as a release and a way of reducing this build-up of tension.

> *The best way to describe it is I felt like a pressure cooker ready to explode and I discovered that by cutting myself it allowed 'the steam' to escape! (Lesbian/gay female, 46)*

> *I had too many emotions and feelings - there was just so much pain, and the pressure just built up until it exploded. I wasn't very good at expressing myself then and I wasn't engaging in sports etc. like I would now so it just came pouring out in self-harm. (Lesbian/gay female, 28)*

For some however, this release was only short-lived:

> *It was a release for me. I felt immense relief initially in cutting myself. It was like opening a pressure valve for me. However I would experience strong self-disgust in days afterwards and that eventually became a strong enough deterrent to stop this behaviour! (Lesbian/gay female, 32)*

Another common motivation influencing self-harm behaviour centred on feeling pain. In particular, many participants expressed a desire to feel physical pain in an attempt to block or lessen psychological pain. Physical pain was also seen by some as a manifestation of their psychological pain:

> *To find something strong enough to stop the pain in my mind. To bring an immediate focus to my body and away from my mind. To stop the pain in my mind. I didn't want to die but I didn't want to continue living. (Lesbian/gay female, 57)*

> *I was about 16 and very unhappy, I didn't know how to talk about it and it released the sadness from me for a while. It also gave me a physical manifestation of the pain I felt which was easier to deal with and accept then. And I was able to look after the physical cuts which gave me comfort, whereas I didn't know how to look after the mental pain. (Transgender, bisexual, 31)*

Wanting to feel 'something'

For some participants, self-harm was primarily driven by the desire just to feel 'something'. Participants reported feeling numb, dazed and empty but self-harm and the associated pain reminded them that they were still alive.

Most of the time, I feel pretty empty, feel no big emotions and when I harmed myself, at least I was feeling some pain and I knew I was still alive. (Bisexual female, 21)

To feel something and not be numb. (Bisexual female, 16)

A desire to 'feel'. A desire to feel that I'm actually 'alive'. (Questioning/not sure, female, 17)

Control

For some participants, self-harm acted as a means to gain control over various aspects of their lives, their thoughts and their body.

I felt very lost and very numb. I was extremely lonely and felt cut off from my family and friends. I was very stressed as it was nearing exam time (in school) and was under a lot of pressure from my family. I think I did it to feel that I was in control of something (my body) and to know that I was still capable of making decisions for myself. (Bisexual female, 23)

I felt very out of control and extremely upset. I felt like I needed to do it to calm myself down, to gain back some self-control of my thoughts and body. (Lesbian/gay female, 32)

Escape

Some participants described how self-harm was a means to escape the pain they were feeling. When escape was the motivation behind self-harm, there appeared to be greater suicidal intent.

Everything in life was awful. Had no friends or support. Harassment from every direction possible. I wanted it to stop. Death seemed the best way of achieving that end. (Transgender, male with desire to be female, bisexual, 24)

When I took an overdose, I just wanted it all to end. For the noise to stop and for peace to arrive. (Gay male, 30)

Feelings of worthlessness

Many participants reported that their self-harm was related to their feelings of worthless and low self-esteem. Some believed that their family, friends and society would be better off without them.

I didn't feel like I was worth anything as a person. I hadn't met a lot of my now friends at the time and found life difficult and heavy. (Bisexual female, 17)

I felt worthless and a burden to my family and friends and lonely. (Gay male, 30)

I felt very isolated and alone and just wanted to die so badly because I felt so unbelievably shit about myself. (Questioning/not sure, female, 15)

To get help

Some participants described not wanting to, or not being able to, ask for help when feeling distressed. In these situations, self-harm was a means to communicate to the outside world that they were in distress and needed help.

I was hoping someone would see it and therefore try and get me help. I had a lot of problems and I was too embarrassed to ask for help myself. (Bisexual male, 15)

Was unhappy. Was ambivalent about death and was testing the waters. Also a cry for help to show how bad I was feeling as I couldn't put it into words. (Transgender female, lesbian/gay, 29)

I just wanted someone to pay me attention and see I needed help. (Transgender, 34)

Family/friends' self-harm

Some participants were aware of the self-harm of a friend or family member and this influenced their decision to harm themselves.

I had friends who did the same thing and they would describe to me how it took away the bad thoughts and how it preoccupied their minds. (Lesbian/gay female, 17)

Didn't understand my mental health difficulties, felt like a release of tension, probably also because I knew other people that did it. (Bisexual female, 24)

Thoughts about suicide

In total, almost 60% (59.1%; n=1,129) of the sample has seriously thought of ending their own life. Nearly half (44.7%; n=501) had thoughts of doing so within the past year and 60% (60.1%; n=673) reported that their suicidal thoughts were at least somewhat related to being LGBTI. Of those aged 14-18, over two-thirds (69.4%; n=229) had

seriously thought of ending their own life. Of these, over two thirds (68.5%; n=157) had considered ending their own life within the past year. Among participants aged 19-25, nearly two-thirds (62.2%; n=323) had seriously thought of ending their own life. Of these, nearly half (48.6%; n=156) had considered ending their own life within the past year (See table 3.10).

Of the participants who had seriously contemplated ending their own life, 1,089 provided an age at which they had first thought of it. The mean age was 18.03 years (SD=7.46), with a range from 4.5 to 59 years. The most common age was 15 years. One participant wrote that they had thought seriously about suicide since they were a child, and two others said they had considered it for as long as they could remember.

Table 3.10: Suicide Thoughts: Rate, recency and age first considered

		ALL LGBTI	L	G	B	T	I
Ever thought about suicide	**All Ages**	59.1% (n=1,129)	56.4% (n=301)	52.4% (n=421)	65.3% (n=186)	75.6% (n=189)	84.2% (n=32)
	14-18	69.4% (n=229)	80.3% (n=49)	58.3% (n=56)	68.8% (n=64)	73.9% (n=51)	81.8% (n=9)
	19-25	62.2% (n=323)	58.1% (n=72)	55.3% (n=121)	68.4% (n=65)	79.5% (n=58)	87.5% (n-=7)
Thought about suicide in last year	**All Ages**	44.7% (n=501)	39.6% (n=118)	36.6% (n=153)	50.0% (n=93)	62.6% (n=117)	62.5% (n=20)
	14-18	68.5% (n=157)	65.3% (n=32)	68.2% (n=38)	70.3% (n=45)	70.6% (n=36)	66.6% (n=6)
	19-25	48.6% (n=156)	47.2% (n=34)	37.8% (n=45)	44.6% (n=29)	74.2% (n=43)	71.5% (n=5)
Age first thought about suicide	**Sam-ple**	M=18.0 Mode=15 (n=1089)	M=19.0 Mode=15 (n=284)	M=18.2 Mode=16 (n=412)	M=16.5 Mode=15 (n=179)	M=17.4 Mode=14 (n=182)	M=17.4 Mode=16 (n=32)

Chi-square tests were conducted to test whether there were any differences in whether a person had contemplated suicide depending on their LGBTI identity and age. Statistically significant differences in thoughts about suicide were found by both variables.

- Intersex (84.2%), transgender (75.6%) and bisexual (65.3%) participants were more likely to have considered suicide compared to lesbian/gay females (56.4%) and gay males (52.4%).
- As the age of a participant increased, their likelihood of reporting suicidal thoughts decreased. A much higher proportion of the youngest age group (14-18 years: 69.4%) had seriously thought of ending their own life compared to approximately 50% of those aged 36+ (36-45: 50.9%, 46+: 50.8%).
- The analysis also revealed that the younger age groups had thought of ending their life most recently when compared to the older age groups (See table 3.11).

No statistically significant differences were found for whether a person had seriously thought of ending their own life depending on whether he/she had told anyone about their LGBTI identity.

Table 3.11: Last seriously considered suicide by age group

	Less than a month ago % (n)	**Between a month and a year ago % (n)**	**Between a year and five years ago % (n)**	**More than five years ago % (n)**
All ages	18.4% (206)	26.3%(295)	28.1% (315)	27.2% (305)
14-18 years (n=229)	28.8% (66)	39.7% (91)	31.0% (71)	0.4% (1)
19-25 years (n=321)	19.0% (61)	29.6% (95)	30.5% (98)	20.9% (67)
26-35 years (n=281)	13.9% (39)	22.1% (62)	28.1% (79)	35.9% (101)
36-45 years (n=163)	16.0% (26)	18.4% (30)	19.6% (32)	46.0% (75)
46+ years (n=124)	11.3% (14)	12.9% (16)	27.4% (34)	48.4% (60)

Suicide attempts

In total, over one in five people in the sample (21.4%; n=407) had seriously tried to take their own life. Of these, 26.3% (n=105) had tried to take their life within the past year. Approximately two-thirds (66.8%; n=267) reported that their suicide attempt(s) was at least somewhat related to being LGBTI. Of those aged 14-18, nearly one third (31.9%; n=105) had seriously tried to take their own life, with over half (52.5%; n=53) having tried to do so within the last year. Of those aged 19-25, over a fifth (21.1%; n=110) had seriously tried to take their own life, with a quarter (25%; n=27) having tried to do so within the last year (See table 3.12).

Of the 407 participants who had tried to take their own life, 390 provided the age at which they first attempted to do so. The mean age was 18.52 (SD=7.31), with a range from 6 to 55 years. The most common age was 15 years.

Table 3.12: Suicide Attempt: Rate, recency and age of first attempt

		ALL LGBTI	L	G	B	T	I
Ever seriously attempted suicide	All Ages	21.4% (n=407)	18.4% (n=98)	16.6% (n=133)	23.5% (n=67)	35.1% (n=87)	57.9% (n=22)
	14-18	31.9% (n=105)	37.7% (n=23)	21.1% (n=20)	31.2% (n=29)	37.7% (n=26)	63.6% (n=7)
	19-25	21.1% (n=110)	24.2% (n=30)	14.1% (n=31)	17.7% (n=17)	38.4% (n=28)	50.0% (n=4)
Attempted suicide in the last year	All Ages	26.3% (n=105)	23.7% (n=23)	23.8% (n=31)	19.7% (n=13)	30.6% (n=26)	54.5% (n=12)
	14-18	52.5% (n=53)	56.5% (n=13)	57.9% (n=11)	39.3% (n=11)	54.2% (n=13)	71.4% (n=5)
	19-25	25% (n=27)	24.1% (n=7)	26.7% (n=8)	5.9% (n=1)	32.1% (n=9)	50.0% (n=2)
Age first attempted suicide	Sam-ple	M=18.52 Mode=15 (n=390)	M=17.60 Mode=15 /16 (n=92)	M=20.3 Mode=14 (n=129)	M=16.59 Mode=15 (n=65)	M=17.55 Mode=14 (n=82)	M=21.27 Mode=15 (n=22)

Chi-square tests were run to test whether there were any differences in rates of suicide attempts by LGBTI group and age group. Statistically significant results found for both variables:

- Transgender (35.1%) and intersex participants (57.9%) were more likely to have seriously attempted to take their own life compared to lesbian/gay females, gay males and bisexuals (17-24%).
- In terms of age, the younger a person was, the more likely they were to report that they had tried to take their own life. Nearly one-in-three participants in the youngest age group (14-18 years: 31.9%) had tried to take their own life compared to 18% in the 46+ age group. The younger age groups had also tried to take their own life more recently than the older age groups (See table 3.13).

No statistically significant differences in rate of suicide attempts were found depending on whether a person was out.

Table 3.13: Recency of suicide attempt by age group

	Less than a month ago % (n)	Between a month and a year ago % (n)	Between a year and five years ago % (n)	More than five years ago % (n)
All ages (n=407)	4.3% (17)	22% (88)	34.3% (137)	39.5% (158)
14-18 years (n=101)	10.9% (11)	41.6.% (42)	45.5.% (46)	2% (2)
19-25 years (n=108)	4.6% (5)	20.4% (22)	57.4% (62)	17.6% (19)
26-35 years (n=96)	1% (1)	13.5% (13)	17.7% (17)	67.7% (65)
36-45 years (n=51)	0.0% (0)	13.7% (7)	14% (6)	74.5% (38)
46+ years (n=43)	0.0% (0)	9.3% (4)	14% (6)	76.7% (33)

Help-seeking

Self-harm

Of the participants who had self-harmed, approximately two-fifths (41.2%; n=268) reported that no one knew they had tried to self-harm. One in ten participants (10.6%; n=69) reported that the self-harm resulted in an injury which required treatment in an Emergency Department. Of those who had harmed themselves, 61.4% (n=399) had sought help. Participants were most likely to seek professional help from a counsellor/therapist (68.6%; n=275) or psychiatrist/psychologist (47.4%; n=190). Large numbers of participants also sought help from their friends (45.9%; n=185), family doctor/GP (39.4%; n=158), or their mother (32.9%; n=132).

Suicidal thoughts

Of those who had seriously considered ending their own life, 60.1% (n=676) had sought help for their problems. This means that four in ten (39.9%; n=449) did not seek any help for the problems that led them to seriously consider ending their life. Participants were most likely to seek professional help from a counsellor/therapist (38.1%; n=429) or psychiatrist/psychologist (28.4%; n=320). Large numbers of participants also sought help from their friends (25.5%; n=287) or family doctor/GP (24.4%; n=275). 16.4% (n=185) reported seeking help from their mother.

Suicide attempts

Of those who had attempted suicide, 35.8% (n=143) ended up in the Emergency Department as a result of their injuries. One in three (33.5%; n=133) reported that no one knew they had tried to take their own life. Furthermore, 30.2%; (n=121) reported that they did not seek help or support for the problems that led them to try and take their own life, meaning that nearly 70% (69.8%; n=280) did seek help. Participants were more likely to seek professional help through a counsellor/therapist (40%; n=161), psychiatrist/psychologist (37.2%; n=150), or GP (26.8%; n=108). Following this, the greatest proportion of participants sought help through their friends (25.6%; n=103) or mother (19.6%; n=79).

Alcohol, recreational drug use and smoking

Alcohol

Participants were asked 10 questions to ascertain their alcohol use based on the Alcohol Use Disorders Identification Test (AUDIT) (Babor *et al.* 2001). Responses were scored from zero to four. Scores were totalled and fell into four categories: no alcohol problems (7 or lower), medium level of alcohol problems (8-15), high level of alcohol problems (16-19), and very high level of alcohol problems (20+). The mean score for the scale was just above the 'no alcohol issue' level at 8.10 (SD=5.61), with a range of 1-33. In total, 14% (n=278) of the sample never drank alcohol. Of those who drank alcohol

(n=1,712), approximately a quarter (25.5%; n=436) reported doing so at least twice a week while just under a tenth (8.4%; n=144) reported doing so at least 4 times a week.

In terms of the AUDIT, over half the sample (56.2%; n=914) were within the 'no alcohol problem' category, meaning that 43.8% of the sample's scores indicated some level of alcohol problems or dependence. One-third (33.3%; n=541) scored at the medium level, with AUDIT guidelines recommending that, at this level, the best course of treatment by healthcare professionals is to provide advice and information in order to reduce hazardous drinking behaviour. Just over 5% (5.5%; n=90) of the sample's scores indicated a high level of alcohol problems, with recommended treatment at this level being brief counselling and continued assessment. A further 5% (n=81) of the scores were within the very high level category indicating a need for further diagnostic evaluation for alcohol dependence by a healthcare provider.

Gay male participants had the highest mean scores on the scale when compared to the other LGBTI groups (Table 3.14). This indicates that gay male participants engaged in more alcohol use behaviour. Among all LGBTI people who drink alcohol, those aged 19-25 and 26-35 year had the highest scores in the sample. This means that alcohol use was higher amongst the 19-35 year olds when compared to those aged 14-18 and those aged 36+ (Table 3.14). The differences between those aged 14-18 and those aged 19-25 are further illuminated in table 3.15.

Table 3.14: Mean AUDIT scores by LGBTI group and age group

LGBTI GROUP				
L	**G**	**B**	**T**	**I**
M=7.32 SD=5.06 (n = 455)	M = 9.02 SD = 5.72 (n = 710)	M = 7.49 SD = 5.45 (n = 241)	M = 7.46 SD = 6.19 (n = 185)	M = 7.09 SD = 5.46 (n = 35)
AGE GROUP				
14-18 years	**19-25 years**	**26-35 years**	**36-45 years**	**46+ years**
M=7.14 SD=5.78 (n = 204)	M = 9.18 SD = 5.7 (n = 486)	M = 8.57 SD = 5.7 (n = 446)	M = 7.41 SD = 5.23 (n = 290)	M = 6.38 SD = 4.84 (n = 197)

Table 3.15: AUDIT scores for 14-25 year olds in the survey sample

	No alcohol issue % (n)	Medium level of alcohol problems % (n)	High level of alcohol problems % (n)	Very high level of alcohol problems % (n)
14-18 years	62.3% (127)	28.4% (58)	4.4% (9)	4.9% (10)
19-25 years	47.9% (233)	38.7% (188)	7.2% (35)	6.2% (30)
14-25 years	52.2% (360)	35.7% (246)	6.4% (44)	5.8% (40)

Recreational drug use

Just over half of the sample had taken drugs recreationally during their life (55.9%; n=1,095). More than a quarter of participants aged 14-18 (29.8%; n=101) had taken drugs recreationally during their life and nearly two-thirds of those aged 19-25 (62.5%; n=340) had done so. The three drug types used most often by participants within the past month and year were: hashish/marijuana/cannabis; codeine-based drugs; and ecstasy/E/yokes. Chi-square tests were conducted to determine whether there were any significant differences in drug use by LGBTI group and age group. Significant differences in recreational drug use were only found by age:

- Participants between 19-45 years of age reported the highest rates of drug use (62-66%). The youngest age group (14-18) reported the lowest levels of drug use (29.8%), followed by those aged 46+ years (49.2%).
- Hashish/marijuana/cannabis was used most often by participants aged 14-25. Only 3.4% (n=15) of participants aged 14-25 who took drugs recreationally had never used hashish/marijuana/cannabis with over two-fifths (41.2%; n=184) having used them with the past month and a further third (32.9%; n=147) having used them within the previous year.

Smoking

The results showed that 24.8% (n=491) of the sample were current smokers, with 8.3% (n=164) smoking more than 50 cigarettes a week and another 6.7% (n=132) smoking between 21 and 50 cigarettes a week (Table 3.16). Of the age groups, those aged 14-18 were significantly more likely to have never smoked or to smoke up to 5 cigarettes per week while those aged 19-25 were significantly more likely to smoke between 5 and 50 cigarettes per week. The 26-35 and 36-45 age groups had higher proportions of smoking (approximately 11%); smoking 50 cigarettes or more per week compared to the other age groups (3-9%).

Table 3.16: Cigarette use of the survey sample

How many cigarettes do you smoke in a typical week? (n=1,979)	
I never smoke	54.9% (1,087)
I used to smoke but I have given it up	20.3% (401)
Up to 5 cigarettes a week	4.1% (82)
6 to 20 cigarettes a week	5.7% (113)
21 to 50 cigarettes a week	6.7% (132)
More than 50 cigarettes a week	8.3% (164)

Discussion

While between 50-60% of the sample recorded no or very few indicators of depression, anxiety, stress or problematic alcohol consumption, and between 70-80% did not report self-harm behaviour or suicide attempts, the findings still support the dominant narrative, both internationally and in Ireland, that a significant proportion of LGBTI people experience significant mental health difficulties. Consistently, across the varied measures of mental health issues, a significant proportion of the sample reported symptoms which are indicative of depression, anxiety, and substance misuse. In terms of depression, 46.8% of the sample registered DAAS scores which indicated some level of depression with over 20% of participants recording either severe (7.1%) or extremely severe depression (12.9%) scores. This finding is approximately half of the 86% reported by Mayock *et al.* (2009), however, Mayock *et al.*'s (2009) study did not employ a standardised and validated instrument to measure indicators of depression. Similarly, in *LGBTIreland* over 20% of the sample recorded scores indicative

of either severe (7%) or extremely severe (15.6%) levels of anxiety. Such heightened prevalence rates of depression and anxiety reiterate previously recorded rates in the LGBT population. King *et al.*'s (2008) meta-analysis identified that depression and anxiety disorders were 50% more common among bisexual, lesbian and gay people as compared with non-LGBT people; findings which are supported by later reviews (Bariola *et al.* 2015; Llhomand & Saurel-Cubizolles 2009; Marshal *et al.* 2011; Ploderl *et al.* 2013).

As other contemporary research has suggested (Cochran & Mays 2009), in this study mental health difficulties were not homogenously experienced across each of the LGBT populations. A comparative analysis of DASS-scores revealed that intersex participants had the highest mean scores on each of the scales. The study findings therefore suggest that, with mean scores of 21.00, 15.68, and 19.89 for depression, anxiety, and stress respectively, intersex people are to be considered as particularly at risk of developing significant mental health difficulties. Within this study indicators among intersex people for some aspect of depression (80%) and anxiety (63%) were particularly high. In addition, they were also more likely to have considered suicide or have seriously attempted to take their own life.

Following the intersex participants, the transgender participants had the second highest mean scores across the three domains of the DASS-scale (16.02, 12.28, 15.81) for depression, anxiety and stress respectively. In contrast to the intersex participants whose DASS-mean scores suggested susceptibility to severe levels of depression and anxiety, the transgender participants mean scores indicate moderate levels of depression and anxiety symptomology, with 48.8% having self-harmed. The moderate scores, specifically in relation to depressive symptomology, recorded by the transgender participants in this study are comparatively higher than previously recorded for the transgender population in other countries. For example Dickey *et al.* (2015) administered the DASS-21 scale with an online sample of transgender people and identified only mild levels of depressive symptomology. However, Dickey *et al.* (2015) did reveal anxiety and stress scores which were actually higher than those recorded in this study's sample. Nevertheless, the evidenced susceptibility to the development of depression and/or anxiety demonstrated in this study sample is reflective of both international and Irish literature within which transgender individuals are specifically identified as experiencing substantially higher mental health challenges and morbidities as compared to both the general population and their LGB counterparts (Bariola *et al.* 2015). In relation to depression and anxiety specifically, internationally reported rates of depression for transgender individuals range from 48% to 62% (Clements-Nolle *et al.* 2001; Nemoto *et al.* 2011; Nuttbrock *et al.* 2010), whilst reported rates of anxiety are slightly lower, ranging from 26% to 38% (Hepp *et al.* 2005;

Mustanski *et al*. 2010). Within this study similar rates for some level of depression (61%) among transgender participants were found, with higher rates for some level of anxiety (54%) being recorded. Data from Ireland has also previously identified transgender individual's mental health vulnerability in this regards. *Speaking from the Margins*, a study which specifically examined the health and well-being of transgender people in Ireland, reported that over half (57%) of their participants fitted the criteria for some level of depression (McNeil *et al*. 2013) and 87% of transgender participants in Mayock *et al*.'s (2009) study reported feeling down or depressed at some point in their lifetime.

Alongside differences in mental health difficulties between LGBTI groups, there were also differences in participants' DASS-scores mediated by age. On all scales, the youngest age group (14-18 years) had the highest scores, followed by the 19-25 year olds and the 26-35 year olds. Whilst Dooley and Fitzgerald's (2012) *My World* anonymous survey of Irish adolescent and young people (12-25 year olds) indicated some level of depression, anxiety and stress, the rates reported among the *LGBTIreland* cohort are significantly higher. In the *My World* survey reported rates of severe or extremely severe depression, anxiety and stress, among the 12-19 year olds, were 8%, 11% and 5% respectively, where as in this study rates of severe or extremely severe depression, anxiety and stress among the 14-18 year olds are 35%, 43% and 24% respectively.

In relation to self-harm, a lifetime history of self-harm was reported by 34% of participants in this study, which represents an increase on the 27% previously reported in the LGBT population in Ireland (Mayock *et al*. 2009). This increase is particularly noteworthy as the methods used to categorise self-harm in the present study were more rigorous as they did not rely solely on participants' own interpretation of self-harm. Instead participants were required to provide a description of the act which was subsequently coded; a method which has been suggested as the best way to elicit the true extent of self-harm in survey research (Evans *et al*. 2005). However, it is possible that the apparent rise in the rate of self-harm in the time period between the *Supporting LGBT Lives* study (Mayock *et al*. 2009) and the present *LGBTIreland* study is reflective of an overall rise in the national rate of self-harm (Griffin *et al*. 2015). Accounting for the fact that there have been successive decreases and a levelling off of self-harm rates in the past 4 years (Griffin *et al*. 2015), the rates of self-harm among LGBTI people in 2014 were still considerably higher than those pre-recession.

It is particularly noteworthy that over half (55%) of those aged 14-18 years had engaged in self-harm. A number of community studies have been carried out in Ireland to identify the prevalence of self-harm in young Irish people. Two studies have used methods to elicit self-harm which were similar to those in the present study and therefore allow comparison of self-harm rates. In a study of 3,881 young people in Cork

and Kerry, a lifetime history of self-harm was reported by 9.1% of adolescents aged 15-17 years (Morey *et al*. 2008). A later study conducted in Dublin reported a lifetime self-harm prevalence rate of 12.1% among 856 young people aged 15-17 years (Doyle *et al*. 2015). Notwithstanding the small disparity in age range between *LGBTIreland* and these studies (14-18 years v 15-17 years), it is apparent that there is a considerable difference between the self-harm rates of young people generally when compared to young people who identify as LGBTI. In this context, it is also important to note that in the Doyle *et al*. (2015) study, being worried about sexual orientation was identified as one of the strongest risk factors for self-harm.

Other recent Irish studies which have used different methods to elicit the rate of self-harm in young people also suggest significant differences between young people generally and those who identify as LGBTI. A recent study of 237 adolescents aged 16 and 17 from one county in the West of Ireland reported a self-harm rate of 7.2% (Martyn *et al*. 2014). A programme of research from the PERL (Psychiatric Epidemiology Research across the Lifespan) group in Ireland has reported on findings relating to mental health, including self-harm, in young people. Their recent research has identified a self-harm rate of 4.8% in young adolescents (Coughlan *et al*. 2014). However, there are a number of important points which may explain the very low rate; firstly this study concentrated on young adolescents aged 11-13 years. Evidence suggests that self-harming rates increase as adolescents get older (Skegg 2005). Secondly, self-harm was elicited through the use of a clinical interview. The lack of anonymity when eliciting self-harm behaviour is known to lead to an under-reporting of self-harm (Safer 1997; Evans *et al*. 2005). A second study within the PERL programme of research focused on young adults aged 19-24 years (Cannon *et al*. 2013). In this second study a lifetime history of self-harm was reported by 8.5% of participants. This is compared to 43.3% of those aged 19-25 in the present study. While Cannon *et al*. (2013) used non-anonymous methods to elicit self-harm, it is reasonable to suggest that this does not account for the significant differences in self-harm between young adults generally and young adults who identify as LGBTI. This is further confirmed by results of the recent *My World* Survey of 8,221 young adults aged 17-25 which identified that 21% of young adults have a lifetime history of self-harm (Dooley and Fitzgerald 2012), a rate which again is significantly lower than the rate of 43.3% for 19-25 year olds identified in the *LGBTIreland* study. The data from the Cannon *et al*. (2013) study was further analysed to compare the self-harm rate in those who were heterosexual and those who identified as non-heterosexual. Findings report that those who identified as being non-heterosexual were over 6 times more likely to engage in self-harm when compared to their heterosexual peers (Power *et al*. 2015).

The findings in relation to self-harm and suicide again demonstrate that LGBTI people are not a homogeneous group as bisexual (54.5%) and transgender participants (48.8%) were more likely to have self-harmed compared to gay males (19.5%), while intersex, transgender and bisexual participants were more likely to have considered suicide compared to lesbian/gay females and gay males. Transgender and intersex participants were also more likely to have seriously attempted to take their own life compared to lesbian/gay female, gay male and bisexual participants.

While participants in this study identified many common motivations behind their self-harm experience, such as release of tension and the need to regulate how they were feeling, it was striking to note that for approximately 60% of participants, their self-harm was to some degree related to their LGBTI identity. It was clear from the open-ended questions, that for most people it was the struggles around being LGBTI and the responses of others that caused distress, rather than being LGBTI, a proposition which is supported by other research (Meyer 2003; Mayock *et al*. 2009; Higgins *et al*. 2011)

Aside from the prevalence rate, it would appear that the characteristics of self-harm are similar among participants in this study compared with other Irish studies. In this study, cutting was the most common method of self-harm followed by overdose. This is the same trend that is captured in Irish studies which report on method of self-harm (Morey *et al*. 2008; Doyle *et al*. 2015). Help-seeking trends were broadly similar, although there were some notable differences. In this study, 61.4% sought help following their self-harm, which is higher than other Irish studies of self-harm (Morey *et al*. 2008; Doyle *et al*. 2015). This may be explained by the age range which in this study also included older adults who are more likely to seek help. However, it is encouraging to note that there was an increase of just over 10% in those seeking help following self-harm in this study when compared to Mayock *et al*.'s (2009) study suggesting that there has been an increase in help-seeking behaviour in the preceding 5-year period. Only 10.6% of participants presented to the Emergency Department after an incident of self-harm which is similar to the 11.3% identified by Morey *et al*. (2008) and the 11.8% in the study by Doyle *et al*. (2015). These findings are further evidence that official national self-harm rates as determined by the National Self-Harm Registry are only the tip of the iceberg and that most self-harm is hidden from the health service (Griffin *et al*. 2015).

One in five participants in this study had seriously attempted suicide (21.4%). This is broadly in line with the *Supporting LGBT Lives* study which reported that 17.7% of survey participants had attempted suicide. As with the self-harm data, the rate of suicide attempt is higher in the younger age group (14-18 years) where almost one-third had seriously tried to take their own life (31.9%). In the 19-25 year age group the rate remains at 21%. When compared to Irish studies of the mental health of young

people, it is again evident that a higher proportion of participants in the present study reported suicide attempts. In the *My World* Survey of 8,881 young adults aged 17-24 years, only 7% identified that they had attempted suicide which is similar to the figure of 6.8% of young adults in the study by Cannon *et al.* (2013). However, once again it is clear from further analysis of the PERL data from the Cannon *et al.* (2013) study that those who identified as non-heterosexual were almost 7 times more likely to report a suicide attempt (Power *et al.* 2015). While suicide attempts appear to be high amongst LGBTI people it is encouraging to note that as with self-harm, the help-seeking rate appears to be higher than that reported in other studies. In the *My World* survey (Dooley & Fitzgerald 2012), only 47% of participants sought help following a suicide attempt compared to 70% in the present study, suggesting LGBTI people are more likely to seek help following a suicide attempt. Finally, a greater proportion of participants (35.8%) reported attending the Emergency Department following a suicide attempt than those who attended following self-harm which likely reflects the requirement to treat what may be a medically more serious injury.

In terms of alcohol use, 43.8% of the sample's AUDIT scores indicated some level of alcohol problems or dependence. This is slightly increased from Mayock *et al.* (2009) in which 41% of their LGBT sample had CAGE scores indicating problem drinking. However, it is approximately 10% lower than the estimated rates found using the AUDIT-C tool in the general population, in which more than half (54%) of 18-75 year old drinkers are classified as harmful drinkers (Long and Morgan 2013). In terms of drug-use however the LGBTI sample surpassed rates found in the general population. Whilst 27% of the general population have reported using any illegal drugs in their lifetime (National Advisory Committee on Drugs 2011), just over half of the *LGBTIreland* study sample had taken drugs recreationally during their life (55.9%; n=1,095). Likewise, in the general population the lifetime prevalence rate for any illegal drugs was lowest amongst the younger age cohort of 15-24 (27%) (National Advisory Committee on Drugs 2011), whereas in this study 49.9% (n=441) of participants aged 14-25 had taken drugs recreationally (14-18: 29.8%; 19-25: 62.5%).

The comparatively high risk of mental health issues revealed in this study, particularly amongst BTI participants, may be informed by the distinct and complex challenges that BTI people's experience. In the case of intersex people for example, Hird (2003) suggests that there may be particularly pertinent risk factors associated with being intersex which may impact upon mental health, including the development of trauma from repeated invasive surgeries, medical examinations, aftercare procedures, loss of erotic sensitivity, ambivalent feelings regarding gender identity, sexual orientation, and intimate relationships, and difficult parental and familial relationships. In

addition, the reported lack of specialised therapeutic support for intersex people may also serve to further induce their feelings of isolation and of not being understood, which in turn may exacerbate mental distress. However, the causes and extent of intersex people's mental health vulnerability in this regard has gone relatively unacknowledged in much of the research literature to date. Traditionally, the needs of intersex people have largely been conflated with those of their LGBT counterparts and consequently little is known about their mental health. This study, to the best of our knowledge, contains the largest research sample of intersex people whilst also being the first study to distinctly measure indicators of their mental health. Further research is however needed with this group in order to expand upon the findings in this study and explore in greater depth the discrete determinants which may be informing the mental health of intersex people.

Like intersex participants, transgender participants demonstrated a higher susceptibility to mental health difficulties. This may be explained by their experiencing distinct challenges to those endured by the rest of the LGB community, specifically gender-related stressors such as discrimination, victimization, exposure to transphobia, and internalised stigma; indices which have all been identified as strong predictors of psychopathology among transgender people (Clements-Nolle *et al*. 2001; Hepp *et al*. 2005; Nuttbrock *et al*. 2010; Spicer, 2010).

A similar argument regarding distinct experiences of discrimination and social isolation could be postulated to explain bisexual participants' comparatively higher DASS-scores, self-harming behaviour, and thoughts of suicide than LG participants. Bostwick *et al*. (2015) suggest that bisexual people's experiences of stigma, prejudice, and discrimination are qualitatively different as compared to LG people. One of the reasons for this difference, the authors suggest, is that bisexual people are often rejected and excluded not only by the heterosexual population but also by the sexual orientation and gender minority community (Bostwick 2012; Hequembourg and Brallier 2009; Ross *et al*. 2010). This can mean that bisexual people feel a lesser sense of belonging and connectedness to both the general population but moreover to the sexual and gender minority community; a primary source from which many LGBT people derive significant social support from (Herek *et al*. 2010; Kertnzer *et al*. 2009). Furthermore, the now prolifically cited incidence of bisexual erasure may result in considerable additional stress for bisexual people as they may need to defend consistently and affirm the legitimacy of their sexual orientation (Gurevich *et al*. 2007). These distinct experiences associated with bisexual orientation may have informed the comparatively higher rates of mental distress; a study finding which supports previous evidence indicating that bisexual individuals experience worse mental health outcomes as compared to both the general population, lesbians, and gay men,

including higher levels of mood disorder, anxiety disorder, suicidality, self-harm, substance use, and eating disorder (Bostwick *et al*. 2010; Colledge *et al*. 2015; King *et al*. 2008; Jorm *et al*. 2002).

CHAPTER 4

FINDINGS: LGBTI SCHOOL YEARS

Introduction

The increasingly younger age at which LGBT adolescents are coming out presents a greater challenge to schools while peer acceptance of LGBT identities remains problematic and societal homophobia and transphobia still prevails (Russell *et al*. 2014; Seelman *et al*. 2015). School can be a hostile and unsupportive environment for LGBT students making them feel unsafe, like they don't belong, and unable to express freely their sexual orientation or gender identity (Fisher *et al*. 2008; Murphy 2012; Seelman *et al*. 2015). The presence of heteronormativity in schools can also contribute to a hostile and stigmatising environment for sexual and gender minority students (Currie *et al*. 2012; Russell *et al*. 2014).

Research shows that sexual minority students experience higher rates of school-based victimisation than their heterosexual counterparts (Craig 2013). Two national studies, one in the USA (n=7,261) (GLSEN 2009) and one in the UK (n=1,600 LGB Only) (Guasp 2012), both identified that homophobic bullying was widespread in schools. The GLSEN (2009) study identified four main issues affecting LGBT students in school. These were a hostile school climate, absenteeism, lower educational aspirations and academic achievement, and poorer psychological well-being. Experiences of victimisation among sexual minority youth has been found to be associated with psychological distress, depression, anxiety, social phobias, and suicidality, as well as increased drug and alcohol use, while coping strategies may include truancy and dropping out of school (Walls *et al*. 2013; O'Higgins-Norman *et al*. 2010; Murphy 2012; Craig 2013; Davis *et al*. 2014; Heck *et al*. 2014). LGBT students have been found to be more likely to skip school due to safety concerns (Fisher *et al*. 2008). Time in school may be characterised by being left out, decreased grades and having to move schools (Tucker and Potocky-Tripoli 2006; Birkett *et al*. 2009; GLSEN 2009; Mayock *et al*. 2009; Metro Youth Chances 2014). The effects of bullying, especially peer on peer abuse such as teasing and harassment, include social isolation can cause a loss of confidence, poor results, increased truancy, diminished self-esteem, a reduced ability in academic work and leaving school early (O'Higgins-Norman 2009a; Lombardi 2009; Mayock *et al*. 2009; Minton *et al*. 2008; Johnson and Amella 2014). Guasp (2012) found that people may review their decision to go to university due to negative school experiences. All this can have a long-term impact on an LGBT person's potential to earn income throughout their life (Lombardi 2009). Interestingly, some studies have found that students who were not out in school were not automatically exempt from bullying and even those that did escape direct experiences bore the effects of witnessing it and being enveloped in heteronormative-laden environments which could be equally damaging in terms of psychological distress (Mayock *et al*. 2009; Russell *et al*. 2014).

Since the 1990's it has been recognised in Ireland that bullying in schools can have a long-term impact on a person's life, and students that are different, including LGBT students, are more prone to bullying (O'Higgins-Norman 2009a). Research in the Irish context has invariably demonstrated that many LGBT young people have negative experiences of school and are at greater risk of engaging in self-harming behaviour, experiencing mental health problems and low self-esteem, and leaving school early (Norman and Galvin 2006; Minton *et al*. 2008; Mayock *et al*. 2009).

Homophobic remarks by both students and teachers have been shown to be a significant problem in schools, with studies indicating that homophobic bullying, including derogatory language and slurs of a homophobic nature, being widespread in Irish second-level schools (Minton 2011; Minton *et al*. 2008; Norman and Galvin 2006; Norman 2005). A study conducted in Northern Ireland found that over 60% of pupils reported hearing homophobic terms used in their school at least once every school day, whilst almost 30% of teachers reported hearing homophobic slurs either once or more during the school day (Beattie 2008). Mayock *et al*. (2009) also found that 34% of pupils had heard homophobic comments by teachers with 8% called homophobic names by teachers. Minton's (2011) study in nine secondary schools found that non-heterosexual females were statistically significantly more likely to report having been bullied than were heterosexual females.

Research has found a lack of action from school authorities when LGBT pupils reported harassment, as well as low reporting of the harassment experienced (Heck 2015). Therefore, it is unsurprising that there is a lack of support for some LGBT pupils in schools (Metro Youth Chances 2014; Norman and Galvin 2006; Mayock *et al*. 2009; McBride 2013). In terms of addressing bullying, the *Supporting LGBT Lives* study described official school responses as being "non-existent, ineffective or complicit with a culture of hostility towards LGBT students" (Mayock *et al*. 2009: 365). Similarly, McBride (2013) found poor school responses to transphobic bullying in Northern Irish schools, inadequate support for victims and an absence of education and awareness around gender identity, which exacerbated transgender pupils' already negative experiences, resulting in poor mental health outcomes and drop out. Reasons suggested for the failure of teachers to intervene in cases of LGBT bullying include lack of knowledge of how to intervene, and normalization of bullying or homophobic attitudes (Fisher *et al*. 2008). A study exploring the attitudes and experiences of pupils, parents, teachers and school principals in five second-level schools in the Greater Dublin Area reported that teachers were reluctant to tackle homophobic bullying for a variety of proposed reasons: including its pervasiveness in everyday interactions and the religious ethos of school (Norman and Galvin 2006). The most commonly cited reasons for not addressing homophobic bullying reported in one Northern Irish study were: parental disapproval (53%); a lack of confidence in developing and delivering resources (39%); pupil disapproval (35%) and school inexperience in dealing with these issues (29%) (Beattie 2008).

CHAPTER 4

Mayock *et al.*'s (2009) study found that the curriculum was virtually devoid of any LGBT content (5-8% aware of LGBT content) which rendered LGBT people and issues invisible within the school setting. This pervasive silence allows homophobia to go unchallenged and for discourses about lesbian/gay women and gay men to be continually framed in negative terms (Norman and Galvin 2006). In more recent times however, a number of initiatives have been established in Irish schools to address some of the aforementioned issues. In particular, in 2013 the Department of Education and Skills launched *Anti-bullying Procedures for Primary and Post-primary Schools* which specifically identifies LGBT pupils as a vulnerable/at risk cohort of the school population and requires all schools to implement an identity inclusive anti-bullying policy. Other important initiatives have included the Department's support for GLEN's recently launched report *Being LGBT in School (2016)*, and the Department's support for BeLonG To's annual *Stand Up Awareness Week against Homophobic and Transphobic Bullying*. These all provide advice and practical steps for schools to generate a positive and inclusive school culture and climate which promotes wellbeing and respect for all students, including LGBT students. Indeed, in recent years a growing number of schools have begun to implement the advice provided in these guidelines by, for example, displaying LGBT affirmative posters, and introducing measures that are inclusive of transgender students in regard to toilet facilities and uniforms.

In this chapter, participants' school experiences are explored. Participants' ratings of their schools on an LGBTI-friendly scale are presented, along with figures related to their sense of belonging and experiences of positive affirmation. Next, data related to negative experiences which participants had in school, including bullying, are presented. Following this, there is an examination of the impact of bullying on various factors related to mental health. Concluding this chapter is a presentation of the recommendations participants made for improving schools for LGBTI students.

LGBTI-friendly rating, sense of belonging, and experiences of positive affirmation in past five years

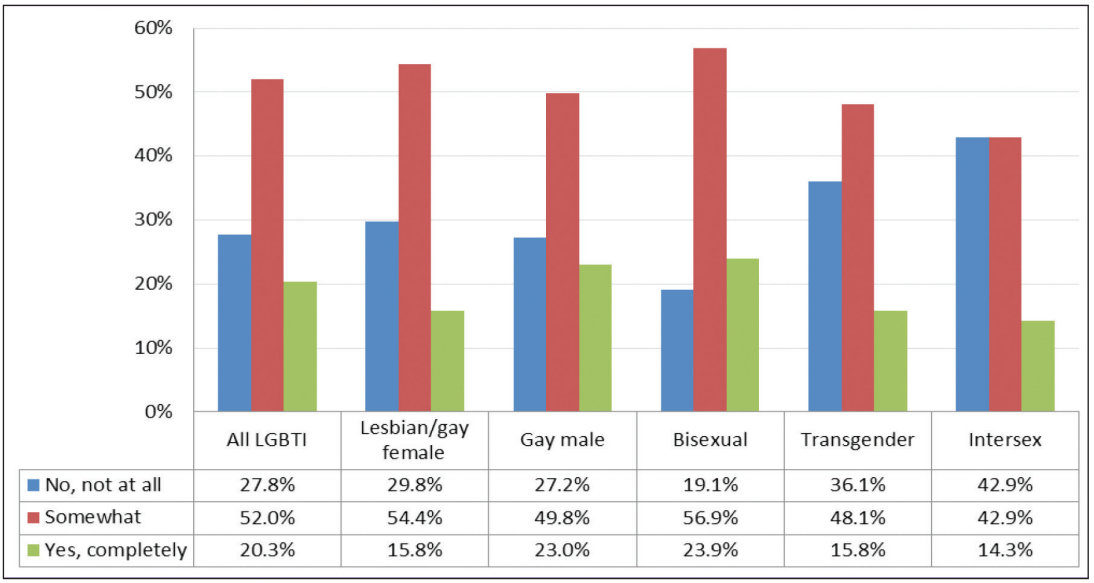
Almost 40% of the participants (38%; n=805) were currently enrolled in either primary or secondary school in the Republic of Ireland or had attended school in the Republic of Ireland within the past five years, and they were asked three questions about the culture of their school. Participants who were/had been in school in the past five years were asked to rate how LGBTI-friendly their school was on a scale of 0 to 10 (0= 'not at all LGBTI-friendly'; 10= 'completely LGBTI-friendly'). In total, 803 participants responded to this question. The mean rating given was 4.43 (SD=2.68), with a range from 0 to 10. The most common rating was a 5 meaning 'somewhat LGBTI-friendly'. Just 25% (n=201) of the participants scored their school as a 7 or above on the scale (Table 4.1).

Table 4.1: LGBTI-friendly rating of school

	ALL LGBTI	L	G	B	T	I
All Ages	M=4.43 Mode=5 (n=803)	M=3.94 Mode=5 (n=173)	M=4.67 Mode=5 (n=287)	M=4.57 Mode=5 (n=189)	M=4.40 Mode=5 (n=133)	M=4.05 Mode=0 (n=21)
14-18	M=5.04 Mode=5 (n=354)	M=4.60 Mode=5 (n=68)	M=5.42 Mode=5 (n=103)	M=5.22 Mode=5 (n=97)	M=4.73 Mode=5 (n=74)	M=4.83 Mode= 0/4/5/6/8 (n=12)
19-25	M=3.97 Mode=5 (n=408)	M=3.55 Mode=5 (n=99)	M=4.31 Mode=5 (n=160)	M=3.84 Mode=5 (n=88)	M=4.00 Mode=0 (n=54)	M=3.43 Mode=0 (n=7)

Participants were also asked whether, as an LGBTI person, they felt they belonged in their school. Just one in five (20.3%; n=162) felt they completely belonged in their school, while about half (52%; n=416) felt they somewhat belonged. Approximately 28% (27.8%; n=222) did not feel they belonged in their school as an LGBTI person (Figure 4.1). In addition, participants were asked whether they received positive affirmation of their LGBTI identity within school. Less than half (43.7%; n=345) indicated that they received positive affirmation of their LGBTI identity within school.

Figure 4.1: As an LGBTI person, do you feel that you belong(ed) in your school? (n=800)



	All LGBTI	Lesbian/gay female	Gay male	Bisexual	Transgender	Intersex
No, not at all	27.8%	29.8%	27.2%	19.1%	36.1%	42.9%
Somewhat	52.0%	54.4%	49.8%	56.9%	48.1%	42.9%
Yes, completely	20.3%	15.8%	23.0%	23.9%	15.8%	14.3%

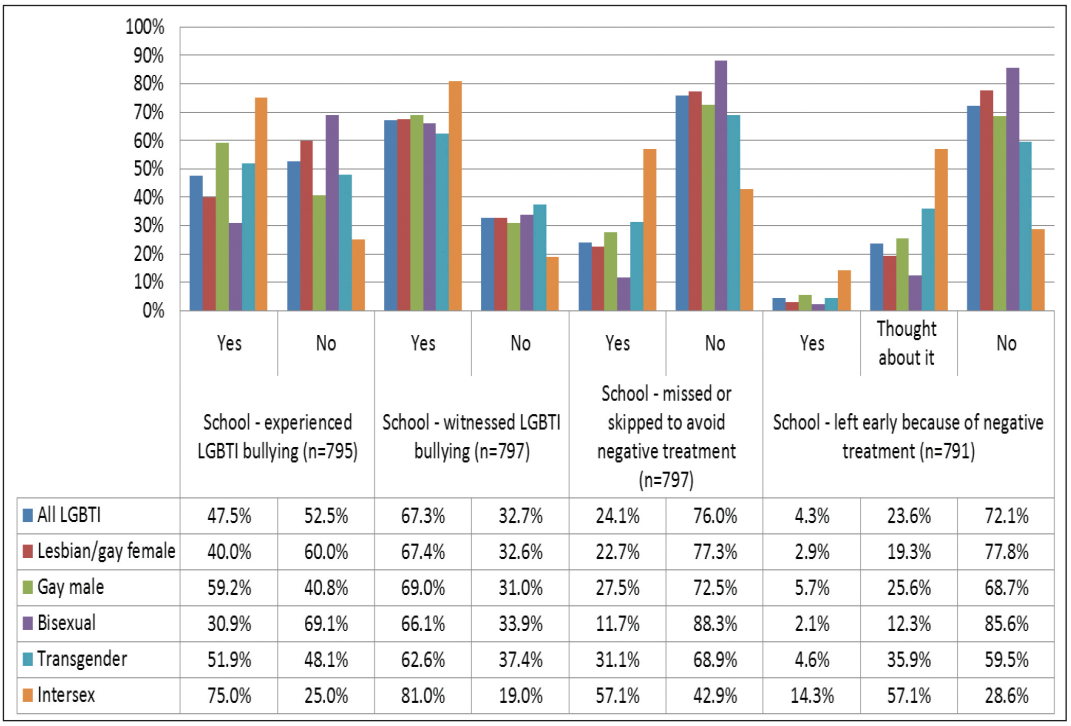
ANOVA and Pearson chi-square tests were conducted to compare LGBTI-friendly ratings of school, feelings of belonging in school and receiving positive affirmation by LGBTI group and age group. Only the three youngest age groups could be included for analysis as the age groups for those 36+ were too small for calculations.

- No significant differences in LGBTI-friendly ratings of school or experience of positive affirmation were found by LGBTI group. However, significant differences were found in relation to feelings of belonging. Transgender (36.1%, n=48) and intersex participants (42.9%; n=9) were more likely to report that they did not feel they belonged in school, compared to bisexuals (19.1%; n=36), gay males (27.2%; n=78) and lesbian/gay females (29.8%; n=51).
- In terms of age, those aged 14-18 years were significantly more likely to rate their school as LGBTI-friendly (M=5.04; SD=2.61) compared to those aged 19-25 years (M=3.97; SD= 2.61) or 26-35 years (M=3.7; SD=2.72). They were also more likely to feel that they completely belonged (23.5%) compared to the older age groups (19-25: 17.9%; 26-35: 13%) and to have experienced positive affirmation (56%) compared to the older age groups (19-25: 35.3%; 26-35: 17.4%).

Negative school experiences in past five years

Participants were also asked about whether they personally experienced or witnessed LGBTI related bullying in school. Of the 795 participants who responded to the question on personal experience of LGBTI related bullying, approximately 48% (47.5%; n=378) had experienced LGBTI bullying in school, while about two-thirds (67.3%; n=536) had witnessed bullying of other LGBTI people within their school. Approximately one in four students (24.1%; n=192) said that they had missed or skipped school or school events to avoid negative treatment due to being LGBTI. While 72.1% (n=570) of the sample had never thought about leaving school early due to the negative treatment they received because they are LGBTI, 23.6% (n=187) did consider leaving school early and 4.3% (n=34) reported leaving school early due to negative treatment (Figure 4.2).

Figure 4.2: LGBTI bullying and negative treatment in school



	School - experienced LGBTI bullying (n=795)		School - witnessed LGBTI bullying (n=797)		School - missed or skipped to avoid negative treatment (n=797)		School - left early because of negative treatment (n=791)		
	Yes	No	Yes	No	Yes	No	Yes	Thought about it	No
All LGBTI	47.5%	52.5%	67.3%	32.7%	24.1%	76.0%	4.3%	23.6%	72.1%
Lesbian/gay female	40.0%	60.0%	67.4%	32.6%	22.7%	77.3%	2.9%	19.3%	77.8%
Gay male	59.2%	40.8%	69.0%	31.0%	27.5%	72.5%	5.7%	25.6%	68.7%
Bisexual	30.9%	69.1%	66.1%	33.9%	11.7%	88.3%	2.1%	12.3%	85.6%
Transgender	51.9%	48.1%	62.6%	37.4%	31.1%	68.9%	4.6%	35.9%	59.5%
Intersex	75.0%	25.0%	81.0%	19.0%	57.1%	42.9%	14.3%	57.1%	28.6%

Pearson chi-square tests were conducted to determine whether there were statistically significant differences on any of the school variables by LGBTI group. Statistically significant differences were found for all variables except witnessing LGBTI bullying.

- Of the LGBTI groups, intersex and gay male participants were significantly more likely to have experienced LGBTI bullying, with bisexual participants least likely to have experienced it. Bisexual participants were also least likely to have skipped school due to negative treatment while intersex participants were most likely to have done so.
- Intersex and transgender participants were more likely than the LGB groups to have considered leaving school early; the intersex group had the highest proportion of participants who left school early due to negative treatment, followed by gay males and transgender participants.

Pearson chi-square tests were also conducted to determine whether there were statistically significant differences on any of the school variables by age group. Due to expected small cell counts, only the three youngest age groups (14-18; 19-25; and 26-35) could be included for analysis. Statistically significant results were found for age

group and witnessing LGBTI bullying and skipping school to avoid negative treatment due to being LGBTI. No statistically significant results were found for age group and experiencing LGBTI bullying and (considering) leaving school early due to negative treatment due to being LGBTI.

- Those aged 14-18 (61.9%, n=218) were less likely to have witnessed LGBTI bullying than those aged 19-25 (72.2%, n=293) and those aged 26-35 years (69.6%; n=16).
- A higher proportion of the 26-35 year old age group (47.8%; n=11) reported missing or skipping school to avoid negative treatment related to being LGBTI compared to the younger age groups (19-25: 23.2%; n=94) and 14-18 (23.6%; n=83).

Impact of anti-LGBTI bullying on the mental health of young people

Independent sample t-tests were run to examine the relationship between experiences of LGBTI bullying in school and impact on depression, anxiety, stress, self-esteem, and alcohol use scores for 14 to 25 year olds in the sample. Statistically significant results were found for all the scales: depression [t(606.264)=-5.679, p=.000]; anxiety [t(604.08)=-5.706, p=.000]; stress [t(595.633)=-6.373, p=.000]; self-esteem [t(689)=2.778, p=.005]; and alcohol use [t(509.949)=-2.568, p=.010]. Those who had experienced LGBTI bullying in school had statistically significantly higher scores on the depression, anxiety, and stress scales and lower scores on the self-esteem scale. They also had significantly higher scores on the alcohol use scale, indicating more problematic alcohol use and behaviours (Table 4.2).

Table 4.2: Impact of LGBTI bullying on depression, anxiety, stress, self-esteem, and alcohol use among 14-25 year olds.

Scale (n)	Mean (SD)
Depression Scale	
Yes, experience of LGBTI bullying in school (n=306)	18.48 (12.89)
No experience of LGBTI bullying in school (n=353)	13.11 (11.11)
Anxiety Scale	
Yes, experience of LGBTI bullying in school (n=305)	14.45 (11.33)
No experience of LGBTI bullying in school (n=362)	10.73 (9.76)
Stress Scale	
Yes, experience of LGBTI bullying in school (n=304)	19.10 (11.31)
No experience of LGBTI bullying in school (n=357)	13.86 (9.55)
Rosenberg Self-Esteem Scale	
Yes, experience of LGBTI bullying in school (n=318)	24.64 (6.41)
No experience of LGBTI bullying in school (n=373)	25.98 (6.15)
AUDIT Score	
Yes, experience of LGBTI bullying in school (n=249)	9.03 (6.0)
No experience of LGBTI bullying in school (n=282)	7.73 (5.6)

The impact of LGBTI bullying on participants aged 14-25 in the sample was examined by looking at the relationship between those who did and did not experience LGBTI bullying in school and rates of self-harm, suicidal thoughts, and suicide attempts. Statistically significant results were found when comparing the rates of self-harm [$x(1)=9.892$, $p=.001$], suicidal thought [$x^2(1)=23.448$, $p=.000$], and suicide attempts [$x(1)=30.258$, $p=.000$] between those who did and did not experience LGBTI bullying in school. Those who experienced LGBTI bullying in school were 12% more likely to self-harm, 18% more likely to have seriously considered ending their life, and 19% more likely to have attempted suicide than those who had not experienced LGBTI bullying in school (Table 4.3).

Table 4.3: Impact of LGBTI bullying on self-harm, suicidal thoughts, and suicide attempts of participants aged 14-25

		Bullied in School % (n)	Not Bullied in school % (n)
Self-harm	**Yes**	56.5% (178)	44.4% (164)
	No	43.5% (137)	55.6% (205)
Ever seriously thought of ending own life	**Yes**	76.2% (237)	58.6% (212)
	No	23.8% (74)	41.4% (150)
Ever seriously tried to take your own life	**Yes**	36.3% (113)	17.6% (64)
	No	63.7% (198)	82.4% (299)

BeLonGTo's "StandUp!" Awareness Week

Participants who had been enrolled in school in 2010 or later were also asked about their awareness regarding BeLonGTo's "StandUp!" Awareness Week against Homophobic and Transphobic Bullying. They were first asked whether any school staff, including teachers or their principal, had spoken about the "StandUp!" Awareness Week. More than three-quarters (77.5%; n=476) reported that no member of staff had spoken about the campaign, while 8.6% (n=53) were not sure or could not remember. Just 13.8% (n=85) reported that staff in their school did speak about the campaign. Next, participants were asked whether their school displayed posters for the campaign. Approximately 60% (60.4%; n=457) reported that their school did not display the posters and a further 14.4% (n=109) did not know or could not remember. In total, 25.2% (n=191) reported that their school did display posters for the "StandUp!" campaign (Table 4.4).

Table 4.4: BeLonG To's "StandUp!" campaign findings

If you were enrolled in school in 2010 or later, did your teachers/principal/other school staff talk to you about BeLonGTo's "Stand Up!" Awareness Week against Homophobic and Transphobic Bullying? (n=705)	
Yes	13.8% (85)
No	77.5% (476)

I can't remember or don't know	8.6% (53)
Did your school display the posters for BeLonGTo's "Stand Up!" Awareness Week against Homophobic and Transphobic Bullying? (n=887)	
Yes	25.2% (191)
No	60.4% (457)
I can't remember or don't know	14.4% (109)

What would be the one thing you would do to improve your school the most for LGBTI students?

In total, 752 responded to this question. Five major themes emerged from the recommendations made: safe space; affirming LGBTI identity; formal education on LGBTI issues in class; promoting inclusion, diversity, and equality; and teaching the teachers (Table 4.5). A small proportion (6.5%; n=50) commented on their experience of their school (such as not being out, no LGBT students in their school) without offering any suggestion as to how it could be improved.

Table 4.5: Themes and subthemes related to improving school for LGBTI students (N=743)

Safe space 34% (n=249)	**Affirming LGBTI identity** 25% (n=188)	**Formal education on LGBTI issues in class** 25% (n=188)	**Promoting inclusion, diversity and equality** 12% (n=92)	**Teaching the teachers** 4% (n=26)
Addressing bullying (n=105) Creating a safe space (n=93) Support group for LGBTI people (n=51)	Creating awareness and positivity (n=173) De-privilege heteronormativity (n=8) Having LGBTI teachers (n=7)	What to teach (n=88) How to teach (n=79) When to teach (n=21)	Promoting diversity (n=58) Policy changes (n=34)	

Safe space

This theme has three elements: addressing bullying so that school is a safe space in which to be out, having a safe space to come out and be yourself, and finding support among other LGBTI students or allies.

Participants expressed strong views that more needed to be done about school policies and non-tolerance of bullying by teachers and other students. In particular, the use of the words 'gay', 'dyke', 'tranny' and 'faggot' caused them distress and were used regularly as an insult to some of the students. It was felt that bullying was not dealt with sufficiently with most reporting that while teachers were aware of such activity, it was ignored. The other response reported was for teachers to tell students to ignore it or toughen up. They also made some suggestions as to how bullying could be dealt with in school on a practical level.

> *A bigger stance towards the use of homophobic/ transphobic comments. Nearly every day in school teachers do hear students being called various slurs and they do not take any action towards the people using the language or help the victims in any way. (Intersex, pansexual, 16)*

> *Have the teachers and other disciplinarians of the school actually take homophobic and transphobic seriously and to have repercussions for the bullies – rather than tell the victims to "toughen up" or "ignore them". (Bisexual female, 22)*

> *I would have more homophobic and transphobic bullying awareness programmes in schools at both secondary and primary schools so that young people can identify and tackle head on any transphobic and homophobic bullying they witness in their school. (Transgender, Gender Variant, gay, 22)*

Another issue for participants was the perceived homophobic/transphobic attitudes among teaching staff.

> *"Make teachers aware that THEIR homophobic discourse is completely unacceptable". (Bisexual female, 22)*

The need to create a safe space for students within school was also highlighted:

> *Make it a safe place to come out. I don't think I even knew this was an option; all I knew was suppression of who I was. I thought it was normal and I had no idea how to even begin to acknowledge that I was LGBTQIA. I was good at suppressing it – schools need to address mental health along with LGBT stuff, so that more people can be reached. (Transgender, pansexual, 21)*

It was also suggested that there should be a Gay-Straight Alliance or similar support group for students in schools to assist them in finding support, identifying allies and showing that they are not alone.

Create an LGBTI club or organisation that would meet up a few times a week with a qualified counsellor who is experienced in LGBT problems and solutions and use the group as a safe place for kids to talk about how they are feeling. (Lesbian/gay female, 23)

Affirming LGBTI identity

By far the most common word that participants included in their recommendations was 'awareness'. Participants felt that LGBTI issues were not talked about in schools and, while there was limited discussion in SPHE, LGBTI discussions did not happen within the school or the curriculum.

Get the conversations going. It's never talked about ever. We have weeks dedicated to health, languages and anti-bullying weeks but even during anti bullying week there is hardly any mention of homophobia and if there is it is a passing comment or very brief. There is no club in school for LGBTI students or allies and everyone pretends it doesn't exist. (Lesbian/gay female, 18)

Participants wished to decrease the privilege that heteronormativity enjoys within the school environment.

More awareness that some students are LGBTI. I was in the closet at school, but it was like we didn't exist. Nothing outside of the heteronormative view was expressed. (Gay male, 22)

Participants also expressed a view that having more LGBTI teachers that were open about their own sexuality would have assisted them in school and made being a LGBTI person more accepted: *"Having an LGBT member of staff would have really made a difference". (Gay male, 21)*

Formal education on LGBTI issues in class

There were 188 recommendations made on the formal classroom education of students on LGBTI issues. These were broken into three areas: what to teach; how to teach; and when to teach. Participants suggested that all sexual orientations and gender identities should be taught with participants suggesting a need to move away from curricula which presumed a heterosexual orientation. In their view, when sexual orientation is discussed, it is limited to gay and lesbian issues, with other sexual orientations and gender identities receiving little attention. Participants recommended that in addition to all sexual orientations and gender identities, specific content on safe sex and the effects of homophobic and transphobic bullying needed inclusion.

> *Drastically change the SPHE syllabus, I constantly felt excluded because there was never any mention of asexuality or non-binary genders. Trans terminology was always outdated and offensive. Cissexism was rampant as it is everywhere, I would like to teach students what cissexist language is and why it is important to be mindful and actively try to remove it from your vocabulary. (Transgender, agender, asexual, 18)*

> *Have more awareness about the spectrum of sexualities/gender identities, instead of the "straight or gay", "male or female" attitude in any discussion about sexuality and gender. (Bisexual female, 19)*

Participants also had clear views on how they wanted these subjects taught in schools and the approach that should be taken by teachers in SPHE classes. This included having the religious aspects removed, using positive language when discussing LGBTI issues, and being taught by people from outside the school teaching cohort.

> *I would have classes that educate individuals about all different types of gender identities and sexual orientation. This class should allow for some form of outside support from trained individuals to do workshops in schools in which a safe environment would be created to openly discuss issues in regards to this. (Gay male, 21)*

Participants were of the view that young people needed to be taught LGBTI issues from a young age. Those that expressed a preference stated that 6th class or 1st year was the most appropriate time to start. By educating students at an early stage, it was felt that this would help to debunk myths and stereotypes, assist students who are questioning their sexuality and may reduce bullying in junior cycle classes.

> *Education from a young age about LGBTI people. The first time pupils learn about LGBTI issues is in secondary school when the homophobic behaviour in many cases has already been entrenched (overtly or otherwise) by the invisible nature of LGBTI in primary schools. (Gay male, 20)*

Promoting inclusion, diversity and equality

It was also suggested that schools would be improved by policy or ethos changes that promoted inclusion, diversity and equality, which would mean schools send a positive message that they welcome diversity and that all students were equal. By promoting this consistently throughout the school and the years, participants felt that students would find school a more welcoming place which discouraged bullying and

discrimination by staff and students. Some participants suggested that schools either remove the religious ethos or make schools more secular. The reasons behind this were the belief that religion was used as a cover for allowing homophobia/biphobia/transphobia and that LGBTI people were not encouraged to be themselves and open while this ethos was in place.

> *Schools should encourage students to be true to themselves, accept themselves, love themselves for who they are whatever their sexual orientation. Then apply the same to everyone else too. They should drill it into their heads every morning instead of the ten minutes of … prayers. (Bisexual female, 23)*

> *Create an environment which secretes the atmosphere of acceptance of all different kinds of people. A good way for a school to do this in my opinion would be to add this accepting attitude into the schools ethos. I feel that most of the time the ethos of the school has a really powerful effect on the students and can be integrated into their personalities as they are developing as a person growing up in that educational environment, and that can be taken advantage of. (Gay male, 16)*

Other changes suggested were the option of bringing same-sex dates to the graduation dance (debs), and a more flexible uniform policy that accommodated students that did not identify within the binary division of male and female. In addition, participants recommended more accessible toilets and proper changing facilities for transgender students, and greater attention and emphasis on the use of preferred names and pronouns.

Teaching the teachers

While recommendations about teachers were prominent in all themes, the education and training of teachers was something participants felt was imperative. Education of teachers about LGBTI issues and how to deal with LGBTI bullying and respond to the needs of LGBTI students was crucial. Specific reference was made to the teaching of SPHE in class and how teachers needed to be equipped to teach LGBTI issues within the subject. Some participants referred to the need for teachers to be educated on LGBTI bullying and the effects of it on students.

> *More training for teachers on LGBTI issues. On a few occasions, SPHE teachers have asked me and other LGBTI students about areas such as being gay or transgender so they can teach their classes about it. (Gay male, 17)*

> *Educating staff so they know how to talk about LGBTI issues in an informed and sensitive way and can also deal more effectively with homophobic bullying. (Lesbian/gay female, 23)*

Discussion

Approximately 48% of participants who were currently in school or had attended school in the past five years had experienced LGBTI bullying, with about two-thirds (67.3%; n=536) reporting they had witnessed bullying of other LGBTI people. Whilst the figure for experiencing bullying is slightly lower than that reported in the *Supporting LGBT Lives* study (Current school goers: 51%) (Mayock *et al*. 2009) and may suggest a slight alleviation of the problem, the figure nevertheless remains high and an issue of concern, given that young people who experience bullying in school are at greater risk of mental health issues, including self-harm and attempts to end their life. Around a fifth to a quarter of LGBTI participants in this study skipped/missed school or thought about leaving school due to LGBTI bullying, while 4.3% quit school as a result. These rates are congruent with the *Supporting LGBT Lives* study where around a fifth skipped school or thought about leaving school while 5% actually left school because of negative treatment related to being LGBT (Mayock *et al*. 2009). The negative impact of bullying in school on transgender participants was highlighted by their greater likelihood, along with intersex participants, of considering leaving school early. The negative experiences of transgender students is well documented in McBride's Northern Irish study where the consequences included poor mental health outcomes and early exit from school (McBride 2013).

More participants in this study said that they felt that they 'somewhat belonged' rather than 'completely belonged' in school, while over a quarter reported that they did not feel like they belonged at all. This feeling of being like an outsider is reflected in findings from *Supporting LGBT Lives* which found that nearly half disagreed that they felt a real part of their school (Mayock *et al*. 2009). In terms of acceptance, less than half of LGBTI participants in this study indicated that they received positive affirmation of their LGBTI identity within school, while a greater proportion of LGBT participants (70%) in *Supporting LGBT Lives* felt that it was hard for them to be accepted in school (Mayock *et al*. 2009).

Overall the findings highlight the need to ensure that school environments are safe, welcoming and supportive places for LGBTI young people. An LGBT positive school climate and a lack of homophobic victimisation has been identified as aiding students in school and enhancing educational outcomes (Birkett *et al*. 2009). Higher levels of school connectedness (i.e. feeling accepted within the school community) is associated with reduced victimisation (Diaz *et al*. 2010) and better mental health outcomes, including less suicidal ideation (Whitaker *et al*. 2016) among LGB students. Fisher *et al*. (2008) identify primary, secondary and tertiary level intervention strategies that should be adopted to achieve a safe and supportive school environment for LGBT students and

to engender resilience amongst them. Primary level strategies target the whole school community and involve policy development, diversity education for students and staff, and integrating diversity into the curriculum. Secondary level strategies focus on the provision of support to at-risk LGBT students and include groups to support LGBT students and allies, and group counselling to promote identity development and coping skills. The provision of social support has been identified as potentially buffering LGBT students from the harmful effects of being stigmatised and bullied in school due to their sexual orientation or gender identity (Davis *et al*. 2014). Tertiary level interventions are centred on students experiencing problems and may involve individual counselling services.

A review of relevant international literature on initiatives and actions that schools can implement to effectively address homophobic bullying, as well as initiatives taken to address homophobic bullying in Irish second level schools, identified a whole school approach to homophobic bullying, across the entire school curriculum and incorporating the involvement of all staff, students, and parents, as the key factors underpinning successful initiatives. In addition, seven essential elements were identified as central to developing a whole school approach to tackling homophobic bullying. These included leadership, policies and protocols for addressing homophobic bullying, fostering a positive school ethos, developing an LGBT inclusive curriculum, student representation, support services for staff and students and partnerships with the community and parents. The need for training for educators was highlighted, as well as access to relevant resources and materials (O'Higgins-Norman *et al*. 2010). Since the publication of this review, it must be acknowledged that a considerable amount of concerted work in this area has emerged. In addition to the policies and guidelines already highlighted in the introduction of this chapter, in 2011 specific guidelines for school principals to counter homophobic bullying and to include LGB students in school policies, were developed by the Department of Education and Skills, the National Association of Principals and Deputy Principals (NAPD) and GLEN (Department of Education and Skills, the National Association of Principals and Deputy Principals (NAPD) and GLEN 2011). Further, the Professional Development Service for Teachers (PDST) also now provides training, support and material resources to schools on topics such as DES anti-bullying procedures and policy and *Growing up LGBT*, the SPHE/RSE resource.

It has been argued elsewhere that informal and formal curriculum strategies which challenge hetero/cisnormative school cultures and disrupt homophobia/transphobia are required, yet caution is also urged against unintentionally pathologising LGBT

students by employing a discourse which frames LGBT students as vulnerable, at risk and in need of safety (Currie *et al*. 2012; Lapointe 2015). Partnership approaches, involving all school and community stakeholders, to implementing changes in school culture or introducing LGBT affirmative school-based interventions, are advocated in order to create understanding of, and support for, initiatives (Meyer and Bayer 2013; Currie *et al*. 2012).

Many participants in this study felt that more awareness of, and positivity towards, LGBTI identities is required in order to improve schools for LGBTI students. While BeLonGTo, Ireland's national organisation for LGBT young people, has developed resources, including an annual 'Stand Up! LGBT Awareness Week' and a complimentary educational pack, to create positive awareness of LGBT people and to prevent bullying, more than three-quarters of participants in this study reported that no member of staff had spoken about BeLonGTo's "StandUp!" Awareness Week against Homophobic and Transphobic Bullying.

A number of interventions to support LGBT students have been examined in the literature, including a group counselling program to promote resilience (Craig 2013), and the role of the school psychologist (Murphy 2012). Many studies have also explored the potential of Gay-Straight Alliances (GSA) (Goodenow *et al*. 2006; Heck *et al*. 2011, 2013; Kosciw *et al*. 2013; Heck *et al*. 2014), such as its educational potential (Lapointe 2015) and the potential to embed a mental health promotion program for LGBTQ youth within its structures and resources (Heck 2015). Some research has focused on what aspects of GSAs account for the positive outcomes associated with them, such as, whether their success is attributable to their presence, the provision of social support within them, their impact on the school climate, or whether it depends on how active and visible the GSA is, or personal involvement in the GSA (Seelman *et al*. 2015; Walls *et al*. 2013).

It has been suggested that, in addition to an inclusive curriculum, supportive educators and strong anti-bullying policies and laws, GSAs would enhance outcomes for students (GLSEN 2009). In the United States, student-led GSAs, defined as "[S]tudent-led clubs open to youth of all sexual orientations with the purpose of supporting sexual minority students and their heterosexual allies and also reducing prejudice, discrimination, and harassment within the school" (Goodenow *et al*. 2006: 575), have emerged in the last ten years. With over 4,000 GSA groups existing in the US, they are now considered to be an initiative which is significantly conducive to strengthening resilience and promoting positive mental health amongst LGBT youth (Currie 2012). A plethora of studies have noted positive outcomes associated with GSA's including an increased sense of belonging, safety, and comfort with LGBT identity,

a more positive and supportive school climate, in addition to improved academic performance and positive identity development, and reductions in social isolation, school-based victimisation and concealment of LGBT identities (Goodenow *et al*. 2006; Heck *et al*. 2011, 2013; Murphy 2012; Kosciw *et al*. 2013; Heck *et al*. 2014). More positive health outcomes, including less harmful alcohol consumption, cigarette smoking, use of illicit substances, have also been linked to schools with GSAs (Heck *et al*. 2014). Further, literature suggests that GSA's have also played an integral part in reducing the rates of suicidality and substance use (Davis 2014; Goodenow *et al*. 2006; Heck *et al*. 2011, 2014; Poteat *et al*. 2013; Toomey *et al*. 2011; Walls *et al*. 2013). Given the apparent effectiveness of GSA's in the United States, and participants' recommendations, it may be logical to develop a pilot program in Ireland to assess its suitability to the Irish context.

CHAPTER 5

FINDINGS: LGBTI EXPERIENCES OF COLLEGE AND UNIVERSITY

Introduction

For many people who identity as LGBTI, college or university often provides the backdrop to their identity formation and disclosure (Garvey and Rankin 2015). For this reason, research has focused on assessing the college and university environment from the perspective of students who identify with a sexual or gender minority, as well as exploring the impact of negative or positive college and university environments on these students' personal well-being and academic progress (Woodford and Kulick 2015; Kirsch *et al*. 2015; Garvey and Rankin 2015). Negative college environments in which homophobia and heteronormativity are present, and where harassment occurs, can have an adverse impact on LGBT students' developmental and learning outcomes with reduced psychosocial well-being and greater academic disengagement (Waldo *et al*. 1998; Woodford and Kulick 2015; Kirsch *et al*. 2015). In addition, discriminatory and hostile experiences at college/university can stifle the development of a positive sense of one's sexual orientation or gender identity and inhibit disclosure (Garvey and Rankin 2015). Furthermore, an environment which perpetuates a heteronormative discourse and climate alienates LGBTI students and limits real opportunities for inclusivity or the possibility of cultivating positive affirmation of diverse identities (Garvey and Rankin 2015).

Several US research studies found that LGBT students experience harassment in their college or university as a result of their gender identity or sexual orientation (Silverschanz *et al*. 2008; Rankin *et al*. 2010; Woodford *et al*. 2013; Garvey and Rankin 2015). For example, Silverschanz *et al*. (2008) found that 57% of sexual minority students at a public university in the US experienced heterosexist harassment. Participants in Rankin *et al*.'s (2010) study reported being harassed on campus due to their sexual orientation (25%), feeling uncomfortable with their campus' overall climate (30%), and having seriously considered leaving their college/university (30%) (Rankin *et al*. 2010). In addition, Rankin *et al*. (2010) also found that many transgender-spectrum community college students, like the larger sample of LGBT college students, had negative college experiences. For example, 38% reported that they had personally experienced exclusionary, intimidating, or offensive behaviour within the past year, and almost 30% stated that they seriously considered leaving their college. In a similar vein, Garvey and Rankin (2015) found that students who identify as transgender had more negative experiences of college compared to cisgender LGB students.

It has been noted the transitioning from school to college/university may be a time of enhanced stress for most young people irrespective of gender identity or sexual orientation, but for students who identity as LGBT the experience may prove more challenging because of their experience of a hostile environment in primary and secondary school which may give rise to increased levels of mental distress (Kirsch *et al*. 2015). At the same time, college/university may also present new opportunities for young people to explore and express their identity, and to access LGBT friendship and support networks as well as other resources (Kirsch *et al*. 2015). This has a demonstrably positive effect on sexual minority students' well-being and serves as a buffer against negative interactions and environments (Woodford and Kulick 2015; Hong *et al*. 2015).

This chapter explores participants' college and university experiences. Participants' ratings of their college/university on an LGBTI-friendly scale are presented, along with figures related to their sense of belonging and experience of positive affirmation. Next, data related to negative experiences participants had in college/university, including bullying, are also presented. Concluding this chapter is a presentation of open-ended responses with the participants' recommendations for improving college and universities for LGBTI students.

LGBTI-friendly rating, sense of belonging, and experiences of positive affirmation

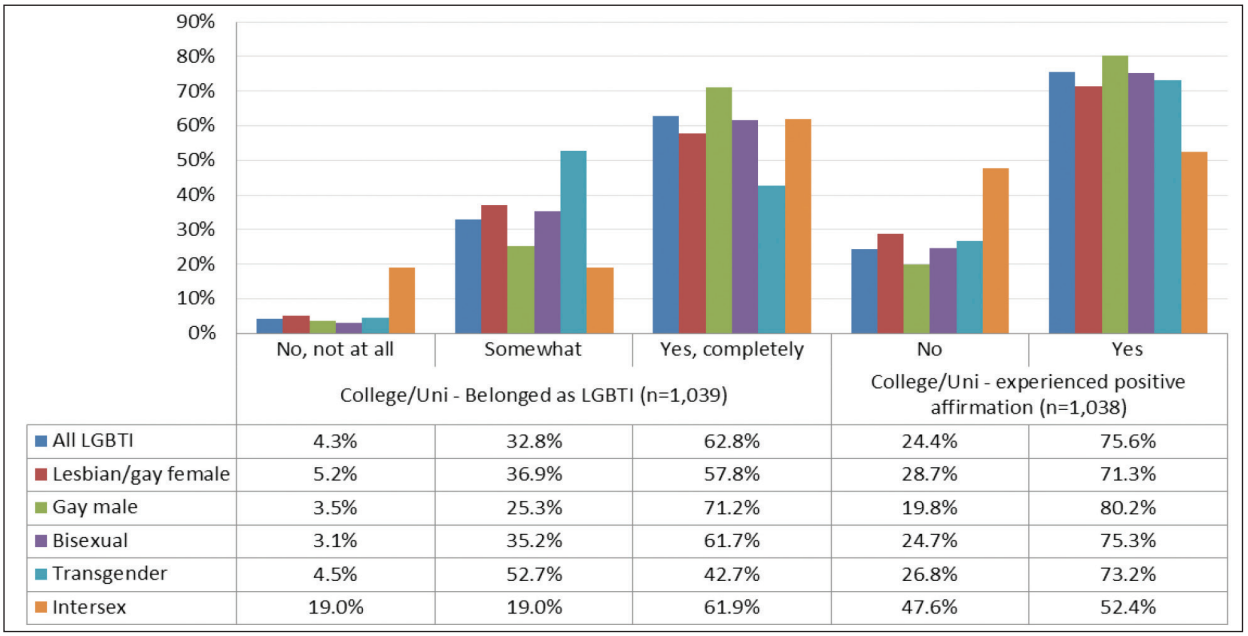
About half of the participants (49.9%; n=1,056) were currently enrolled in college or university in the ROI or had attended college or university in the ROI within the past five years. Those who were currently enrolled or had attended college or university in the past 5 years were asked how LGBTI-friendly their college or university was on a scale of 0 to 10 (0='not at all LGBTI-friendly'; 10 ='completely LGBTI-friendly'). In total, 1,043 participants responded to this question. The mean rating given was 7.63 (SD=2.26; n=1,043), with a range from 0 to 10. The most common rating was a 10 meaning 'completely LGBTI-friendly'. Approximately 25% (n=264) of participants rated their college/university a 6 or less. Gay males, and those aged 19-25, gave the highest ratings for LGBTI-friendliness of college/university with intersex participants and those aged 46+ giving the lowest ratings (See table 5.1).

Table 5.1: Mean LGBTI-friendly rating of college/university by LGBTI group and age group

LGBTI GROUP					
ALL LGBTI	**L**	**G**	**B**	**T**	**I**
M=7.63 (n=1,043)	M=7.40 (n=289)	M=7.96 (n=458)	M=7.61 (n=164)	M=7.07 (n=111)	M=6.62 (n=21)
AGE GROUP					
ALL AGES	**14-18**	**19-25**	**26-35**	**36-45**	**46+**
M=7.64 (n=1,042)	M=8.03 (n=40)	M=8.06 (n=524)	M=7.36 (n=305)	M=6.95 (n=110)	M=6.37 (n=63)

Participants were also asked whether, as an LGBTI person, they felt they belonged in their college or university. While 4.3% (n=45) felt they did not belong at all, 62.8% (n=653) felt they belonged completely and the remaining 32.8% (n=341) felt they somewhat belonged. In addition, participants were asked whether they received positive affirmation of their LGBTI identity within college or university. Approximately three-quarters (75.6%; n=785) indicated that they received positive affirmation of their LGBTI identity within college/university (See figure 5.1).

Figure 5.1: Feelings of belonging and experiences of positive affirmation at college/university by LGBTI group



	No, not at all	Somewhat	Yes, completely	No	Yes
	College/Uni - Belonged as LGBTI (n=1,039)			College/Uni - experienced positive affirmation (n=1,038)	
All LGBTI	4.3%	32.8%	62.8%	24.4%	75.6%
Lesbian/gay female	5.2%	36.9%	57.8%	28.7%	71.3%
Gay male	3.5%	25.3%	71.2%	19.8%	80.2%
Bisexual	3.1%	35.2%	61.7%	24.7%	75.3%
Transgender	4.5%	52.7%	42.7%	26.8%	73.2%
Intersex	19.0%	19.0%	61.9%	47.6%	52.4%

Pearson chi-square tests were conducted to see if there were any significant differences

in feelings of belonging in college/university and experiences of positive affirmation by LGBTI group and age group. Statistically significant differences were found across all variables.

- Intersex participants (19%, n=4) were significantly more likely to feel that they did not belong at all compared to the other groups (Lesbian/gay female: 5.2%, n=15; transgender: 4.5%, n=5; gay male: 3.5%, n=16; and bisexuals: 3.1%, n=57).
- Compared to the other LGBTI groups, gay males were significantly more likely to feel that they completely belonged, while transgender participants were more likely to report feeling that they somewhat belonged.
- In relation to experiences of positive affirmation, intersex participants were significantly more likely to report that they did not receive positive affirmation at college/university while gay males were most likely to report that they experienced positive affirmation.
- Higher proportions of the younger age groups (14-18: 65%; 19-25: 70%) reported that they felt they completely belonged in their college or university compared to the older age groups (49%-56%). The two youngest age groups were also more likely to report that they experienced positive affirmation (14-18: 87.5%; 19-25: 81.9%) compared to the older age groups (57%-71%).

Negative college and university experiences

Participants were also asked about whether they experienced or witnessed LGBTI bullying in college or university. While 84.8% (n=880) had not experienced LGBTI bullying in college or university, the remaining 15.2% (n=158) had. Approximately one-quarter of the sample (25.4%; n=265) had witnessed LGBTI bullying of other LGBTI people within their college or university. A further 6.7% (n=69) indicated that they had missed or skipped college or university classes or events to avoid negative treatment due to being LGBTI. While 92.4% (n=956) had not considered leaving college or university because of negative treatment received due to being LGBTI, 6.1% (n=63) had considered it and 1.5% (n=16) actually left college or university early as a result.

Pearson chi-square tests were conducted to determine whether there were statistically significant differences on any of the college/university variables by LGBTI group. No calculations could be made regarding whether a person had left college/university early due to the small numbers. No statistically significant results were found by LGBTI group for witnessing LGBTI bullying. Statistically significant results were found for experiencing LGBTI bullying and missed or skipped university/college to avoid negative treatment.

- Transgender (23.6%; n=26) and intersex (23.8%; n=5) participants were significantly more likely to have experienced LGBTI bullying compared to lesbian/gay females (15%; n=43), gay males (14.7%; n=67) and bisexual participants (10.4%; n=17).
- Transgender (16.2%; n=18) and intersex (23.8%; n=5) participants were also significantly more likely to have skipped or missed university/college to avoid negative treatment related to being LGBTI compared to lesbian/gay females (7.7%; n=22), gay males (3.9%; n=18) and bisexual participants (3.7%; n=6).

Pearson chi-square tests were also conducted to determine whether there were statistically significant differences on any of the college/university variables by age group. No statistically significant results were found by age group for experiencing LGBTI bullying, witnessing LGBTI bullying, or missing or skipping college/university to avoid negative treatment related to being LGBTI.

What would be the one thing you would do to improve your college or university the most for LGBTI students?

In total, 608 responses focused on this question. The analysis resulted in the following five themes: promoting inclusion and diversity; education and awareness raising; affirming LGBTI identity; inclusive policies and challenging discriminatory practice and homophobic bullying; and removing or curtailing religious influences (see table 5.2).

Table 5.2: Themes related to improving college/university for LGBTI students (n=608)

Theme	% (n)
Promoting inclusion and diversity	53.8% (327)
Education and awareness raising	23.8% (145)
Affirming LGBTI identity	13.5% (82)
Inclusive policies and challenging discriminatory practice and homophobic bullying	5.8% (35)
Removing or curtailing religious influences	3.1% (19)

Promoting inclusion and diversity

The existence of LGBTI groups, such as social or support groups, were deemed to be an integral part of creating a safe space for people who identify as LGBTI to come out, as well as enabling them to form a social network of support. Participants who had no access to an LGBTI society or group at third level lamented the absence of one

and expressed a desire for it to be established. Where an LGBTI society was already in existence, numerous suggestions to improve such societies were made. Some of the comments reflected the concerns about the sustainability and viability of the LGBTI society from one year to the next as it was deemed important for it to be a permanent feature of college life. Suggestions were made for ensuring this, including hiring a permanent paid member of staff to focus on LGBTI issues, greater and continued support from the Students' Union, and the continuation of financial support and resources from college.

> *A better LGBT society and somewhere for people who haven't come out to go and talk about their situation. (Gay male, 23)*

> *I could only wish for a support network within college which would be openly supportive of LGBTI students…during my time in college, there wasn't a counsellor I could fully trust with my issues. (Transgender male, bisexual, 27)*

> *College LGBTI groups are very effective but need more support from their colleges both financial and otherwise. (Lesbian/gay female, 35)*

It was clear from the comments that participants wanted a more inclusive and welcoming LGBTI society that was open to a diversity of members, including people who are older and mature members, new members, those just coming out, those identifying as bisexual, those with disabilities and people from different backgrounds in general. Some participants described the LGBTI society in their college as either being experienced as or perceived as 'cliquish', 'elitist' and 'hostile'. It was also felt that work needed to be done to promote LGBTI societies and groups as welcoming and inclusive places.

> *Try and make the LGBTI society as inclusive and welcoming as possible. Often times it's perceived as cliquey or only for students who fit a certain perception of what being LGBTI is (i.e. that it's only for very camp males or very butch females). Make sure everyone knows that the society caters for people of ALL genders, sexualities, ages, races and personalities. (Gay male, 24)*

Though the presence of LGBTI-specific groups was regarded as largely positive, there was also an expressed view that they had the potential to create or reinforce an 'us and them mentality' between members and the broader college community. In this context, their activism was cited as something which might deter others from joining.

Thus, while the importance of having an LGBTI society or group was emphasised, it was deemed equally important to ensure that the society was included in the broader college community rather than remaining separate and apart. In order to bridge that divide and foster inclusiveness, many participants felt that it was important that the LGBTI society be open to straight allies and work to develop links with other groups within the college. In addition, many participants wished for other college groups and societies to be more inclusive of LGBTI people and for gay straight alliances to be forged within colleges. It was felt that greater integration with the broader college community would facilitate education of people about LGBTI issues, as well as help to build a stronger and more cohesive sense of community within the college environment.

> *Make it clear that straight, cisgender allies are welcome in LGBT societies. Though an LGBTI society is necessary and a great asset, it creates something of an "us and them" dynamic. (Female, pansexual, 22)*

> *There was a particular division between the LGBTI community and the rest of the university, so I would suggest breaking down barriers between societies through joined activities and events. (Female bisexual, 21)*

Participants were also of the view that LGBTI societies should be active and engage in a wide range of diverse activities, rather than being solely centered on the pub/club culture or activities that conform or reinforce stereotypes about LGBTI people. A broader remit, beyond social activities, was advocated for the LGBTI society. Some participants mentioned that the LGBTI society should be more politically active and engage more in social justice issues, as well as adopting an educational and outreach role in terms of raising awareness of and providing information on LGBTI issues. Others expressed a desire for more LGBTI events within college. Suggestions included pride events, transgender events, LGBTI nights, rainbow week, and more awareness raising events.

> *Have more inclusive events in the LGBTI societies. Events only seem to focus on the L and G communities and forget the straight ally community completely whom should be allowed to participate. There is a thing about bisexual people too. (Gay male, 25)*

In addition, greater advertisement of the society's activities was also recommended, particularly advertisement that promoted the group as inclusive. Several participants expressed the view that there should be more promotion of LGBTI societies, groups and services to raise awareness of their existence and to enable students to avail of them.

I think any groups such as the LGBTI group should be highlighted at registration to college so LGBTI can meet others early on in college and support each other. (Lesbian/gay female, 31)

Several participants expressed a desire for LGBTI dedicated services and supports within college, such as access to counselling and for these college services to be better advertised and more accessible to students. Many participants also stressed the importance of creating a more inclusive environment for people who identify as transgender. Participants suggested that transgender-specific supports be made available and that transgender-friendly facilities be created for staff and students, such as having unisex toilet facilities, as well as making the process of changing gender on records easier.

More transgender-friendly facilities for staff and students. That was the main thing that my college lacked for the LGBTI students. (Lesbian/gay female, 22)

A few participants were of the view that the focus of sexual health promotion within college was too narrow and heteronormative. Participants recommended sexual health awareness that is relevant to the needs of LGBTI people in order to make it more inclusive and appropriate.

Safe sex campaigns for those who identify as LGBTI. Most sexual health campaigns consider heternormative sex exclusively (Gay male, 22)

Several participants felt that colleges would be improved by greater visibility of LGBTI staff as it would provide positive role models for students. In addition a strong, more visible LGBTI presence on campus, through the staging of events and use of posters, was identified as something that would contribute to a better environment for LGBTI students. Several participants suggested that LGBTI related topics be incorporated into education and that LGBTI course materials be utilised where possible.

To hear from some LGBTI staff. Maybe a profile of LGBTI lecturers in the college paper. (Gay male, 27)

Education and awareness raising

Several participants underlined the importance of education on LGBTI issues in order to enhance the environment for students who identify as LGBTI, and to create a more understanding, accepting and supportive place. It was felt that training should help to foster positive attitudes and inclusive language towards LGBTI people, normalise the LGBTI identity for people who are unfamiliar with it, enhance people's empathy for the experiences of those who identify as LGBTI and help to ensure that they are treated with respect. Participants were also of the view that the training should imbue people with the knowledge of how to act appropriately and sensitively in a variety of situations, such as when someone comes out or when someone identifies as transgender, and to incorporate LGBTI friendly attitudes and practices in their everyday encounters.

> *I'd like to see the college make the whole student body aware of all LGBTI students, as part our community as a university. (Gay male, 21)*

Participants identified a need for staff to receive ongoing education on a range of LGBTI related topics including sexual diversity awareness, transgender issues, intersex, bisexuality, biphobia, transphobia, LGBTI rights and injustice, gender variance, gender roles/the social construction of gender, anti-bullying training, sensitivity training, as well as promotion of the supports and services available to LGBTI people. One particular area which many participants felt required greater understanding and awareness was the use of offensive, hurtful, and homophobic language towards LGBTI people and its potentially negative and harmful impact. Many participants were of the view that offensive language and behaviour stemmed from ignorance and a lack of appreciation of how hurtful and damaging such language can be to those who are the subject, rather than from any intention to cause harm. For this reason, several participants felt it was important to make people aware of the impact that their words can have.

Educational and awareness raising activities by colleges and the LGBTI societies, such as awareness days or weeks, information days/events and the distribution of information leaflets, class talks, workshops, seminars, and campaigns, were all suggested as ways to increase knowledge of LGBTI related issues. While students and lecturers were identified most often as requiring education, those working in other areas of the college such as administration and in college health services were also singled out by participants as requiring training. Several participants suggested that new students receive some education on LGBTI related issues at the point of induction.

Regularly hold seminars to educate all staff, especially those in the college health service about LGBTI identities and issues. (I met with a confused, blank expression when I went to see a counsellor, described myself as "bi" and talked about events for Rainbow Week. The counsellor wasn't hostile, but she was uninformed, and at the stage I was at this made me feel like crawling back into my shell). (Lesbian/gay female, 28)

Affirming LGBTI identities

Many participants commented that the college could provide more positive affirmations of LGBTI identities to improve the environment for LGBTI students. Many participants felt that the presence of the Pride flag on campus, the pink triangle symbol in SU offices, LGBTI-friendly stickers on lecturers' doors and so forth would send a positive message of support to LGBTI people. Participants expressed a desire to see positive representations and portrayals of LGBTI people displayed on posters and images around the campus and for college media resources to reflect diversity by incorporating LGBTI identities. In this way, visibility would affirm LGBTI identities and create a positive and open culture on campus, which many participants cited as being important.

A rainbow/pride flag on campus permanently would be a great sign of support to LGBTI freshers who come into college for the first time, especially if they come from an unsupportive background. (Intersex, bigender, pansexual, 20)

Many participants commented on the importance of the college and its members fully recognising, accepting and incorporating LGBTI identities into the fabric of the college life. Several participants commented that university-wide acceptance of LGBTI across all facilities and schools was important. Positive endorsements of sexual orientations and gender identities by the college president and lecturers were also cited as desirable. In addition, public declarations of support for the rights of LGBTI people was cited as important. It was felt that an open, accepting and positive culture around LGBTI identities, and more visibility of LGBTI people within colleges, would create a safer space for LGBTI people to be out in college and for role models to emerge.

To ensure LGBTI people know they are welcome, respected, protected, valued and encouraged to open about their sexuality without feeling shame, discrimination , prejudice, fear, ignorance or isolation. (Gay male, 53)

It was also felt that fewer assumptions about sexuality, and a greater appreciation for diversity in relation to sexual orientation and gender identity, would help

affirm LGBTI identities in the college environment. The tendency among people to assume heterosexuality, to characterise LGBTI people in a particular way and to treat LGBTI issues as taboo subjects, were identified as requiring changing attitudes and approaches. Participants identified a need for a more inclusive language in everyday discussions that would not alienate LGBTI identities, and the need for more open discussions about sexuality. Many participants felt that lecturers could reflect inclusiveness and diversity in the language they use within their interactions with students and their teaching by using illustrative examples involving LGBTI.

> *Highlight the fact that the LGBTI community are a very diverse and varied part of the student body and not a one size fits all group which can be defined or catered for by one society or club. College can sometimes stereotype LGBTI people. (Gay male, 26)*

> *Lecturers could mention the possibility of LGBT people when giving illustrative examples in class. (Gay male, 51)*

The importance of support from lecturers and peers was underlined by many participants. It was felt that all members of the college should play a role in standing up for LGBTI people when they witness harassment and that staff, in particular, have a responsibility to tackle bullying instead of letting it go unchallenged. It was felt that there were instances within class when staff should challenge negative or homophobic language and play a part in ensuring that people's chosen pronouns are respected and used.

> *Staff tackling LGBT bullying instead of pretending they didn't hear it and standing up for students. Too many people shy away for fear of getting 'dragged into it'. (Lesbian/gay female, 32)*

Inclusive policies and challenging discriminatory practice and homophobic bullying

Many participants expressed a desire for a zero tolerance approach toward homophobia/biphobia/transphobia to be adopted by college authorities and for this policy, and the existence of anti-discrimination legislation, to be communicated and emphasised to staff and students through email lists and induction training for new students and staff. Some participants highlighted the need for mechanisms and systems for reporting any problems experienced. In addition to having a clear zero tolerance policy in relation to homophobic/biphobic/transphobic bullying, participants stressed the importance of this policy being monitored and enforced. Several participants noted the importance of action being taken by the appropriate person when complaints are made. Other participants underlined the importance of

treating any form of bullying or discrimination seriously by ensuring that there are consequences for people who exhibit discriminatory attitudes and behaviours, such as suspension from the college. In addition to ensuring that people who engage in discriminatory behaviour are sanctioned, a few participants mentioned the possibility of reprimands and disciplinary action for staff who standby while bullying or discrimination is perpetrated.

> *Proper implementation of a zero tolerance bullying or harassment policy. (Gay male, 26)*

> *More visibility of LGBTI-inclusive policies. (Transgender, queer, 31)*

Removing or curtailing religious influences

Several participants expressed the view that religious societies should be banned from expressing views that are anti-LGBTI or that attempt to negate or criticise LGBTI identities. While recognising that freedom of expression applies to everyone equally, it was also felt that some restrictions should be put in place to curtail speech or activities of religious societies that 'cross the line'. Some participants attended colleges or universities that were run by religious organisations or had a high religious involvement. Thus, they were of the view that universities and colleges should become independent of religious influences in its teachings and ethos. Others felt that these colleges should provide a better environment for LGBTI students by finding a way to embrace difference.

> *Universally condemn any university organisation that feels it has a religious mandate to denounce LGBTI students. (Gay male, 28)*

> *... when the religious societies crossed the line into public hate speech and slanderous poster campaigns, I believe the university could have done more to protect their LGBTI community. (Female, 22)*

Other comments

Just over 1% of those who responded (1.4%; n=11) did not provide an answer to the question while just over 3% (2.9%; n=23) indicated that they couldn't think or were not sure as to what improvements were needed. Around 5% of participants (n=42) commented on their experience of their college/university (such as not being out, not getting involved with LGBT society, experiencing bullying and so on) without offering any suggestions as to how it could be improved. 13% (n=106) of participants made positive comments in relation to their college/university experience, which

reflected the view that there was nothing to be improved upon. A very small number of participants (n=4) expressed the view that sexual orientation should be regarded as a 'non-issue' and should not be subject to special treatment or consideration. They felt that placing emphasis on LGBTI students and giving consideration to LGBTI identity differentiated the LGBTI students further and inhibited their identities from being normalised.

> *I didn't go to college to talk about my sexuality, it is about my education. Why should being gay be like a badge to be worn? A heterosexual never goes on about their sexuality. Why does everyone make such a big deal about LGBT sexuality? I think the whole LGBT movement have done us an injustice by sticking our sexuality in everyone's faces all the time. We are all normal people at the end of the day. There is no need to do anything. (Lesbian/gay female, 37)*

Discussion

Compared to both school (Chapter 4) and the workplace (results which follow in the next chapter Chapter 6), college/university rated highest in terms of LGBTI friendliness. There was a substantial difference in the LGBTI friendliness ratings of school and college/university, suggesting that college/university is a vastly improved experience for students who identify as LGBTI. This difference is further underlined when you consider that approximately three fifths of LGBTI students felt that they completely belonged in college/university, compared to one-fifth of LGBTI students who felt that they completely belonged in school. The lowest incidence of bullying in terms of setting was found for college/university (15.2% compared to 17.4% for workplace and 47.5% for school). In this study, approximately 15% of those aged 25 and under experienced LGBTI bullying. This compares to 10% of participants in a large survey of lesbian, gay, bisexual, transgender and questioning (LGBTQ) 16- 25 year olds in England (n=6,514), who reported that their time at university was affected by discrimination or fear of discrimination about their sexuality or gender identity, and 18% who reported being called names at university (Metro Youth Chances 2014).

In terms of the indicators of a negative college/university experience, such as skipping college/university and considering leaving college/university, the figures for both college/university and workplace are very similar, and are considerably lower than the figures for school experience. However, like school experiences, transgender and intersex participants had less of a sense of belonging within college/university compared to LGB participants, with intersex participants more likely to feel that they did not belong at all and transgender participants more likely to report that they felt

that they somewhat belonged. Similar to the workplace results in the next chapter (Chapter 6) transgender and intersex participants were significantly more likely to have experienced LGBTI bullying in college/university. This finding is corroborated by other research which shows, that relative to LGB students, transgender students experience greater harassment and perceive the college/university environment more negatively (Rankin *et al*. 2010; Garvey and Rankin 2015). There remains a lack of knowledge and understanding of the experiences and needs of transgender students in a range of areas, such as, healthcare and counselling, accessing bathrooms and changing rooms, and in conducting administrative tasks such as filling out forms and getting records changed, which may contribute to their more negative encounters in college/university (Schneider 2010). Some of the suggestions made by participants in this study in relation to improving the college/university experience for students identifying as transgender, included the availability of transgender-specific supports and transgender-friendly facilities, as well as making the process of changing gender on records easier.

Similar to the participants' recommendations in Chapter 4, the importance of having resources and supports for LGBTI people to avail of was highlighted by participants, with many signalling the importance of college/university being affirming, supportive and inclusive places for diverse sexual and gender identities. Research has found that identity-based spaces and spaces that foster diversity on campus, together with resources, networks and events, enable identity development and disclosure (Garvey and Rankin 2015; Preston and Hoffman 2015). The participants in this study also expressed a desire to see the discourse around sexuality and gender identity broadened to be more inclusive of minorities. Several commentators have noted the importance of challenging heterosexism and heteronormativity within college/university (Woodford *et al*. 2013; Preston and Hoffman 2015). Preston and Hoffman (2015) argue that even when a college/university strives to create a diverse and inclusive campus environment for students, this can be undermined by the subtle and persistent narrative of heteronormativity which pervades discourse and curricula, shaping interactions within the college/university. Thus, in line with participants' recommendations, training and education could be instrumental in creating awareness among college/university members of the subtle ways in which heteronormativity can operate and be reinforced.

CHAPTER 6

FINDINGS: LGBTI EXPERIENCES OF WORK

Introduction

Workplace studies on minority populations have largely neglected to focus on sexual and gender identity due to the largely invisible nature of these identities within the workplace (Ozeren 2014; McFadden 2015). What is available stems mainly from the US and UK and focuses almost exclusively on LGB identities. An integrative review of US research conducted in the 1980s and 1990s on the workplace experiences of LGB employees found that workplace discrimination was very prevalent, with several studies reporting rates of between 25%-66% (Croteau 1996). A subsequent review, on employment discrimination of LGB workers, reported similar rates (16%-68%) of discrimination during the mid-80's – mid-90s, with some evidence of a reduction in rates (15%- 43%) and a reversal in trend from the mid 90's onwards (Badgett *et al*. 2007).

However, a recent meta-analysis of workplace discrimination among LGB individuals from 1992 to 2009 shows that workplace discrimination and bullying has not abated significantly, with Katz-Wise and Hyde (2012) reporting that 25% of participants experienced discrimination. Research on workplace discrimination in the UK also supports US research indicating that LGB employees experience disproportionately more workplace discrimination and bullying than heterosexual employees (Fevre *et al*. 2009; Jones *et al*. 2011; Katz-Wise and Hyde 2012; Hoel *et al*. 2014). Of the LGBT participants who had ever been employed, in Mayock *et al*.'s. (2009) Irish study, 27% were called names at work, 15% had been verbally threatened and 7% had been physically threatened because they were LGBT. This pervasive discrimination exists in spite of legislation prohibiting discrimination on the basis of sexual orientation and gender identity.

Although transgender people have not featured in many of the workplace studies, the little research that does exist highlights employment as an area of life which causes significant difficulties for transgender people in terms of experiencing discrimination, with many employers inadequately prepared to address issues of gender identity or expression (Whittle *et al*. 2007; Davis 2009). Research from the US shows high rates of employment discrimination and harassment of transgender people in the workplace, with reported rates of workplace harassment of transgender participants being between 22%-31% (Badgett *et al*. 2007).

While the empirical research may be undermined to some extent by methodological limitations and variations in methodology and context (Kuyper 2015), McFadden (2015), who conducted a systematic review of literature on the careers and workplace experiences of LGBT workers, noted that the context of a large proportion of participants' experiences of the workplace was rooted in the fear and experience of prejudice at work as a consequence of being LGBT. The research also demonstrates that negative workplace environments, in which there is a lack of acceptance and bullying of LGBT individuals, can be psychologically distressing for these employees (Hoel *et al*. 2014). In addition, research shows that experiences of bullying and harassment in the workplace can result in LGBT employees' avoidance of colleagues and contribute to the decision to change jobs (Whittle *et al*. 2007; Sears and Mallory 2011). Witnessing homophobic discourse also prevents LGBT people from freely expressing their sexuality, leading them to be overly focused on identity management strategies, thereby distracting them from their work (Willis 2012).

This chapter explores participants' work experiences, both positive and negative. First, participants' ratings of their workplaces on an LGBTI-friendly scale are presented, along with figures related to their sense of belonging and experiences of positive affirmation. Next, data related to negative experiences participants had in the workplace, including bullying, are presented. Concluding this chapter is a presentation of open-ended responses with participants' recommendations for improving workplaces for LGBTI employees.

LGBTI-friendly rating, sense of belonging, and experiences of positive affirmation

About three-quarters of the participants (73.1%; n=1,538) were currently working in the ROI or had worked in the ROI within the past five years. Those who were working, or had worked in the past five years, were asked how LGBTI-friendly their workplace was on a scale of 0-10 (0='not at all LGBTI-friendly', 10='completely LGBTI-friendly'). In total, 1,512 participants responded to this question. The mean rating given was 6.56 (SD=2.81), with a range from 0 to 10. The most common rating was a 10 meaning 'completely LGBTI-friendly'. Less than 25% of participants rated their workplace as less than a 5 (or 'somewhat LGBTI-friendly'). More than 50% (n=832) of participants rated their workplace with a 7 or above. Gay males gave the highest ratings for LGBTI-friendliness of their workplace while intersex participants gave the lowest rating (Table 6.1)

Table 6.1: Mean LGBTI-friendly rating of workplace by LGBTI group

ALL LGBTI	L	G	B	T	I
M=6.56 (n=1,512)	M=6.44 (n=473)	M=7.00 (n=694)	M=6.00 (n=190)	M=5.86 (n=127)	M=4.46 (n=28)

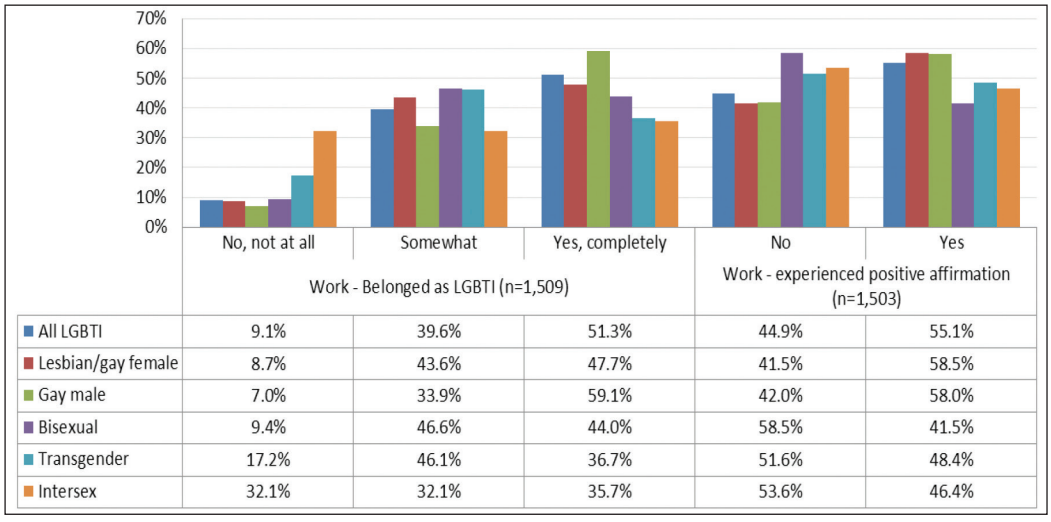
In terms of age, there was very little difference in the mean scores for LGBTI-friendliness (Table 6.2), with the 19-25 age group having statistically significantly lower ratings on the LGBTI-friendliness of their work place than those aged 26-45 years.

Table 6.2: Mean LGBTI-friendly rating of workplace by age group

All ages	14-18	19-25	26-35	36-45	46+
M=6.56 (n=1509)	M=6.58 (n=59)	M=6.08 (n=412)	M=6.86 (n=473)	M=6.83 (n=331)	M=6.42 (n=234)

Participants were also asked whether they felt they belonged in their workplace as an LGBTI person. Just over 50% (51.3%; n=774) felt they belonged completely and 39.6% (n=597) felt they belonged somewhat. Approximately 10% (9.1%; n=138) did not feel they belonged at all in their workplace as an LGBTI person. In addition, participants were asked whether they received positive affirmation of their LGBTI identity within their workplace. Just over half (55.1%; n=828) of the participants indicated that they received positive affirmation of their LGBTI identity within their place of work. Figure 6.1 provides a breakdown by LGBTI group.

Figure 6.1: Feelings of belonging and experiences of positive affirmation in the workplace by LGBTI group



	No, not at all	Somewhat	Yes, completely	No	Yes
	Work - Belonged as LGBTI (n=1,509)			Work - experienced positive affirmation (n=1,503)	
All LGBTI	9.1%	39.6%	51.3%	44.9%	55.1%
Lesbian/gay female	8.7%	43.6%	47.7%	41.5%	58.5%
Gay male	7.0%	33.9%	59.1%	42.0%	58.0%
Bisexual	9.4%	46.6%	44.0%	58.5%	41.5%
Transgender	17.2%	46.1%	36.7%	51.6%	48.4%
Intersex	32.1%	32.1%	35.7%	53.6%	46.4%

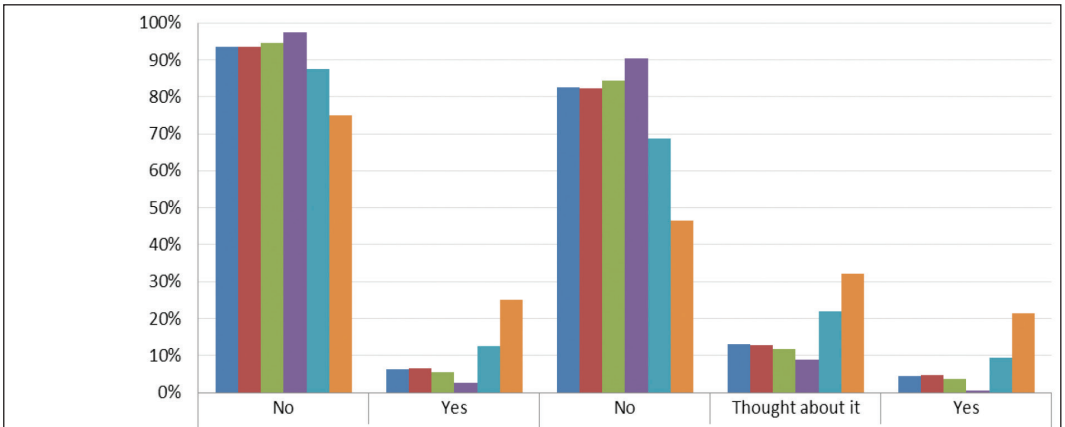
Pearson chi-square tests were conducted to see if there were any significant differences in feelings of belonging and experiences of positive affirmation in the workplace by LGBTI group and age group. Statistically significant differences were found across all variables.

- Gay participants (59.1%; n=408) reported the highest levels of feeling they completely belonged, followed by lesbian/gay females (47.7%; n=225). Intersex (32.1%; n=9) and transgender (17.2%; n=22) participants were more likely to report that they felt they did not belong at all compared to the other LGBTI groups (bisexual: 9.4%, n=18; lesbian/gay female: 8.7%, n=41; gay male: 7%, n=48).
- Bisexual participants (41.5%; n=78) were less likely to have received positive affirmation in their workplace compared to participants who identified as: lesbian/gay female: 58.5%, n=274; gay male: 58%, n=402; transgender: 48.4%, n=61; and intersex: 46.4%, n=13.
- In terms of age, the 19-25 age group (42.1%) reported the lowest levels of feeling they completely belonged in the workplace when compared to those younger (14-18 years: 55.9%) and older (26+ years: 53%-57%).
- A significantly lower proportion of the younger participants (14-25 years) reported receiving positive affirmation of their LGBTI identity (approximately 40%) compared to the older age groups (26+ years: 60-64%).

Negative work place experiences

Participants were also asked about whether they experienced or witnessed LGBTI bullying in their workplace. Approximately 17% (17.4%; n=263) had experienced LGBTI bullying and one in five (21.3%; n=321) had witnessed LGBTI bullying in their workplace. Just over 6% of the working sample (6.4%; n=97) reported that they missed or skipped work to avoid receiving negative treatment due to being LGBTI. While 82.5% (n=1,239) of the sample had never thought about leaving work due to the negative treatment they received because they are LGBTI, 13% (n=196) did consider leaving work and 4.5% (n=67) actually did leave work due to negative treatment. Figure 6.2 provides a breakdown by LGBTI group.

Figure 6.2: Negative experiences in the workplace by LGBTI group



	Work - missed or skipped to avoid negative treatment (n=1,508)		Work - left early due to negative treatment (n=1,502)		
	No	Yes	No	Thought about it	Yes
All LGBTI	93.6%	6.4%	82.5%	13.0%	4.5%
Lesbian/gay female	93.4%	6.6%	82.4%	12.9%	4.7%
Gay male	94.5%	5.5%	84.4%	11.9%	3.8%
Bisexual	97.4%	2.6%	90.5%	8.9%	0.5%
Transgender	87.5%	12.5%	68.8%	21.9%	9.4%
Intersex	75.0%	25.0%	46.4%	32.1%	21.4%

Pearson chi-square tests were conducted to determine whether there were any statistically significant differences on any of the workplace variables by LGBTI group. Statistically significant results were found for all variables.

- Intersex (35.7%, n=10) and transgender (24%, n=31) participants were significantly more likely to have experienced LGBTI bullying compared to gay male (18.6%, n=129), lesbian/gay female (15.9%, n=75) and bisexual (9.4%, n=18) participants. Intersex participants (44.4%, n=12) reported the highest level of having witnessed LGBTI bullying followed by gay male (22.8%, n=157), bisexual (22.5%, n=43), transgender (19.2%, n=25) and lesbian/gay female (17.9%, n=84) participants.
- Both intersex (25%, n=7) and transgender (12.5%, n=16) participants were more likely to have skipped work in order to avoid negative treatment related to their LGBTI identity compared to lesbian/gay female (6.6%, n=31), gay male (5.5%, n=38) and bisexual (2.6%, n=5) participants. Compared to the other LGBTI groups, both intersex and transgender participants were also more likely to have thought about leaving their employment, and also more likely to have quit work, as a result of negative treatment.

Pearson chi-square tests were also conducted to determine whether there were any statistically significant differences on any of the workplace variables by age group. No statistically significant results were found for witnessing LGBTI bullying. Statistically significant results were found for: experiencing LGBTI bullying; missing or skipping work to avoid negative treatment due to being LGBTI; and considering leaving work due to negative treatment due to being LGBTI.

- There was an age trend present in terms of negative experiences in the workplace with the older age groups reporting higher levels of negative experiences than the younger age groups.
- Compared to participants aged 14-25 years, those aged 46+ years were 13% more likely to have experienced LGBTI bullying within the work place, 6% more likely to have missed or skipped work to avoid negative treatment due to being LGBTI, and 7%-9% more likely to have considered leaving work as a result of negative treatment.

What would be the one thing you would do to improve your workplace the most for LGBTI staff?

In total, 569 participants suggested improvements to the workplace, yielding 622 comments for analysis. The analysis resulted in four themes and the number of responses for each theme is shown in table 6.3: staff awareness and education; promoting inclusion, diversity and equality; inclusive policies and challenging discriminatory practice and homophobic bullying; and affirming LGBTI identities.

Table 6.3: Themes related to improving the work place for LGBTI staff (n=622)

Theme	% (n)
Staff awareness and education	34.2% (213)
Promoting inclusion, diversity and equality	27% (168)
Inclusive policies and challenging discriminatory practice and homophobic bullying	20.7% (129)
Affirming LGBTI identities	18% (112)

Staff awareness and education

Many participants felt that training and education would increase awareness and understanding of LGBTI related issues in the workplace and foster knowledge, respect and support for diverse identities. They highlighted a number of topics which could be addressed through compulsory participation in educational workshops, seminars and orientation/induction for new staff, as well as informal discussions and meetings. These included LGBTI identities, in particular bisexual and transgender identities, transitioning, LGBTI parenting and families, LGBTI rights, and training in sensitivity, equality and diversity. It was felt that the workplace environment could be made safer for LGBTI staff by making employees aware of homophobic language and behaviours, the types of discrimination that exist, the policies that employers have in relation to discrimination and harassment, and by emphasising a zero tolerance approach to bullying.

> *Inclusion of training on, particularly, bisexual and trans identities for staff as would benefit workplace, individuals and feed into practice. (Lesbian/gay female, 29)*

> *Better awareness of staff around diversity and bullying and the laws that govern this area. (Gay male, 42)*

Education and training were identified as being required to raise awareness around homophobia and transphobia in the workplace. Participants felt that it was important that staff understand that derogatory or joking comments about LGBTI people

are not acceptable and constitute a form of bullying, and that they are more aware of the language and behaviours that contribute to homophobia and transphobia. Furthermore, it was felt that there should be greater awareness of the impact of negative comments related to LGBTI on those who identify as LGBTI. A couple of participants commented on the subtle and underlying homophobia that some colleagues convey through their attitudes and behaviours and highlighted the need to tackle latent forms of homophobia which exist in the workplace.

> *People just need to be more educated on homophobic attitudes and bullying, some of which is so subtle that people don't know they are doing it. (Lesbian/gay female, 28)*

Training was identified as relevant to all staff but in particular management and HR staff. There was a lot of emphasis in participants' responses on ensuring that managers have the education and training to enable them to adopt inclusive and sensitive approaches to personnel. It was felt that management should have knowledge of appropriate LGBTI terminology, a good grasp of the language and behaviours that constitute homophobia, be equipped to respond sensitively and appropriately to transgender people, have passed a mandatory diversity awareness course and take responsibility for ensuring that their staff understand LGBTI issues and bullying. In addition, it was felt that training should underline co-workers' collective responsibility to contribute to a positive atmosphere in the workplace.

> *I think training/information should be provided to all managers to understand the importance of diversity in the workplace and to help them recognise the significance of what counts as homophobic bullying. (Lesbian/gay female, 35)*

The role that LGBTI people themselves can play in educating co-workers was highlighted, although it was also acknowledged that a lack of confidence may deter people from challenging colleagues about their language or behaviour regarding LGBTI people in the workplace. Training specifically for LGBTI staff in the area of self-empowerment and disclosure was recommended by one participant.

> *Delivery of training to empower LGBTI staff to identify as such without being subject to vulnerability. Managing disclosure to clients appropriately and effectively. Increasing awareness, probable and possible outcomes associated with disclosure (Gay male, 34)*

Raising awareness of LGBTI through educational campaigns, by displaying posters and distributing leaflets which promote proper treatment of LGBTI people was also suggested as a way to improve the workplace.

"Have posters and leaflets regarding LGBTI people and staff and for other members of staff to read and get information on how to treat fellow LGBTI members of staff". (Lesbian/gay female, 23)

Participants also felt that training could create a greater awareness of LGBTI identities by challenging negative features of some workplaces environments, especially for LGBTI staff including a prevailing heteronormativity, assumptions of heterosexuality, stereotypes and misconceptions about LGBTI people, including the notion that LGBTI are a homogeneous group instead of a diverse group of people.

More awareness of LGBT staff, the assumption is that everyone is straight and a general awkwardness in talking about my private life can make me feel isolated at work. (Lesbian/gay female, 38)

Understanding that LGBTI people are as socially variegated as the rest of society and not from some "one size fits all" group. (Gay male, 39)

Some participants highlighted prejudices that exist against LGBTI people working with children and vulnerable adults, and felt that the assumption that LGBTI people shouldn't be working in these fields needs to be addressed. It was felt that these workplaces need to address this issue head on through open dialogue in order to create a better working environment for LGBTI staff.

Promoting inclusion, diversity, and equality

Many participants felt that the workplace would be improved by greater visibility and presence of LGBTI employees and LGBTI role models. It was acknowledged that LGBTI employees coming out would contribute to greater visibility. However, it was felt that the employers could promote greater visibility by hiring more LGBTI staff and promoting LGBTI employees to senior management. It was felt that this would send a positive message to LGBTI people within the workplace that their sexual orientation and/or gender identity is not an obstacle to recruitment or advancement.

Visibility and role models make things easier. (Bisexual female, 33)

In addition, many participants expressed the view that they would like to see a stronger LGBTI community and network in the workplace by having active social groups, support groups, sports groups and LGBTI safe places. Many participants expressed the view that routine work events should be more inclusive and reflective of LGBTI

employees by highlighting LGBTI events, having a LGBTI section in the noticeboard and staging staff night outs in LGBTI-friendly venues. With regard to the language within the workplace, many participants felt that it could be more inclusive with work function invitations being cited as one example.

> *An established and maintained LGBTI network for employees. (Lesbian/gay female, 22)*

> *More inclusive language in organisational communication. (Gay male, 60)*

It was also felt that employers could improve the workplace by promoting itself as LGBT-friendly and demonstrating support for LGBTI people by acknowledging and celebrating pride events and displaying rainbow flags in the workplace. Many participants expressed the view that employers should promote diversity and equality for all employees by running initiatives such as diversity day, equality day, and LGBTI awareness week or day. As well as public support for LGBTI people by the employer, participants felt that trade union support and a presence within the workplace would improve the work environment for LGBTI staff. Managers were singled out as having a particular responsibility for demonstrating and articulating support for LGBTI employees and ensuring that the work environment is LGBTI-friendly.

> *Make it obvious in the beginning that the place is LGBTI-friendly. (Lesbian/gay female, 24)*

> *Have the management make regular statements that it is a LGBT-friendly space. Have management actively show support of LGBT people i.e. rainbow flags on desk during pride week for example. (Transgender, bisexual, 31)*

Participants expressed the view that employers and managers should collaborate more with LGBTI staff to develop a support system and ensure that LGBTI employees are supported within the workplace. It was deemed helpful to have an LGBTI officer within the workplace and in-house counsellor as well as promoting external sources of support. A number of participants mentioned that gender neutral bathrooms would makes things easier for employees transitioning gender.

Inclusive policies and challenging discriminatory practice and homophobic bullying

In this theme, participants highlighted employer policies as important for providing a safe environment for LGBTI employees. Many participants highlighted the need for policies which clearly articulate a zero tolerance approach to homophobia, transphobia and discrimination of people based on their gender or sexual orientation identity. In order to aid the development and implementation of policies which protect LGBTI employees, it was mentioned that employers must be aware of LGBTI rights, their requirements under law, and that there must be increased organisational awareness of best practice in this area. Thus, participants placed the onus on organisations to adopt policies and measures which seek to prevent bullying and protect people from bullying where it occurs.

> *I think every company should outline their policies to new employees and state that discrimination due to an LGBTI identity won't be tolerated. (Transgender male, bisexual, 27)*

Some participants mentioned that the workplace environment would be enhanced if the employer was an equal opportunities employer, implemented equal opportunities recruitment and selection practices and ensured that there was no discrimination with regard to pay or promotions. In terms of recruitment, retention and promotion of staff, a few participants were of the view that employees who exhibit homophobic behaviours should not be retained or advance in the workplace.

Many participants also felt that policies should express explicit support for LGBTI employees. A number of ways of achieving this were suggested, including having a formal written statement endorsing equality and rights for LGBTI employees in the mission statement; signing up to a code of conduct, or stating it in the person's work contract. Many participants also expressed a desire for specific references to LGBTI within HR policies, handbooks, sexual harassment policies, policies concerned with life events and so forth.

> *Encourage employers to make positive statements, sign up to a code of conduct, include LGBTI references in staff handbooks, have welcoming statements, etc. (Gay male, 55)*

The need for inclusive policies, and policies that promote equality and diversity, were identified as being required to improve the workplace. Participants identified a need for clearly outlined protocols for transgender staff and those transitioning, to improve

the workplace. It was noted that the workplace environment could be improved by extending the same entitlements and considerations to LGBTI employees as those afforded to heterosexual couples and families with regard to parental leave, marriage leave, and partners being added to insurance policies. Thus, equitable treatment in the workplace was identified as important.

In addition to having policies in place, it was felt that a greater effort needed to be made to ensure that staff are aware that the policies exist and understand how they relate to LGBTI employees. It was also felt that management have a responsibility to emphasise and to reinforce the importance of staff adhering to policies and codes of conduct. Monitoring of homophobia and attention to the enforcement of policies were also cited as important. It was felt that negative comments about LGBTI people should be reported and there should be clear, accessible, timely and confidential way of lodging and dealing with complaints or issues that arise. Participants wanted to see procedures and frameworks to support LGBTI people who encounter difficulties with colleagues or customers in place. Finally, it was felt that there should be repercussions for staff who use homophobic/transphobic language or engage in this kind of behaviour. The importance of employers providing protection for LGBTI staff by having disciplinary procedures in place, and taking disciplinary actions where warranted, was underlined.

> *A clearly articulated, well promulgated and effectively enforced anti-homophobic bullying, language etc. policy. (Gay male, 26)*

Affirming LGBTI identities

Many participants commented on the need to change the culture from one where LGBTI identity and issues are regarded or treated as a taboo subject, to a culture of openness where being LGBTI is spoken about and addressed freely and openly. It was felt that a workplace characterised by openness would allow people to be more open to sharing personal information and would ensure that people do not feel prohibited or inhibited in talking about LGBTI issues or feel afraid to be open about their sexual orientation. In some participants' view, more discussion and chats around people's personal lives and LGBTI-related issues would improve the workplace as it would facilitate a greater awareness of and openness to LGBTI employees and affirm their identity. In addition, it was also felt by some participants that they themselves could contribute better to an environment of openness by being out, mentioning partners, highlighting LGBTI issues and so forth.

A greater openness about LGBTI issues - a culture of silence surrounding such issues is the biggest problem in my current workplace. (Gay male, 21)

Colleagues' recognition of LBGTI identity, by not assuming heterosexuality and by acknowledging partners, was identified as key to affirming the LGBTI identity within the workplace.

That there is recognition of same sex relationships that it isn't automatically presumed I have a husband/boyfriend etc. My boss knows I am a lesbian but has never asked nor referred to my partner in conversation ever! (Lesbian/gay female, 36)

Acceptance was cited by many participants as something that would improve the workplace for LGBTI people. Participants expressed a desire for work environments to be accepting of LGBTI, for it to be received positively, and for there to be no negative implications for how employees are treated in the workplace and their career progression. It was felt that positive affirmations of LGBTI identities in the workplace would indicate that the workplace is a safe and welcoming environment to be open about one's sexual orientation and signal to people that there is nothing to fear about coming out. In one participant's view, it would create an atmosphere conducive to being out and open and able to talk about partners. Work colleagues demonstrating support for the LGBTI community, being 'allies' and challenging homophobia in the workplace, was cited as important for affirming their LGBTI identity and giving reassurance to people about the acceptability of being out at work.

If management assured gay people that they would not lose their jobs if they openly lived who they are. (Gay male, 39)

Subtle remarks and jokes halted by LGBTI allies each and every time it happens and not just when they think there is an LGBTI person in the company or within earshot. (Lesbian/gay female, 46)

Participants felt that the workplace would be greatly improved if being LGBTI was not the subject of jokes and ridicule or spoken about in negative and pejorative terms by colleagues: *"No hurtful/harmful comments from staff and management"* (Lesbian/gay female, 17). In summary, participants felt that to have their LGBTI identity regarded positively, and to be spoken about in positive terms, would point to the positive affirmation of LGBTI within the workplace and would allow LGBTI employees to feel safe and confident to come out.

Other comments

A small proportion of participants made a number of comments that had no direct relation to the question asked (1.1%) or indicated that they did not know, or could not think (6.3%) of, anything to be improved. Almost one-fifth (17.5%) made affirmative comments in relation to their workplace, expressing the view that there was nothing to be improved. Almost one-tenth of participants (8.2%) commented on their experience of their workplace without offering any suggestions as to how it could be improved. A small proportion of participants (1.8%) expressed the view that they did not want any measures to be brought in because they did not want to experience differential or 'special' treatment on the basis of their sexual orientation.

> *Nothing, it was a professional environment for everyone and sexual orientation did not come into it. Also, I don't think that LGBTI people should have any special treatment in the workplace, just be treated that same as everyone else (Bisexual male, 19)*

Discussion

This chapter captures participants' positive and negative perceptions and experiences of their workplace. Compared to both school (chapter 4), and similar to the college/university (chapter 5), the workplace results rated positively in terms of LGBTI friendliness. Overall, the majority (90%) of the working sample felt they belonged in the workplace (51.3% completely belonged, 39.6% somewhat belonged) and experienced positive affirmation (55.1%). Less than 25% of participants rated their workplace as less than a 5 (or 'somewhat LGBTI-friendly').

A relatively underexplored area within research on workplace discrimination of LGBT employees is the experience and impact of witnessing expressions or actions of homophobia (Willis 2012). In a large scale community survey of lesbian, gay, bisexual, and transgender (LGBT) people in the EU more than two-thirds (66%) of participants employed within the last 5 years had some experience of witnessing negative comments or behaviour related to employee's perceived LGBT status (FRA 2013). In contrast, one in five participants (20%) in this study witnessed LGBTI bullying in their workplace, which is clearly an indication of a shift in workforce culture.

Similar to the findings of the aforementioned EU study (FRA 2013) which showed that 18% of LGBT employees in Ireland in the previous 12 months felt discriminated at work, or when looking for a job due to being LGBT, approximately one in six participants (17%) in the *LGBTIreland* study reported negative experiences and bullying related to their LGBTI identity. Again, this rate of 17% is significantly lower than the 33% reported

in McIntyre and Nixon's 2011 study involving 590 LGB employees in Ireland (McIntyre & Nixon 2014).

However, the *LGBTIreland* study demonstrates that LGBTI people are not a homogenous group. While the majority reported positive experiences, some LGBTI employees did not feel completely accepted and affirmed in their workplace. This was especially true for transgender and intersex participants who had a greater sense of not belonging, and the bisexual participants, who reported receiving the least positive affirmation. The difficulties encountered by transgender people at work have been well documented (Whittle *et al*. 2007; Davis *et al*. 2009; O'Sullivan 2013), while feelings of not belonging among bisexuals may be explained by their exclusion from both heterosexual and homosexual communities and their identities not being deemed legitimate and being subjected to stereotypes by some people (McFadden *et al*. 2015).

The figure for negative experiences and bullying rises from 17% for all LGBTI participants to 24% for transgender participants and 36% for intersex participants. Within the EU study, while 19% of LGBT participants from all EU countries had experienced discrimination, this rose to 29% for transgender employees (FRA 2013). High rates of harassment and discrimination against transgender people were also reported in a recent study of transgender people in Ireland. In *Speaking from the Margins*, transgender participants reported numerous incidents of both direct and indirect discrimination including workplace harassment and discrimination (14%), believing they had been unfairly turned down for a job (14%) and believing they had been unfairly fired, dismissed or laid off (9%) (McNeil *et al*. 2013). Higgins *et al*.'s. (2011) *Visible Lives* study on older LGBT people in Ireland also includes some narratives of transgender people's negative experience at work.

The *LGBTIreland* study also examined both quitting and avoidance as two of the potential strategies that people may adopt in response to bullying. There was a slightly lower incidence of missing work to avoid negative treatment in this study (6.4%; n=97) compared to Mayock *et al*.'s (2009) study of the LGBT population in Ireland (9.3%; n=98), although this may be due to methodological differences.[14] Just under a tenth (9.4%; n=12) of transgender participants in the *LGBTIreland* study reported leaving work as a result of negative treatment which is the same as reported by McNeil *et al*. (2013).

Overall, participants' qualitative comments and recommendations highlight the

14 The sample in Mayock *et al.*'s (2009) study included those who had ever worked, and did not limit the question to those who were currently employed or employed within the last five years.

importance of LGBTI affirmative practices which create an equitable and inclusive workplace environment for LGBTI workers. Being out and feeling accepted in the workplace are important determinants of job satisfaction, having positive relationships with colleagues and being productive. Conversely, negative work environments characterised by a lack of LGBT-friendliness contribute to stress, anxiety, a sense of isolation and a desire to leave (Griffith & Hebl 2002; Colgan *et al*. 2006). Though there are employers in Ireland who have adopted good practices which affirm respect for diversity in the workplace (O'Sullivan 2013), this study demonstrates that some LGBTI workers continue to struggle for acceptance in the workplace and this requires urgent attention, through the adoption of the affirmative and inclusive practices suggested by the participants in this study and elsewhere (McIntyre & Nixon 2014).

FINDINGS: MENTAL HEALTH SERVICES IN IRELAND

Introduction

As explored in Chapter 3, this study and previous research have consistently demonstrated that sexual and gender minority populations, including LGBTI individuals, experience poorer mental health outcomes compared to their heterosexual and cisgender counterparts. However, despite this research evidence of increased risk of mental health difficulties and the existence of closely connected research findings demonstrating LGBT individuals' high rate of mental health service utilisations (Bakker 2006; Cochran 2003; McGuire and Russell 2007; Stanley & Duong 2015; Tjepkema 2008; Williams and Chapman 2011), scholarship exploring LGBTI people's actual experiences of, and satisfaction with, mental health services is relatively limited. What is available indicates high levels of dissatisfaction (Avery *et al*. 2001; Page 2004; Ellis *et al*. 2015) with mental health services among LGBT individuals. Avery *et al*. (2001) found that 18% of sexual minorities (LGB) reported dissatisfaction with mental health services as compared to only 8% of heterosexuals (Avery *et al*. 2001). Ellis *et al*. (2015) also found a high level of dissatisfaction (33.8%) amongst their sample of transgender people, with Page (2004) reporting that bisexual people's ratings of mental health services were comparatively worse than those of their gay and lesbian equivalents.

Research conducted within health care domains other than mental health suggests that dissatisfaction with health care services may be related to experiences of discrimination in health services (Beehler 2001). For example, Grant (2010) found that 28% of the transgender participants in their study had experienced verbal harassment in a doctor's office and 19% reported being refused medical care altogether because of their transgender identity (Grant 2010). Whilst discrimination is certainly a pertinent factor, one of the most common themes consistently cited in the literature is the perception that minority sexual and gender identities are either pathologised or erased during interactions with mental health services and mental health service providers (Daley 2010; Golding 1997; Kidd *et al*. 2011; Lucksted 2004; Semp 2006). Ellis *et al*. (2015) reported that 29% of transgender participants felt that their gender identity was invalidated and deemed 'not genuine' by mental health service providers, who instead correlated their gender identity with the causation or symptom of their mental distress. Similarly, Eady *et al*. (2011) found that many of their bisexual participants also experienced negative judgemental behaviour and invalidation of their sexual identity from mental health service providers, with an overemphasis on their sexual

identity as the primary reason for their mental distress (Eady *et al*. 2011). It has been suggested that such negative encounters can, understandably, lead LGBT individuals to conceal their sexual and gender identity when attending mental health services, develop considerable mistrust towards mental service providers, and in some cases terminate their relationship with mental health service providers entirely (Liddle 1996; Tjepkema 2008). Newcomb and Mustanski (2010) found that the majority of LGBT participants in their study indicated that they felt compelled to conceal their sexual orientation or gender identity; a finding reiterated in an Irish study which found that 31% of participants were not able to discuss their LGBT identity with their mental health care provider and a further 20% were unsure (McCann and Sharek 2014). Further, logistical regression performed in Owen's (2007) study, in which 24% of participants felt they needed help for their mental distress but did not seek treatment, indicated that medical mistrust and the availability of an affirmative provider were factors which influenced the likelihood of participants seeking mental health care.

An additional factor of influence is LGBT people's reported perception that mental health service providers are not adequately informed or educated on LGBT specific issues or concerns (McCann and Sharek 2014; Adams *et al*. 2013; Ellis *et al*. 2015; Pitts *et al*. 2009; Sanchez *et al*. 2009; Taylor 2013). Grant (2010) also found that the extent of knowledge specifically about transgender people's concerns and needs was so limited that half of their study participants reported having to teach their providers about some aspect of their health needs as transgender individuals.

Given the evidentially high rates of mental health difficulties in the LGBT population, the fact that mental health service providers are the gatekeepers to gender identity treatment and transition services for transgender individuals, and that LGBT people appear to experience problematic interactions with mental health services, this chapter reports and discusses findings on two questions that participants were asked. First, participants were asked to identify barriers to accessing mental health services in Ireland. Secondly, participants were asked to make recommendations for improvement of mental health services in Ireland.

Barriers to accessing mental health services in Ireland

Participants were asked whether they felt there were any barriers to them accessing mental health services within the Republic of Ireland. Of the 2,122 participants to respond, 23.3% (n=495) indicated there were no barriers to them in accessing mental health services. The largest proportion of participants indicated that barriers were that 'private services are too expensive' (38.5%; n=816) and that they were afraid of the stigma of being labelled (29.2%; n=619). The view that services are not LGBTI-friendly

and cannot help was held by 18.9% and 17.7% of participants respectively. More than a quarter of participants either knew someone who had a bad experience of mental health services or had a bad experience themselves (27.1%) (Table 7.1).

Table 7.1: Barriers to accessing mental health services for the survey sample

Tick whether the following are barriers for you accessing mental health services in Ireland.* (n=2,122)	**% (n)**
There are no barriers.	23.3% (495)
Private services are too expensive.	38.5% (816)
I am afraid of stigma or being labelled.	29.2% (619)
I don't think the services are LGBTI-friendly.	18.9% (402)
I don't think the services can help me.	17.7% (375)
I know of people who have bad previous experiences.	13.7% (290)
I have had bad previous experiences.	13.4% (284)
Other	7.9% (167)

**Participants could choose multiple response categories.*

Pearson chi-square tests were conducted to determine whether there were any statistically significant differences on any of the barriers by LGBTI group. Significant differences were found on all variables.

- Both bisexual (37.5%; n=122) and transgender participants (35.1%; n=98) had higher proportions who reported being afraid of stigma compared to intersex (26.7%; n=12), gay male (26.7%; n=233) and lesbian/gay female (25.7%; n=154) participants.
- Both transgender (35.5%; n=99) and intersex (31.1%; n=14) participants were more likely to think that the services were not LGBTI-friendly compared to lesbian/gay female (18.5%; n=111), gay male (14.2%; n=46) and bisexual participants (14.2%; n=46).
- Gay males (8.6%; n=75) and lesbian/gay females (11.5%; n=69) had lower proportions who had previous bad experiences of mental health services compared to bisexual (19.4%; n=63), transgender (21.1%; n=59) and intersex participants (40%; n=18), while transgender (21.5%; n=60) and intersex participants (24.4%; n=11) were more likely to know of someone who had previous bad experiences

compared to gay male (9.7%; n=85), lesbian/gay female (13.2%; n=79) and bisexual (16.9%; n=55) participants.
- Higher proportions of intersex (35.6%; n=16), transgender (22.6%; n=63) and bisexual (21.8%; n=71) participants reported that they did not think the services could help them compared to lesbian/gay female (14.8%; n=89) and gay male (15.6%; n=136) participants.
- Gay males (34.6%; n=302) were less likely than the other LGBTI groups (Lesbian/gay female: 39%; n=234; bisexual: 41.8%; n=136; transgender: 43.4%; n=121; intersex: 51.1%; n=23) to report that the services are too expensive.

Pearson chi-square tests were conducted to determine whether there were any statistically significant differences on any of the barriers by age group. Statistically significant differences were found for: afraid of stigma; know of people who had bad experiences of mental health services; mental health services cannot help and private services are too expensive.

- Higher proportions of the youngest age groups feared stigmatisation (14-18: 41.1%; 19-25: 37.5%) compared to the three older age groups (26-35: 23%; 36-45: 21.1%; 46+: 17.5%).
- The younger the participant the more likely they were to report knowing someone who had previous bad experiences of mental health services (14-18: 17.9%; 19-25: 16.4%; 26-35: 13.6%; 36-45: 8.4%; 46+: 8.9%).
- The youngest age groups were also significantly more likely to perceive that mental health services cannot provide help to them (14-18: 28.8%; 19-25: 22.2%) compared to the older age groups (26-35: 11.9%; 36-45: 11.8%; 46+: 11.9%).
- The 14-18 age group (32.2%) and the 46+ age group (33.1%) were less likely to cite the expense of private services as a barrier compared to those aged 36-45 (38.5%), 19-25 (40.3%) and 26-35 (42.6%).

There was also an open-ended space for participants to identify other barriers to accessing mental health services in Ireland. In total, 252 survey participants provided open ended responses to this question, of which 37 participants stated they could not comment on the barriers as they had no experience of trying to access mental health services. In addition, 22 participants provided responses that did not provide enough information to be coded, with most simply stating that access was a problem. Thus, data was coded for 193 participants who together provided 217 comments on barriers to accessing mental health services in Ireland. The findings are described along two themes: systematic barriers and psychosocial barriers.

Systemic barriers

A significant number of people were concerned that due to a lack of training, mental health practitioners were not sufficiently aware of and understanding of LGBTI identities and the appropriate language and terminology to use. They were also of the view that mental health practitioners were lacking in knowledge about the issues and challenges that people identifying as LGBTI encounter in their daily lives. Some participants reported a lack of therapists with expertise in gender and LGBTI issues. Therefore, within this theme, most of the participants were of the view that they could not be assured of the service providers' sensitivity towards their minority status as a part of an LGBTI minority.

> *...in my short time engaging with counselling I found it unpleasant that it was often inferred or stated that my orientation was or could be or probably is how it is because I was abused. In this way, the services weren't LGTBI-friendly. (Bisexual female, 40)*

> *..I am a trained psychologist, and we received zero input on LGBTI issues during training. I would worry about the level of knowledge among HSE employees. (Bisexual female, 32)*

Indeed, a couple of participants' experiences of trying to access services resulted in failure, as healthcare professionals were unable to provide access to the help they required, and the participant could not identify a service either willing or able to meet their specific needs.

> *There are no psychiatrists willing to see me. I'm "too complicated" and they're "not equipped to deal with" me because I'm trans and depressed and anxious and [names a service] refuse to refer me for surgery until I have a psychiatrist letter which I cannot get because no psych will see me. (Transgender, non-binary, 25)*

Participants identified a number of barriers to accessing and attending mental health services, which exist at the service's operational level. In the first instance, participants reported that it is often unclear how and where to access mental health care. It was felt that services were not promoted and that the access points available to people are limited, as mental health services are only accessible through referral from a GP or through emergency services. In one participant's view such limited access routes to mental health care result in some people in need falling through the cracks and not receiving adequate treatment:

> *Currently, if you don't have a referral, your only option is to turn up to A & E where, let's face it, you won't be treated adequately to diagnose and treat the problem effectively or efficiently. (Gay male, 41)*

Exacerbating the issues around access was the urban-centric location, as well as the cost, of mental health services. The most frequent complaint among participants was that services were not locally available and involved travelling significant distances to avail of them. The restriction of services to specific catchment areas also served to prevent some participants from availing of the service geographically closest to them or the service that was most appropriate to their needs.

> *Mental health services in Ireland are underfunded and are lacking in many parts of the country. (Bisexual female, 27)*

Young people were particularly vulnerable in this regard due to their age (i.e. being under 18) and thus their reliance on their parents, primarily for reasons of consent but also because of the need for support and transport, to access services.

> *Because I'm young I would have to get parents' help. (Transgender male, heterosexual, 14)*

Participants described a number of additional systemic deficits which acted as further barriers to accessing adequate mental health care including: waiting lists which prohibited timely access to services; the lack of continuity of care and carer; the lack of quality care; poor follow-up; and the short-term nature of the help offered. Unsatisfactory interactions with mental health professionals in particular were cited as potential barriers which would discourage their engagement with mental health services in the future. These included experiences of homophobia, difficulties in building rapport with mental health professionals, and challenges in establishing a therapeutic relationship. Specifically, the dominant medical model of mental health care encountered was perceived by participants to apply an overemphasis on prescribing medication and to act coercively, as opposed to addressing the underlying issues and working in partnership with service users. This led some participants to assert that their care had not furnished them with the help that they needed and did not improve their well-being.

> *I tend to think these services rely too much on medication. (Lesbian/gay female, 27)*

> *Mental health is a service that is "done to you" instead of working with you. A bit heavy handed. (Gay male, 60)*

Psychosocial barriers

While the many systemic barriers highlighted posed significant challenges for participants, they also noted that they were further barriers at the individual level which would impinge on their accessing services. These included individuals' self-assessment and self-acceptance of their need to access mental health services, as well as their depleted confidence in receiving a beneficial outcome if they were to do so.

> *I always think my mental health isn't bad enough to need help. (Lesbian/gay female, 22)*

> *Going for help means accepting the severity of my mental health problems. (Gay male, 41)*

> *My issues are minor and the Irish health system is so dysfunctional there's no point in trying. (Other gender identity, queer, 45)*

However, by far the most prominent individual barrier cited was that of fear. Fear, whether grounded in the rational or irrational, was cited by participants as preventing them from taking the leap from wanting to access services to realising that desire. The comments below reflect how people's fears prevented them from opening up about their need for help.

> *I was too afraid to talk to anyone about what I was going through. (Gay male, 21)*

> *Too afraid to ask for help. (Queer/pansexual female, 18)*

Though the reasons for not wanting to disclose their need to access services to family and others was not always elaborated on, for those that did articulate their reasons, these most often related to not wanting to worry or be a burden to family.

> *I don't want to worry my family by alerting them to the fact I'm not feeling good. (Bisexual female, 20)*

A few participants also expressed fears about the consequences of accessing services. Fears of inappropriate and/or adverse treatments being foisted upon them, and the possible course of actions following disclosure of a mental health problem, deterred some participants from seeking help. In particular, participants expressed significant fears that their LGBTI status would be pathologised and thus attributed as the cause of the mental health problem.

> *Fear they will attribute my depression to my trans status and will instead focus on that, potentially implicating my access to healthcare related to my trans status. (Transgender male, bisexual, 28)*

A few participants also expressed concerns that disclosing a mental health problem would have negative implications for their family life and parenting. One participant was concerned that the stigma associated with mental illness would cast aspersions on their ability to parent, while another participant was fearful of the health services intervening to take their child into care.

> *I'm concerned that if I apply for adoption in later years, that any history of seeking help for mental health problems will label me as an 'unfit' parent. (Bisexual female, 32)*

> *I fear my child being taken into care. I fear the HSE. (Bisexual female, 47)*

Recommendations for improving mental health services in Ireland

In total, 1173 participants responded to this question, with 1037 participants providing 1163 suggestions for improving mental health services for the LGBTI community in Ireland. The recommendations are presented along two themes below: recommendations to redress the systematic barriers and recommendations to address the psychosocial barriers to access.

Recommendations to redress the systemic barriers

Many of the participants felt that in order to provide responsive, sensitive and quality mental health care to LGBTI people, mental health professionals needed education to address what was considered to be the pervasive lack of awareness and understanding about LGBTI people, and the challenges and issues which may impact on their mental health.

> *I think all professionals should appreciate how important and difficult some issues relating to LGBTI people can be and address them in such a way. I feel some dismiss some experiences if they themselves are comfortable with LGBTI people rather than viewing it from the patient's point of view. (e.g. I've been told by some professionals that "being gay" isn't a big issue anymore and "no one minds" when in fact I have and continue to experience negativity regarding my sexuality and this has a deep impact on my mental health, whether it's having comments/jokes made towards me, feeling uncomfortable to be myself in certain situations, being afraid to be affectionate with a partner in public or the fact I don't have the same rights in my own country as my straight friends do) These*

things matter to a LGBTI person and should be respected by mental health professionals/ GP's etc. (Lesbian/gay female, 37)

This was identified to be particularly the case for people who identified as bisexual and transgender.

Lack of awareness of specific LGBTI+ issues, especially for bisexual and trans people…I don't think there's any awareness of specific problems for bisexual people. There doesn't seem to be welcoming groups or targeted services. (Bisexual male, 27)*

Most mental health providers are extremely uninformed about trans people. This can make it difficult not only to access mental health support for transitioning, but makes it extremely challenging to get quality care for mental health co-morbidities (Transgender male, gay, 47)*

A change at a systemic level and in individual professionals' attitudes was cited by many participants as being needed in order to improve mental health services for LGBTI people. A large proportion of the participants identified the need to establish mental health services independent of religious institutions.

Take health/education facilities run by religious institutions back into the hands of the state. The state pays for them. They should control them also. (Gay male, 22)

It was also felt that the preconceptions of LGBTI identity held by professionals contributed to non-LGBTI friendly service provision. It was felt that eradication of these negative aspects of some professionals' attitudes would improve the services. In several participants' views, this required an attitudinal shift away from heteronormative assumptions and/or pathologisation of LGBTI identity towards the adoption of an open-minded, non-judgemental and positive approach. Participants wanted to see heteronormative assumptions of sexuality being disposed of and replaced with a normalisation of different identities, particularly within mainstream mental health service provision.

Have counsellors/others not presume that everyone is straight. Normalise different sexual orientations within existing organisations instead of having to go to specific groups. (Bisexual female, 18)

Similarly, participants rejected the pathologisation of LGBTI sexuality by some mental health professionals who linked it to the experience of abuse or who attributed it to the cause of their mental health problem.

> *Improve training so that therapists don't assume sexuality is an issue when it isn't, or attempt to pathologise it by linking it to parental abuse. (Lesbian/gay female, 18)*

Participants suggested increased education and training as a means of progressing attitudinal change and increasing mental health professionals' awareness and knowledge of LGBTI identities and the negative impact that social stigma, discrimination and exclusion can have on mental health well-being. Specific training topics identified included: non-binary identities; sexual identities that are not gay or straight; intersex and transgender identities; and non-discriminatory and inclusive practice. Some participants suggested that training be mandatory and that mental health services should be required to obtain LGBTI-friendly accreditation.

> *Make it compulsory for mental health service providers to pass LGBTI-specific training modules, involving in-person panel interviews, and make it illegal to offer mental health services without the necessary LGBTI-friendly accreditation. (Bisexual female, 39)*

It was strongly felt that any of the suggested improvements in services, professional training, and/or new initiatives should be developed in partnership with LGBTI people, to ensure that their needs and priorities were adequately incorporated and responded to.

> *Consult with LGBTI people, identify issues and needs and then focus services, based on this feedback. (Lesbian/gay female, 51)*

Participants suggested a number of possible improvements in the operational culture of mainstream mental health services which would, if implemented, ease access to mental health services for all, not just the LGBTI community. These included the need to: increase funding in order to make mental health services and resources more widely available; remove the current restricted availability of services by establishing service provision outside normal school/working hours; provide 24/7 services; and provide phone services with extended opening times. In addition, removing the requirement to access services according to catchment area and ensuring that people can access whichever service is closest to them, or most appropriate to their needs, were also highlighted.

However, while many people were happy to avail of mental health services as long as they were LGBTI-friendly and inclusive, others expressed a desire for services specifically provided for and focused on the LGBTI population. A number of the participants felt that more resources should be allocated to LGBTI groups and supports, especially in areas where there is evidential need, such as in the area of suicide and self-harm in the LGBTI community.

> *Allocate more funding to the mental health services for LGBTI people, based on the statistics around the growing levels of suicide and self-harm. (Lesbian/gay female, 33)*

> *Mental health services are completely under resourced in general, there's little or nothing on offer for LGBT people in the public health system. (Lesbian/gay female, 38)*

Many participants felt that there was a need to employ more mental health professionals with the right skills and knowledge to provide services to LGBTI people. Examples were of mental health professionals who could facilitate talk therapies and group support, for example, therapists who specialised in gender therapy. The employment of LGBTI mental health professionals was also advocated by a few participants as it was felt that they would receive greater understanding from peers.

> *Have LGBTI working within mental health services so they can talk and support people as they can connect and know how you might be feeling. (Lesbian/Gay female, 30)*

Participants identified a range of services that should be made available to LGBTI people, including counselling, psychotherapy, cognitive behavioural therapy (CBT), peer group support, social groups, positive transgender support groups, and self-help groups. In addition, some participants felt that services should be focused on mental health promotion and illness prevention and identified areas in which LGBTI people should receive education, such as, self-management of illness, self-esteem/assertiveness training, and mindfulness.

> *Start in schools and put supports for LGBTI people in there. Teach mindfulness to all kids from the start. Educate them about emotions and heartfelt expression. Teach diversity and acceptance. (Bisexual female, 36)*

To circumvent concerns which some participants highlighted in relation to confidentiality and anonymity, several means of accessing services that safeguarded these principles were suggested. Online services were deemed particularly useful for this purpose. Phone-based and text-based services were also viewed as having merit.

> *Set up a confidential listening service (both online and by phone, as some people may not want to communicate verbally) specifically for those who are LGBTI and need help or someone to listen. (Questioning/not sure female, 19)*

There were also specific concerns in relation to the processes that people who identify as transgender have to go through to access transition services. Participants deemed current requirements to be inappropriate because they delayed access to treatment. They felt that decisions regarding their access to transition services were made on the basis of the knowledge and opinions of the mental health professionals, rather than acknowledging the experiences and feelings of the transgender person. A number of mechanisms were suggested to address these concerns.

> *For trans individuals; streamlining the extremely aggravating process of getting treatment. Possibly incorporating a signed consent to speed the whole thing up for those who truly know and believe transitioning to be the right way to proceed and get better. Not wasting two years for so-called experts to make judgements on a scant hour long meeting, only prolonging things needlessly for those who don't fit comfortably inside expected boxes (even among trans people). (Trans woman, bisexual, 24)*

Recommendations to redress the psychosocial barriers

The participants' recommendations to redress the psychosocial barriers to accessing mental health services were strongly focused on removing the stigma associated with mental health difficulties, in addition to normalising LGBTI identities and easing the task of identifying appropriate, and LGBTI-friendly, services. Many of the participants felt that promoting the universality of mental health well-being could help reduce the stigma attached to mental health difficulties. A number of participants suggested ways of implementing mental health promotion including: more openness and discussion around mental health issues and help-seeking; positive attitudes towards help-seeking behaviours; changing the culture of pathologising distress and stigmatising people with mental health problems as dangerous; and reducing discrimination against people who access mental health services. In addition, it was felt that everyone should be given the skills and tools to manage and cope with mental health challenges such as meditation, confidence, self-esteem and mindfulness.

> *For more people to talk to one another and perhaps attend regular counselling sessions at least once or to be registered with the counselling service so that they know it is not as scary as they think it will be and if everyone is doing the same thing and looking after their mental health then there is no stigma to be applied. (Gay male, 21)*

A few participants were of the view that, in order to reinforce the universality of mental health, there should be a compulsory component to accessing services, such as regular check-ups. They also felt that services should be located beyond health service sites, being embedded within the community in places which people frequent, for example libraries, shopping centres, schools, workplaces, and primary care centres.

> *With a magic wand I would have a state medical service that removed all stigma by providing mental health check ins at intervals in people's lives the same way we vaccinate children etc. By that I mean, having every adult scheduled for a couple of chats a year and if they requested more help, anything from therapy to mentorship, that they would be referred. (Bisexual female, 41)*

> *Have a wide variety of mental and physical health practitioners under community group practice or wellness centres and covered by public and private health care schemes. Accessibility is paramount and mental health should be considered primary care. (Lesbian/gay female, 42)*

Such compulsory mental health checks were perceived to be particularly pertinent for young people as it offered them the opportunity to come in contact with services without having to be proactive about help-seeking or making it public knowledge. Indeed, one participant commented that it is important to create opportunities for young people to access support without being identified or singled out.

The need for public awareness and education about mental health and LGBTI people was also strongly identified by participants. It was suggested that the provision of education from a young age about LGBTI identities, devoid of Catholic-influenced thinking, could help to create more awareness of LGBTI, normalise it and promote coming out supports to young people. Schools, in particular, were again identified as being well placed to play a vital role in educating young people by facilitating LGBTI mental health campaigns, inviting LGTBI organisations to provide talks, and also by providing resources for young people to access mental health services.

> *Better education around "normalising" LGBTI in schools would prevent internalised homophobia, stigma and shameful thinking which leads to suicide/self-harm. (Gay male, 45)*

In terms of easing access to LGBTI friendly services, it was felt that more clearly mapped out access routes were required, in addition to increased promotion of LGBTI-friendly services. Suggestions for promoting such services included the launch of

a mental health campaign aimed specifically at LGBTI people, which could include the development of advertisements, and user-friendly listings, websites, service reviews by LGBTI people, and mobile applications. Participants also felt that services should provide literature that is LGBTI-supportive, friendly and inclusive and that information should be provided on a range of options in order to provide choice to LGBTI people. Other ways to ensure LGBTI-friendly services were to be as explicitly identifiable as possible, and included the suggestion that services display a visible quality assurance mark, such as a badge, rainbow stickers, flag, and/or LGBTI posters in buildings.

> *Campaign of awareness of the presence of services, particularly aimed at LGBTI people so if they feel they need to access services they will be more likely to seek help. (Lesbian/gay female, 32)*

> *Advertise in mental health service areas that the service is LGBTI friendly. Service areas to provide this in policy. There is little point in the Mental Health commission stating that services should be inclusive of LGBTI needs when the service don't inform the user that they are inclusive. (Gay male, 30)*

Other comments

Seventy seven participants felt they could not provide suggestions to improve mental health services for LGBTI people as they had no experience of services and were unaware of what provision is currently available, did not perceive any barriers or didn't know what improvements could be suggested. In addition, 30 participants gave responses that did not provide enough information to be coded, with most simply stating that services and accessibility should be improved. A further 29 participants provided responses that did not relate directly to the question. Many of these were focused on societal, political and policy changes that participants would like to see take effect in relation to greater acceptance and the advancement of equal rights.

Discussion

The study findings indicate that whilst over a fifth of participants (23.3%) reported that they experienced no barriers to accessing mental health services, the vast majority of participants identified a number of both systemic and psychosocial inhibitors to accessing mental health care. Interestingly, however, a large proportion of the barriers cited by participants were non-LGBTI specific. For example, participants reported the non-LGBT specific factors of cost (38.5%), and fear of being stigmatised or labelled (29.2%) for seeking the help of mental health services, as being primary barriers. Further, participants' qualitative narratives supported this quantitative trend with

many citing both systemic (i.e. cost, bureaucratic processes involved in accessing services, the lack of services in rural areas, the under-funding of services, and the biomedical underpinnings of psychiatry) and psychosocial barriers (i.e. stigma and fear) which are applicable across all sexual and gender identities and not just those of LGBTI people. The generic nature of the non-LGBTI specific barriers to help-seeking identified is also reflective of previous research conducted with LGBT populations (Green 2008; Shipherd 2010; Williams and Chapman 2011). Green (2008) reported that 60% of participants in their study endorsed one or more items related to stigma concerns and 55% endorsed one or more items related to fear of social consequences (e.g., "I thought I'd lose friends if I went for help"). Transgender participants in Shipherd's study (2010) reported barriers related to cost of services (42%), hearing about bad experiences from others (32%), not liking to talk about personal life (22%), not liking to talk in groups (22%), and not wanting to be put on medications (21%). Such generic barriers have been widely discussed both internationally and within the Irish context, reminding us to also view LGBTI people's mental health within a holistic framework which includes socio-demographic, socio-cultural, and socio-ecological factors.

It is noteworthy, however, that when results in *LGBTIreland* were analysed by age higher proportions of young people feared stigmatisation, reported knowing people who had a bad experience of mental health services and were more likely to perceive that mental health services could not help them. These findings are supported by Irish research into barriers to mental health help-seeking in young people. Doyle (2011) found that stigma and the fear of being judged was a major barrier to help-seeking among young people. In addition, young people had overwhelmingly negative perceptions of what they believed to be very formal mental health services and were largely unaware of more youth-friendly services in Ireland such as *Jigsaw*; an accessible support service for young people provided in a low-stigma setting (Doyle 2011). These findings suggest that there is a continued requirement to raise awareness of the types of support available to young people in distress in Ireland.

In addition to the generic barriers identified, participants also cited LGBTI-specific barriers to accessing mental health services. In particular, one of the most pertinent barriers was the fear that their sexual or gender identity would be pathologised and consequently, correlated to the causation of their mental distress. Such problematic assumptions about, and resistance to, non-binary complexities of sexuality and gender on the part of mental health providers have been repeatedly emphasised elsewhere (Daley 2010; Golding, 1997; Kidd *et al*. 2011; Lucksted 2004; Semp 2006; Taylor 2013). The potential consequence of such perceived and/or experienced pathologisation

of sexual and gender identities is that it further promotes mental health services as heteronormative, perhaps even homo-negative, bi-negative and trans-negative, spaces. Such a heteronormative culture may therefore make it extremely hard for LGBTI people to trust, and consequently disclose their sexual and gender identity to, their mental health service provider. As a result, LGBTI individuals may, for fear of a negative response, conceal their sexual and gender identity when interacting with mental health service providers, which may serve to exacerbate existing mental health difficulties (Beals *et al*. 2009; Frost *et al*. 2007; Pachankis *et al*. 2015).

In addition, alongside the pathologisation of their sexual and/or gender identities, participants also noted that mental health professionals lacked knowledge about LGBTI people and relationships, and in some cases demonstrated negative attitudes and behaviours towards them. The lack of knowledge and competence around transgender issue are particularly problematic, given that mental health services are the gatekeepers to services for transgender individuals who wish to transition. Such experiences are unfortunately not new and are reflective of previous international and Irish research that reported mental health professionals lacking knowledge and competence in this regard (McCann and Sharek 2014; Knight *et al*. 2014; Adams *et al*. 2013; Sanchez *et al*. 2009; Taylor, 2013).

Previous research has identified that mental health providers' attitudes and beliefs about LGBT clients affects the quality of service they offer (Berkman and Zinberg 1997; Caisango 1996; Cribben 1996; Friedman 1996; Garnets *et al*. 1991; Kalbac 1998; Thoreson *et al*. 1993) and may decrease the likelihood of a positive outcome from therapy (Bieschke *et al*. 2007; Gelso *et al*. 1995; Hardman 1997). It is therefore vital that health professionals be educated in LGBTI-specific issues and that education and training, as participants suggest, is mandatory, conducted in partnership with LGBTI individuals, and focus on the eradication of heteronormative assumptions and/or pathologisation of LGBTI identities. However, despite participants' recommendations and previous research, Rutherford *et al*. (2012: 904) argue that to date "explicit teaching on LGBT health is either not occurring or, at least, is not achieving widespread curricular integration at either the undergraduate or postgraduate level of medical and nursing training". Rutherford *et al*. (2012) also note that the relative inertia with regards to integration of LGBT content in curricula may be, at least in part, as a result of the limited existence of empirical investigation into this topic and the fact that there are extremely few evaluative studies examining the effectiveness of LGBT health education initiatives.

Outside of education and training, participants also felt that there was an explicit

need to develop targeted, LGBTI-affirmative initiatives in order to respond to the high incidence of mental health difficulties in the LGBTI population. Whilst some participants felt that up-skilling existing staff and increasing the employment of new, specialist, mental health professionals within mainstream services was sufficient, others felt that there was also a need to direct additional resources to LGBTI specific groups and supports; not least because the LGBTI community are regarded as having distinct needs and experiences that require LGBTI affirmative knowledge, skill, and competency, in addition to empirically supported LGBTI affirmative interventions. It was felt that such LGBTI-affirmative supports should be established with a definitive directive to reduce the rates of LGBTI mental health difficulties, especially with regards to self-harm and suicide. These recommendations may be grounded in the knowledge that whilst the effectiveness of LGBT-affirmative initiatives has not yet been empirically established, they do appear to increase LGBT people's satisfaction with mental health services. Specifically, the implementation of LGBT-affirmative therapeutic practice and spaces which embrace a positive view of LGBT identities and relationships, whilst also directly responding to the detrimental effects that heteronormativity, homophobia, bi-phobia and transphobia can have on the lives of LGBT people, appear to be particularly helpful to LGBT people (Bockting *et al*. 2013; Craig 2013; Lebolt 1999; Langdridge 2007). LGBT affirmative Cognitive Behavioural Therapy (CBT) has also received growing attention in recent years for its potential to improve the cognitive, affective, and behavioural minority stress processes that many LGBT people experience (Austin & Craig 2015; Balsam *et al*. 2006; Craig 2013; Pachankis *et al*. 2015). CBT's potential value is now also tentatively supported by empirical evidence from Pachankis *et al*. (2015) who found, in their study with gay and bisexual men, that LGBT adapted CBT treatment significantly reduced depressive symptoms and alcohol use problems, whilst also yielding moderate and marginally significant improvements in anxiety symptoms and past-90-day heavy drinking; outcomes which were generally maintained at follow-up. Nevertheless, it must be recognised that Pachankis *et al*.'s (2015) study is the only study of its kind to empirically suggest the effectiveness of an LGBT-specific intervention in reducing minority stress processes. Whilst there is a plethora of professional guidelines available to promote LGBT-affirmative practice, there remains a significant dearth of evidence on interventions that promote the translation of these guidelines into practice.

CHAPTER 8

MODULE ONE SUMMARY DISCUSSION

Summary

The six sections of module one (LGBTI experiences of well-being, mental health, school, college, work and mental health service) have, in their entirety, provided invaluable insights into the lives of LGBTI people in Ireland. Encouragingly, certain aspects of module one's study findings do suggest that LGBTI people are to some degree experiencing positive levels of happiness, acceptance and sense of belonging in some areas of their lives. In particular, in both the happiness and life satisfaction scales described in Chapter two, the majority of participants rated their levels of happiness and life satisfaction above the midway point of the scales. In addition, many participants recounted that there were proud of their LGBTI identity (n=348). Correspondingly, LGBTI people's experiences of college and work also appear to be improving. In relation to both college and work, the most common rating of LGBTI-friendliness was 10, meaning 'completely LGBTI-friendly'. Further, the majority of participants felt like they completely belonged in college/university (62.8%), that they received positive affirmation of their LGBTI identity in college/university (75.6%), and that they had not experienced LGBTI bullying in college/university (84.8%). Also encouraging is that an overwhelmingly majority of participants in this study had told somebody that they were LGBTI, with only 3.1% reporting that they had not told anybody. Further, the time delay between awareness/knowing and telling appears to be narrowing, with the youngest cohort demonstrating only a one to two year time delay between awareness/knowing and telling, in comparison to the longer time delays demonstrated by the older age cohorts. This suggests that it may be becoming easier for LGBTI people to publicly disclose their LGBTI identity, at least to some people.

Whilst these study findings are to be welcomed, the majority of study findings across the six sectors strongly indicate that some LGBTI people are still experiencing significant difficulties and distress in their lives. In particular, as outlined in Chapter three, the high rates of mental health difficulties, including depression, anxiety, self-harm, substance misuse (alcohol and drug), and exposure to worrying levels of discrimination/victimisation amongst the study sample, particularly within school years, are of notable concern. Consistently, across the various measures of mental health difficulties, a significant proportion of the study sample reported symptoms indicative of depression, anxiety, stress, and substance misuse. Further, 34% of

participants reported a lifetime history of self-harm, and one in five participants (21.4%) had seriously attempted suicide. Although it cannot be directly surmised from the study findings, it may nevertheless be postulated that such mental health difficulties may be informed, at least in part, by LGBTI people's continued exposure to victimisation, discrimination and harassment. Indicative of this postulation is that the vast majority of study participants (75.2%) reported that over their lifetime they had experienced being verbally hurt, with approximately one fifth of participants having experienced physical attacks, due to being LGBTI. However, although the findings reiterate the now predominant narrative, both internationally and in Ireland, that the LGBTI population can experience significant mental health difficulties and harassment, study findings strongly suggest that the incidence of mental health difficulties and harassment are certainly not homogenously experienced across each of the LGBTI communities, but instead appear to be strongly mediated by age, sexual orientation and gender identity. The cohorts which appear to be at particular risk within the LGBTI communities are those aged 14-18, and those who identify as intersex or transgender.

The younger age cohort of the study sample appeared to be experiencing significant levels of distress over and above their older age LGBTI counterparts. The rates of severe or extremely severe depression, anxiety and stress among the 14-18 years olds were 35%, 43% and 24%. When juxtaposed against the rates found in the *My World* survey, a general population study of 12-19 years which found rates of 8%, 11% and 5% respectively, it is surmised that LGBTI young people in Ireland are 4 times more likely to experience such mental health difficulties than their peers in the general population. It is also particularly noteworthy that over half (55%) of those aged 14-18 years had engaged in self-harm; a rate which is once again four times higher than comparable rates reported in studies examining the general population in Ireland, and three times more than the rates reported in the *My World* survey. Of still greater concern is that almost one third (31.9%) of the 14-18 year old cohort had seriously tried to take their own life.

In addition to the younger cohort, intersex and transgender participants were also identified as some of the most pertinently distressed cohorts within the LGBTI community. Study findings indicate that intersex participants, with high mean DASS scores for depression (m=21), anxiety (m=15.68), and stress (m=19.89) respectively, are consequently to be considered particularly at risk of developing significant mental health difficulties. This susceptibility to mental health difficulties is also reinforced by the study finding that intersex participants were more likely to have considered suicide and to have seriously attempted to take their own life. Similarly, the transgender

participants also demonstrated significant mental health vulnerability with the second highest mean scores across the three domains of the DASS-scale (16.02, 12.28, 15.81 for depression, anxiety and stress respectively), and high rates of reported self-harm, suicidal thoughts and serious attempts to take their own life, in comparison to their LGB counterparts. Following intersex and transgender participants' risk in this regards was the bisexual cohort of the study sample who also reported higher rates of self-harm and suicide thoughts as compared to their LG peers.

A possible determining factor behind the comparatively high rates of mental distress within the younger age, intersex and transgender cohorts of the study sample is the distinct exposure to discrimination, victimisation and bullying endured by these specific groups within the LGBTI community. Whilst all of the participants across the LGBTI community experienced high levels of victimisation and harassment, transgender and intersex participants reported comparatively higher rates of verbal, physical and sexual harassment. In the same light, the younger cohort of 14-18 year olds appeared to endure a particularly hostile experience within the school context. As described in the school chapter, just 25% (n=201) of the participants scored their school as a 7 or above on the LGBTI-friendliness scale, only one in five (20.3%; n=162) reported feeling they completely belonged in their school, half (52%; n=416) felt they somewhat belonged, less than half (43.7%; n=345) indicated that they received positive affirmation of their LGBTI identity within school, 47.5% experienced LGBTI bullying, and over two-thirds (67.3%; n=536) had witnessed bullying of other LGBTI people within their school.

At this stage with the current data available, the link between transgender and intersex people's mental distress and experiences of harassment can only be tentatively postulated rather than statistically proven. However, statistical inferences can be made in the younger age cohort between their experiences of LGBTI bullying and their mental health difficulties. Results indicate that those who had experienced LGBTI bullying in school (47.5% of those who are or were in school in the last five years) had statistically significantly higher scores on the depression, anxiety, and stress scales and lower scores on the self-esteem scale than those who had not experienced LGBTI bullying in school. They also had significantly higher scores on the alcohol use scale, indicating more problematic alcohol use and behaviours. Those who experienced LGBTI bullying in school were also 12% more likely to self-harm, 18% more likely to have seriously considered ending their life, and 19% more likely to have attempted suicide than those who had not experienced LGBTI bullying in school. These study findings strongly indicate that the social environment LGBTI people interact with significantly mediates their mental health outcomes.

Despite LGBTI people's increased risk of encountering mental health problems, the

vast majority of participants identified a number of both systemic and psychosocial inhibitors to accessing mental health care. Whilst some of the barriers cited were common to all people (lack of services, stigma, fear of being medicated), some LGBTI specific barriers were cited, including fear that their sexual or gender identity would be pathologised and consequently correlated to the causation of their mental distress, and a lack of knowledge and skill among staff to respond to the needs of LGBTI people in a non-discriminatory fashion.

Participants were asked for their recommendations for future development and progress in each of the six areas of LGBTI people's lives in Ireland. Interestingly, there was a consistency in the themes proffered by participants across all areas, these included recommendations for: visibility and normalisation of LGBTI identities; awareness and positive affirmation of LGBTI identities; and protection and support for LGBTI identities. This overlap of recommendations explicitly reiterates the strong mediating role which experiences of heteronormativity, rejection, victimisation, and harassment may have on LGBTI people's feelings of societal acceptance and sense of belonging and, in turn, their mental health outcomes and their willingness to publicly disclose their LGBTI identity. It is therefore argued that concerted efforts to dissipate heteronormativity, LGBTI harassment, and victimisation will promote a societal culture which is conducive to positive LGBTI-affirming experiences and practices, and subsequently to positive mental health outcomes for LGBTI people.

In an effort to further assess module one's study findings of perceived levels of heteronormativity and harassment, module two presents the study's findings on the attitudes and opinions of a nationally representative sample of the Irish public about LGBT people. Module two, therefore, validates some of module one's findings, and provides further data from which to construct timely, relevant, and rigorously informed recommendations for embedding a culture within Irish society which is genuinely supportive of LGBTI people.

CHAPTER 9

MODULE TWO: PUBLIC ATTITUDES TOWARDS LGBT PEOPLE

PUBLIC ATTITUDES TOWARDS LGBT PEOPLE

Introduction

Research has shown that attitudes within society can have a direct impact on the lives and experiences of LGBT people. However, little is known about the current perspectives of the general public on LGBT in Ireland. For this reason, this study aimed to assess attitudes towards, and perceptions of, LGBT people in a nationally representative sample of the Irish public. The general public's knowledge and understanding of intersex people was perceived to be too limited to ensure reliable responses. Consequently, based on the recommendation of the Steering Group, this module did not explore public attitudes towards intersex people. This chapter provides an overview of the methodology employed in module two, including the module aim, research design, data analysis and ethical considerations, a profile of the sample and the findings on public attitudes towards LGBT people.

Methodology

Aim

The overall aim of this module was to measure attitudes towards LGBT people in a nationally representative sample of the Irish public, with an emphasis on identifying homophobic, biphobic and transphobic attitudes.

Research design

This module employed a survey design to address its aim. A survey design was considered most appropriate as it allowed for the measurement of attitudes towards LGBT people in a large, national sample based on age, gender, class and geographic region.

Inclusion criteria

The inclusion criteria for the survey were any person living in Ireland, aged 18 years or over, and who fit within the nationally representative profile.

Data collection methods

In designing the survey, a number of previously developed instruments were reviewed

and considered (See Appendix 7). However, as none of the previously developed tools were considered suitable to answer the research objectives for this module, a questionnaire was developed by the research team. The questionnaire incorporated 39 statements regarding attitudes towards LBGT people, using Likert scales of 1 to 5 (1 meaning 'disagree strongly' and 5 meaning 'agree strongly'), and explored:

- Frequency of interaction with LGBT people
- Belief system about being LGB
- Belief system about being transgender
- Comfort with contact / proximity
- Sexual expression / affection of LGB people
- Acceptance of discrimination against LGBT people
- Tolerance of school bullying
- Education about LGBT issues within school
- Politics of being LGB and the equality agenda

The following demographic information was also collected: gender, age, social class, area/geographic region, working status, living arrangements, civil status, urban/rural, dependent children, and level of education achieved to date. Participants were also asked how frequently, if at all, they interact with people who are (a) lesbian, gay or bisexual and (b) transgender.

While the purpose of the module was to garner information on attitudes and behaviour towards the LGBT population as a whole, LGB and Transgender were separated throughout the survey, in order to ascertain whether attitudes differed towards each. The survey started on the question of education as a means of a neutral introduction to the topic before moving towards more sensitive statements. This was done in order to ensure that participants did not drop out of the survey before completion. The survey was administered through a telephone interview of approximately 15 minutes duration.

Validity

The survey was reviewed for face and content validity by the Steering Group. Face validity is the subjective extent to which the tool actually measures the concepts it intends to measure. Content validity is the extent to which each concept accurately captures all facets of the phenomenon it is aiming to measure.

Recruitment and sampling

In order to ensure that a nationally representative sample was achieved, the research team hired the market research company Red C to conduct the telephone interviews.

In order to ensure that the sample was as truly representative as possible, Red C used 'random digit dialling' – a technique that takes all publicly available phone numbers, and increments them by 1 in order to reach those households who are ex-directory. A mix of landline and mobile numbers was used to reflect the existing mix of mobile-only households, landline-only households and dual-phone households.

Sample size

In total, 1,008 telephone interviews were conducted. The margin of error on a representative sample of 1,008 was set at +/- 3%, with a confidence level of 95%, which means we can be 95% sure that the figures presented are within plus or minus 3 percentages points of the actual population figure. Quotas were set on age, gender, class and region, and the final data was weighted to known profiles to ensure that it was representative of the total Irish population aged 18+.

Data analysis

Basic frequencies were calculated for each statement. Responses were scored on a scale of 1 to 5, with more negative responses being given lower scores. For the Likert scale statements, response categories were combined into three overall categories: 'agree strongly' and 'agree slightly' were combined into a 'agree' category; 'disagree strongly' and 'disagree slightly' were combined into a 'disagree' category; and 'neither agree nor disagree' was left on its own. A small number of participants answered 'I don't know' or refused to answer each of the questions. These participants were removed from the final analysis.

Spearman rho tests were used to identify correlations between certain variables. Chi-square tests were also performed to examine whether there were any statistically significant differences by age group (18-24, 25-34, 35-44, 45-54, 55-64, and 65+); gender (male, female); frequency of interaction with LGB people (never, rarely, occasionally, frequently); and frequency of interaction with transgender people (never, rarely, occasionally, frequently) (See Appendix 8 for detailed results of statistical tests). The frequency of interaction variables were collapsed into two overall categories: 'never' and 'rarely' were combined into one category, and 'occasionally' and 'frequently' were combined into a second category.

Ethical considerations

Ethical approval for this module was received from the Research Ethics Committees of the Faculty of Health Sciences in Trinity College Dublin. All participants in the survey conducted by Red C were reassured that their responses would remain strictly confidential throughout the study. All data files were password protected and stored in

accordance with the Data Protection (Amendment) Act 2003.

Sample Profile

Gender, age group, social class, and region

In total, 1,008 interviews were conducted. The socio-demographic profile of the sample is shown in table 9.1. The sample was more or less evenly split between males (51.0%; n=514) and females (49.0%; n=494). Ages ranged from 18 to 65 and over, with 11% (n=111) in the youngest age group (18-24 years) and 16% (n=161) in the oldest age group (65+ years). In terms of social class, 14% (n=141) of participants were in the AB social class, 28% (n=282) in the C1 social class, 21% (n=212) in the C2 social class, 31% (n=312) in the DE social class, and the remaining 6% (n=60) in the F social class. The participants were spread throughout the country: 54.0% (n=544) were in Dublin or the rest of Leinster, 28.0% (n=282) in Munster, and the remaining 18.0% (n=181) in Connacht/Ulster.

CHAPTER 9

Table 9.1: Gender, age group, social class, and region of sample

Gender (n=1,008)	**% (n)**
Male	51.0% (514)
Female	49.0% (494)
Age group (n=1,008)	
18-24	11.0% (111)
25-34	21.0% (212)
35-44	21.0% (212)
45-54	17.0% (171)
55-64	14.0% (141)
65+	16.0% (161)
Social class (n=1,007)*	
AB	14.0% (141)
C1	28.0% (282)
C2	21.0% (212)
DE	31.0% (312)
F	6.0% (60)
Region (n=1,007)	
Dublin	28.0% (282)
Rest of Leinster	26.0% (262)
Munster	28.0% (282)
Connacht/Ulster**	18.0% (181)

**Social class is defined by the chief wage earner in the household and is broken down as follows: A = chief income earner's occupation is higher managerial, administrative or professional; B = Chief earner's occupation is intermediate managerial, administrative or professional; C1 = Chief earner's occupation is supervisory or clerical, junior managerial, administrative or professional; C2 = Chief earner's occupation is as a skilled manual work-*

er; D = Chief earner's occupation is as a semi or unskilled manual worker; and E = Chief earner's income is from casual or lowest grade work, this category also includes pensioners and others who depend on the welfare state for their income.

***Please note that Ulster only includes the three ROI– Donegal, Monaghan and Cavan.*

Employment status

Of the sample interviewed, nearly half were working full-time (45.2%; n=438), with a further 15.3% (n=148) working part-time. An additional 11.4% (n=111) were unemployed and 16.6% (n=161) were retired. The remainder of the sample was comprised of students (4.0%; n=39) and homemakers (7.5%; n=73) (Table 9.2). As is typical in a sample of this size, a small proportion declined to provide this information. Although the market research company did not use precisely the same categories as the Central Statistics Office in Ireland, some comparison can be drawn. About 10% more of the survey sample (60.4%; n=586) was working as compared to 50.1% of the general population. Nearly equal amounts were unemployed in both samples. There were 7% fewer students or pupils in the current survey (4.0%; n=39) as compared to the general population (11.3%) (See table 9.3).

Table 9.2: Employment status of sample

Employment status (n=970)*	**% (n)**
Working full time (30 hours or more)	45.2% (438)
Working part time	15.3% (148)
Unemployed	11.4% (111)
Home maker, housekeeper, house person	7.5% (73)
Full-time student	4.0% (39)
Retired	16.6% (161)

**This does not include the 37 people who declined to answer this question.*

Table 9.3: Employment status of survey sample compared to national population

	Employment status of module 2 survey (n=970)	**Employment status of population (CSO 2011)**
Working for payment or profit	60.4% (586)	50.1%

Student or pupil	4.0% (39)	11.3%
Looking for first regular job		0.9%
Looking after home/family	7.5% (73)	9.4%
Unemployed	11.4% (111)	10.8%
Unable to work due to permanent sickness or disability		4.4%
Retired from employment	16.6% (161)	12.7%
Other		0.4%

Civil status

Almost half (49.4%) of the sample were either married or in a civil partnership, with a further 8.9% (n=86) living as married/cohabitating. Almost 3 in 10 (29.6%; n=287) were single, with just over 1 in 10 (12.2%; n=118) widowed, divorced or separated (Table 9.4).

Table 9.4: Civil status of sample

Civil status (n=970)*	**% (n)**
Married/civil partnership	49.4% (479)
Living as married/cohabiting	8.9% (86)
Single	29.6% (287)
Widowed/divorced/separated	12.2% (118)

**This does not include the 39 people who declined to answer this question.*

Dependent children

Just under half the sample (46.7%; n=454) had dependent children (Table 9.5)

Table 9.5: Dependent children of sample

Dependent children (n=972)*	**% (n)**
Yes	46.7% (454)
No	53.3% (518)

**This does not include the 36 people who declined to answer this question.*

Living situation

One fifth of the sample (21%) was living in private rented accommodation. In total 60% were living in their own home, split equally between those who were paying off a mortgage and those who were not. Ten percent were living with their parents or in the family home (Table 9.6).

Table 9.6: Living situation of sample

Living situation (n=963)*	**% (n)**
Living in private rented accommodation	21.0% (202)
Living in council provided accommodation	6.4% (62)
Living in own home with a mortgage	29.9% (288)
Living in own home with no mortgage	30.5% (294)
Living in parents'/family home	10.5% (101)
Other	1.7% (16)

**This does not include the 45 people who declined to answer this question.*

Education level

As education level was not one of the quota variables used by Red C, the research team included a question on educational attainment in order to facilitate comparisons with other studies. Nearly half of the participants (46.3%; n=455) had completed third level education compared to 32.7% (n=321) who had finished upper secondary school. A further 16.1% (n=158) had achieved lower secondary level education, while 5% (n=49) in total had completed, or attained some level of, primary education (See table 9.7). Compared to the general population and CSO data from 2011, this sample was more highly educated, with just 5.0% (n=49) having primary education or less compared to 16.0% of the general population. Similar figures had completed third level education in both this survey (46.3%: n=455) and the general population (45.6%) (See table 9.8).

Table 9.7: Education level of sample

Education level (n=983)*	**% (n)**
Some primary education or less	1.1% (11)
Completed primary education	3.9% (38)
Completed lower secondary level (Intermediate/Group/Junior Cert, GCSEs)	16.1% (158)
Completed upper secondary level (Leaving Cert, A Levels)	32.7% (321)
Completed third level education (Diploma, Degree, Postgraduate Degree)	46.3% (455)

**This does not include the 25 people who declined to answer this question.*

Table 9.8: Education level of survey sample compared to national population

	Education level of module 2 study sample (n=983)	**Education level of population** (CSO 2011) (n=2,863,619)
Some primary education or less / Completed primary education	5.0% (49)	16.0% (456,896)
Completed lower secondary level	16.1% (158)	17.4% (499,489)
Completed upper secondary level	32.7% (321)	21.0% (601,498)
Completed education higher than upper secondary (diploma, technical courses, PhD, Masters, etc.)	46.3% (455)	45.6% (1,305,736)

Limitations and Strengths

When interpreting the findings, the following study limitations require consideration. Firstly, whilst the survey was designed using rigorous face and content validity methods, the questions have not been previously validated. Data was collected through the use of telephone interviews and it is impossible to tell the impact of the interview on people's responses, thus participants may have provided what they viewed to be socially desirable answers. In addition, participants' understanding of the questions asked was not explored. Consequently, there is no way of knowing if the questions were interpreted as intended by the researchers. The sample under-represents people with a lower level of education and does not explore public attitudes towards intersex people.

In all other respects, the sample is representative of the Irish population in terms of gender, age, social class, geographical region and working status. It is also, to our knowledge, the largest study to explore public belief systems about LGBT people, including their beliefs about discrimination, inclusive curricula, acceptance of public displays of affection by LGB people and the LGBT equality agenda.

Findings

Introduction

Public attitudes towards LGBT people are more than just aggregated individual opinions which occur in a harmless vacuum, but instead play a very real and influential part in determining the shape of, and experiences within, LGBT people's lives. For example, there is an iterative, interconnected relationship between positive public attitudes towards LGBT people and the establishment and implementation of LGBT favourable policies, laws, and legislation (Lax and Phillips 2009, Loftus 2001, Meeusen and Hooghe 2012; Riggle *et al*. 2010; Takács and Szalma 2011). Conversely, negative attitudes towards LGBT people can manifest into discriminatory behaviour, including restricted access to services, social ostracism, and verbal, physical and/or sexual abuse (Dermer *et al*. 2010). As previously discussed in module one, discrimination can result in significant negative emotional and psychological outcomes for LGBT people. In light of this, considerable research efforts have been undertaken exploring the various facets of public attitudes towards lesbian and gay (LG) people. Recent cross-European reports by the European Agency for Fundamental Rights (FRA 2008, 2009, 2011), the European Commission (EC 2008, 2009, 2012), and The Netherlands Institute for Social Research (Keuzenkamp 2011; Keuzenkamp and Bos 2007), all suggest that societal attitudes are moving towards higher levels of tolerance and acceptance towards same-sex couples and relationships in Europe. Kuyper *et al*. (2013), who utilised data from the European Values Study (EVS) and the European Social Survey (ESS) to map longitudinal changes in attitudes towards LG people, identified that Europe overall has become more tolerant towards LG people, evidenced by an 11 percentage point reduction in levels of rejection of homosexuality every nine years since the inception of the surveys in 1981. Kuyper *et al*.'s (2013) analysis also revealed that Europe is not only demonstrating increased tolerance towards LG people in relation to general or abstract contexts, but also within close quarter contexts, with the number of participants indicating that they would not want a gay neighbour falling from 40% in 1991 to 25% in 2008.

Ireland was defined by Kuyper *et al*. (2013) as 'relatively tolerant', alongside a group of jurisdictions, which included Great Britain, Northern Ireland, Austria, Czech Republic, Slovak Republic, Portugal and Italy. Within these 'relatively tolerant' jurisdictions, it was found that, whilst the majority of people think that gay men and lesbians should be allowed

to live their lives as they wish, between one-fifth and one-third of the population believe that homosexuality can never be justified and that they would prefer not to have homosexual neighbours.[15] Similarly, other research conducted in Ireland, albeit limited, identified similar findings to Kuyper *et al.* (2013). Morrison *et al.* (2005: 243) found that 46% of male undergraduate psychology student participants indicated that 'gay men should stop shoving their lifestyle down other people's throats', with 29% stating the same for lesbians. In addition, 24% of female participants indicated that gay men should stop 'making a fuss' of their sexuality, with 28% believing the same for lesbians. Recent data from Northern Ireland noted that between 2005 and 2011 negative attitudes have risen towards an LGB work colleague (14% to 22%), neighbour (14% to 27%) or person in a relationship with a close relative (29% to 42%) (ECNI 2012).

Contrasting public attitudes have also been reported in relation to specific cohorts of the population represented within the LGBT acronym. Herek *et al.* (2002) reported that heterosexual people articulated more negative attitudes towards bisexual men and women than towards gay and lesbian people. Eliason (1997) highlights that such findings may be informed by unique, stereotypes about and prejudices towards bisexual people, such as bisexuals are more "preoccupied with sex"; have more "flexible attitudes about sex" (Eliason 1997: 324); that "no one [is] really bisexual"; that the bisexual label is "a politically incorrect and unauthentic identity" (Weinberg *et al.* 2009: 270); and that people are either "gay, straight, or lying" (Dodge *et al.* 2008: 184). In relation to public attitudes towards transgender individuals, the comparatively high prevalence of transphobic hate crime across Europe, the UK and Ireland (McBride and Hansson 2010; McIlroy 2009; TENI 2014; Turner *et al.* 2009; Whittle *et al.* 2007) suggests that public attitudes towards transgender individuals may also be somewhat different to those expressed towards their LG counterparts. In Northern Ireland, 35% of participants to the ECNI (2012) expressed negative attitudes towards a transgender work colleague, with 40% stating that they 'would mind' if they had a transgender neighbour, and 53% stating that they 'would mind' if one of their relatives were to marry a transgender person. Grossman *et al.* (2006) demonstrated that public attitudes may even change in relation to Male to Female (MtF) and Female to Male (FtM) transgender individuals. Grossman *et al.*'s (2006) study of 31 MtF and 24 FtM youth aged 15–21, showed that MtF youth experienced earlier and more frequent prejudicial treatment than FtM youth (Grossman *et al.* 2006).

15 The researchers are aware of the sensitivity around language, and wish to note that the terms 'homosexuality' and 'homosexual' are the terms used in Kuyper et al.'s research.

Furthermore, as previously stated, public attitudes towards LGBT people do not happen or exist in a social or historical vacuum. There are innumerable mediating factors which may influence people's thoughts and opinions towards LGBT people and consequently account for differences in public attitudes. Several research studies have revealed that there is a positive correlation between contact with LGBT people and positive public attitudes towards LGBT people, a correlation which strengthens as contact becomes more frequent and bonds deepen (Barth and Parry 2009; Herek and Glunt 1993; McAlister *et al*. 2014; Mohipp and Morry 2004; Morales 2009). In addition to contact with LGBT people, younger age, higher levels of education, and ethnic minority status is associated with positive attitudes, while older age, lower or no education, and ethnic majority status has been consistently shown to predict more pronounced negative attitudes (Hayes and Dowds 2015; Jarman 2010; McAlister *et al*. 2014; Perry 2013; Pew Research Center 2006; ECNI 2012; Ellison *et al*. 2011; Loftus 2001). There are also gender differences in acceptance and support of LGBT people. Men are consistently identified as expressing more negative attitudes towards LGBT people, particularly towards bi/homosexual men and transgender people, than their female counterparts (ECNI 2012; Hayes and Dowds 2014; Herek 2002; Jarman 2010; Kite and Whitley Jr 1998; McAlister *et al*. 2014; Perry 2013; Willoughby *et al*. 2010). Finally, a particularly strong mediating factor correlated with negative public attitudes towards LGBT people is religious denomination (Fisher *et al*. 1994; Olson *et al*. 2006; Schulte and Battle 2004; Whitley JR 2009) or more specifically a religious denomination's degree of religious fundamentalism (Altemeyer and Hunsberger 1992; Hill *et al*. 2010; Hunsberger 1995; Kirkpatrick 1993; Laythe *et al*. 2002; Schwartz and Lindley 2005). There are of course other societal, contextual or national influences on people's attitudes towards LGBT people which are less discussed, such as a country's governmental policies, laws and legislation on LGBT rights, the religious, political and economic climate, the strength of LGBT civil movements, and emerging population changes whereby the proportion of older, more conservative generation is being surpassed with a younger, more tolerant population (Kuyper *et al*. 2013; Van den Akker *et al*. 2013).

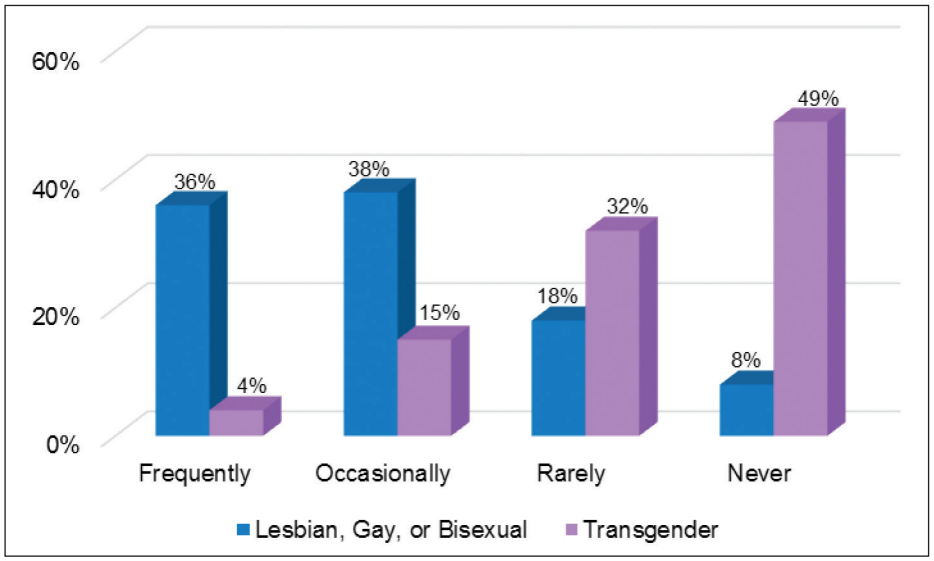
This module presents the findings from the survey on attitudes towards LGBT people within the Republic of Ireland. These findings are broken into a number of sub-sections by theme: frequency of interaction with LGBT people, belief system about being LGB, belief systems about being transgender, comfort with contact and proximity, comfort with public expressions of affection by LGB people, acceptance of discrimination of LGBT people, tolerance of school bullying, education about LGBT issues within schools, politics of LGBT issues, and equality agenda.

Frequency of interaction with LGBT people

Participants were far more likely to report interacting with LGB people compared to transgender people. Nearly three in four (74%) participants had frequent or occasional interaction with LGB people compared to just 19% who had frequent or occasional interaction with transgender people. While just 8% of the sample had never interacted with an LGB person, nearly half had never interacted with a transgender person (Figure 9.1). These findings might be related to the fact that there are more LGB people in the population or that LGB people are more out and visible.

The frequency of interaction variable was re-coded, with 'occasionally' and 'frequently' combined into one category and 'rarely' and 'never' combined into another category. Younger people (18-34) were more likely to have frequent/occasional interaction with LGB people when compared to older participants (65+). Female participants were 7% more likely than male participants to have frequent/occasional interaction with LGB people. However, there were no statistically significant differences for frequency of interaction with people who are transgender.

Figure 9.1: Frequency of interaction with LGBT people

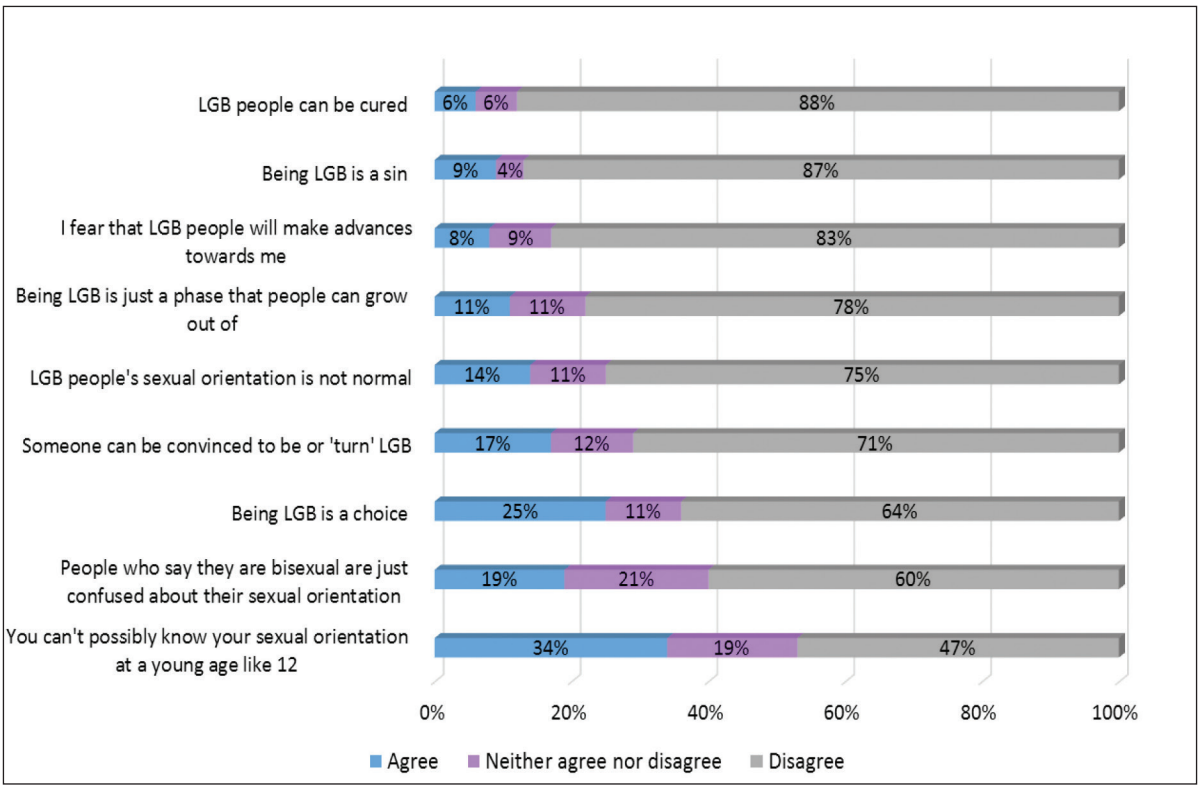


Belief system about being LGB

Participants were asked to rate their level of agreement with seven statements that were designed to capture their beliefs about being a LGB person. Positively, three out of four participants believe that LGB people's sexual orientation is normal. In addition, the majority of participants do not believe that being LGB is a choice, and believe it is a sin, a phase that the person is going through, something that can be cured, or something that someone can be convinced to be. However, there are still a number of people who are of the view: that being LGB is a phase that people will grow out of (11%); that someone can be convinced to be, or 'turn', LGB (17%); and that being LGB is a choice (25%). Less than one in ten participants (8%) fear that LGB people will make advances towards them (Figure 9.2).

In relation to bisexuality, greater proportions tended to believe that bisexual people are just confused about their sexual orientation, with one in five (19%) participants being of that view, and another 21% neither agreeing nor disagreeing that bisexual people are just confused about their sexual orientation (Figure 9.2).

Figure 9.2: Belief system about being LGB



In relation to age of awareness of sexual orientation, one in three participants (34%) did not believe you could know your sexual orientation at a young age like 12, suggesting it is a relatively common belief. This view is not in line with findings from module one of this study, and *Supporting LGBT Lives* (Mayock *et al*. 2009), which both found that the most common age of awareness of sexual orientation was 12 years of age.

A chi-square analysis of the impact of age, gender and frequency of interaction on responses revealed some statistically significant findings. Age was a significant factor on two statements. Slightly lower proportions of older people disagreed with the statement that 'being LGB is a sin'. 25-34 year olds agreed most often with the statement (13%) compared to the other age groups which ranged between 6%-10% in agreement. Older age groups (55+) tended to agree that 'LGB people's sexual orientation is not normal' more than younger age groups.

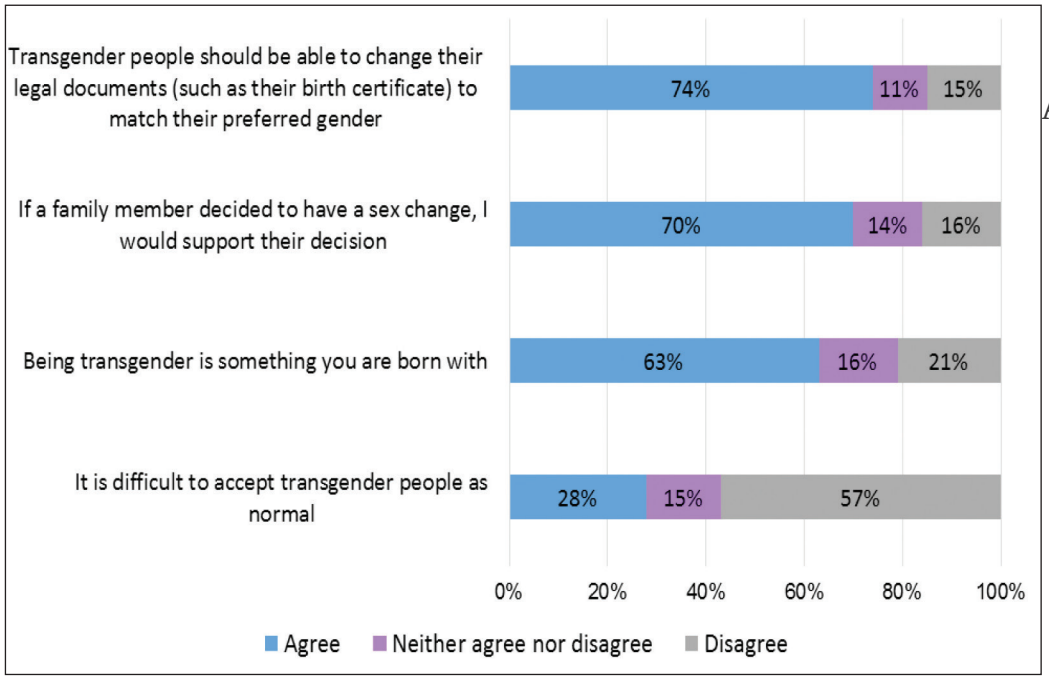
Gender was found to be statistically significant on 7 of the 9 statements related to belief system about being LGB. In all cases, female participants were significantly more likely to hold positive views towards LGB people and their sexuality. There were no significant differences in terms of gender and whether people believed that 'being LGB is a sin' or 'people who say they are bisexual are just confused about their sexual orientation'.

Frequency of interaction with LGB people was found to be significantly correlated with 8 of the 9 statements on beliefs about LGB people. The only exception was on the statement, 'you can't possibly know your sexual orientation at a young age like 12', in which there were no statistical differences by frequency of interaction with LGB people. In all other cases, those who rarely/never interacted with LGB people held less positive views towards LGB people compared to those who frequently or occasionally interacted with LGB people.

Belief system about being transgender

Participants were asked to respond to four statements on transgender issues. Although 63% of the sample agreed that 'being transgender is something you are born with', 21% disagreed and 16% were unsure. While approximately one in four participants (28%) felt it was difficult to accept transgender people as normal, nearly 60% disagreed with this statement. Positively, seven out of ten participants reported that they would support a family member if they decided to have a sex change. The majority of participants (74%) also agreed that transgender people should be able to change their legal documents to match their preferred gender (Figure 9.3).

Figure 9.3: Belief system about being transgender



A

chi-square analysis of the impact of age, gender, and frequency of interaction on responses revealed some statistically significant findings. There was an age difference on only one statement. Interestingly, those 55+ were more likely to agree that 'being transgender is something you are born with'. In the youngest age group (18-24), just 46% of people agreed with this statement compared to over 70% of those aged 55+. Gender was a significant factor on all four statements, with females 5-15% more likely to hold positive views towards transgender people than male participants.

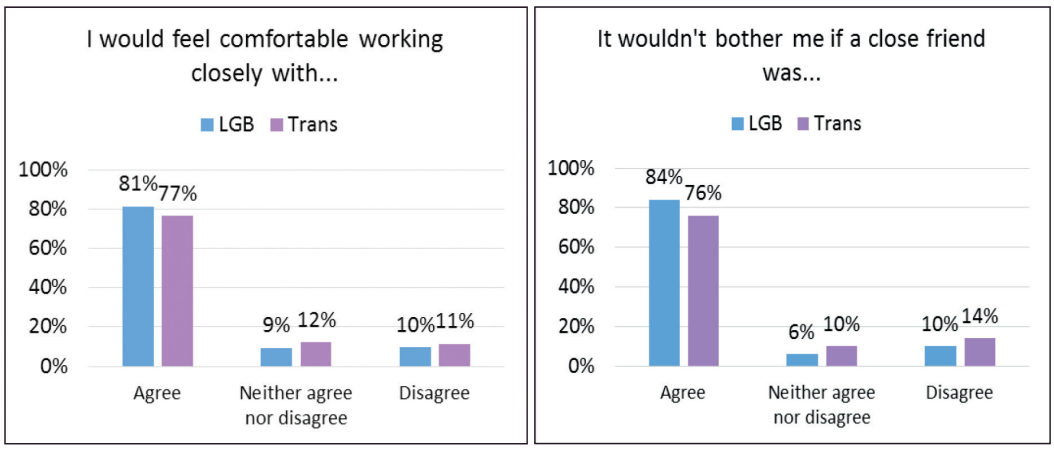
Participants who frequently/occasionally interacted with LGB people were between 10-25% more likely to hold positive views towards transgender people than those who rarely/never interacted with LGB people. Participants who frequently/ occasionally interacted with transgender people held a significantly more positive view towards LGB people on three of the four statements, with the exclusion of the statement 'being transgender is something you are born with'.

Comfort with contact/proximity

Participants were asked to agree or disagree on a series of four statements involving their comfort with various levels of contact/proximity with LGB or T people. They were asked how comfortable they would be working closely with someone who is LGB or T, having a close friend who is LGB or T, having their son or daughter taught by someone who is LGB or T, and having a son or daughter who was LGB or T.

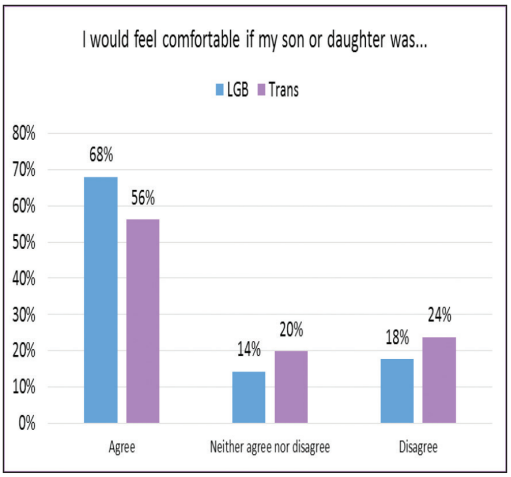
Positively, approximately 80% of participants reported that they would be comfortable working closely with a person who is either LGB (81%) or transgender (77%) (See figures 9.4 & 9.5). The responses become slightly more disparate when related to a close friend, with 84% reporting that it would not bother them if a close friend was LGB and 76% saying it would not bother them if a close friend was transgender.

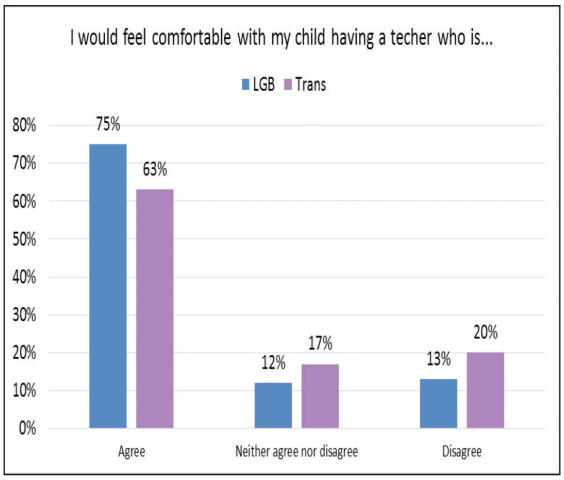
Figures 9.4 and 9.5: Comfort working closely with, and having a close friend who is, LGB or T



While nearly 70% of participants reported that they would feel comfortable if their son or daughter were LGB, just 56% reported they would feel comfortable if their son or daughter were transgender (See figures 9.6 and 9.7). Participants were also more likely to report that they would feel comfortable with their child having a teacher who is LGB (75%) compared to a person who is transgender (63%).

Figures 9.6 and 9.7: Comfort with a son/daughter who is LGB or T and comfort with child having a teacher who is LGB or T





A number of factors could explain the differences in rates of reported comfort. Firstly, people are less knowledgeable and understanding about what it means to be transgender; therefore, they might hold common misconceptions about this. Secondly, people might have concerns about the challenges their son or daughter might face as a transgender person in today's society, especially around transphobia, discrimination, access to health care and legal equality.

Participants were also asked if they agree with the statement, 'I can't help but feel uncomfortable in the company of LGB people'. Three-quarters of participants (76%) disagreed, while 14% did agree that they can't help but feel uncomfortable in the company of LGB people. A further 10% neither agreed nor disagreed.

A chi-square analysis of the impact of age, gender and frequency of interaction on responses revealed several statistically significant findings. Age was found to be a significant factor on 5 of the 9 statements: working closely with someone who is LGB, comfort with child having a LGB or T teacher, and comfort if son/daughter were LGB or T. Just 4% of those aged 55-64 felt that they would not be comfortable working closely with someone who is LGB compared to 6%-11% of those aged 18-44. 14% of those aged 45-54 and 65+ felt that they would not feel comfortable working closely with someone who is LGB.

The youngest age group (18-24) was between 14-15% more likely to agree that they would feel comfortable with their child having a LGB or T teacher when compared to the oldest age group (65+). The youngest age group (18-24) was between 22-24% more likely to agree that they would feel comfortable if their child were LGB or T when

compared to the oldest age group (65+).

Age did not impact on whether it would bother the participant if a close friend told them they were LGB, feeling uncomfortable in the company of LGB people, working closely with someone who is transgender, or having a close friend who is transgender.

Gender was found to be a significant factor on 8 of the 9 statements, with females 10-14% more likely to hold positive views on comfort with contact/proximity towards LGBT people. There was no difference by gender on 'I can't help but feel uncomfortable in the company of LGB people'.

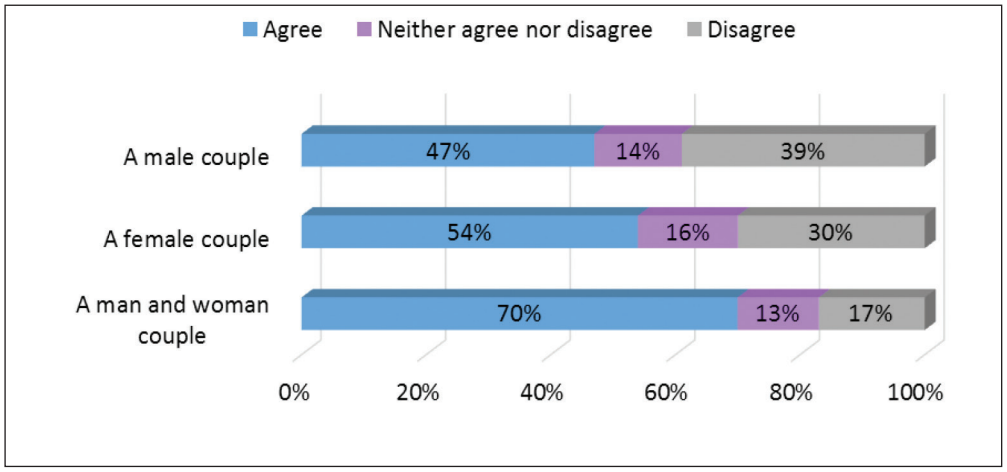
People who frequently/occasionally interacted with LGB people were more likely to have significantly more positive responses on all of the statements. People who frequently/occasionally interacted with transgender people were more likely to have significantly more positive responses to 7 of the 9 statements.

Sexual expression/affection of LGB people

Participants were asked to respond to four statements about their comfort with sexual expression and affection. The sample was nearly evenly split between those who agreed (38%) and disagreed (41%) with the statement that 'people should keep their sexuality to themselves', with the remaining 21% neither agreeing nor disagreeing.

Participants were also asked about their comfort with three different types of couples kissing in public: a man and a woman, two women, and two men. Findings indicate that comfort levels decrease around displays of same-sex affection, with a greater percentage of participants indicating discomfort with a male couple kissing (39%), compared with a female couple kissing (30%) or a heterosexual couple (17%) kissing in public (Figure 9.8).

Figure 9.8: Comfort with different types of couples kissing in public



Responses towards the statement 'people should keep their sexuality to themselves' and comfort with couples kissing in public were correlated using Spearman's rho: a male couple (r=.40), a female couple (r=.31), and a male and female couple (r=.15). The r values indicated a weak to moderate, yet positive statistically significant, relationship between the variables. This means that the more likely a person was to agree that people should keep their sexuality to themselves, the less likely they were to feel comfortable with the various types of couples kissing in publics. Participants who disagreed that people should keep their sexuality to themselves were:

- 41% more likely to report they would be comfortable with a male couple kissing in public;
- 32% more likely to report they would be comfortable with a female couple kissing in public; and
- 17% more like to be comfortable with a male and female couple kissing in public.

There were statistically significant age differences for all statements. The older the participant, the more likely they were to agree that people should keep their sexuality to themselves. The younger the participant, the more likely they were to agree that they are comfortable with a man and woman couple, a female couple, and a male couple kissing in public.

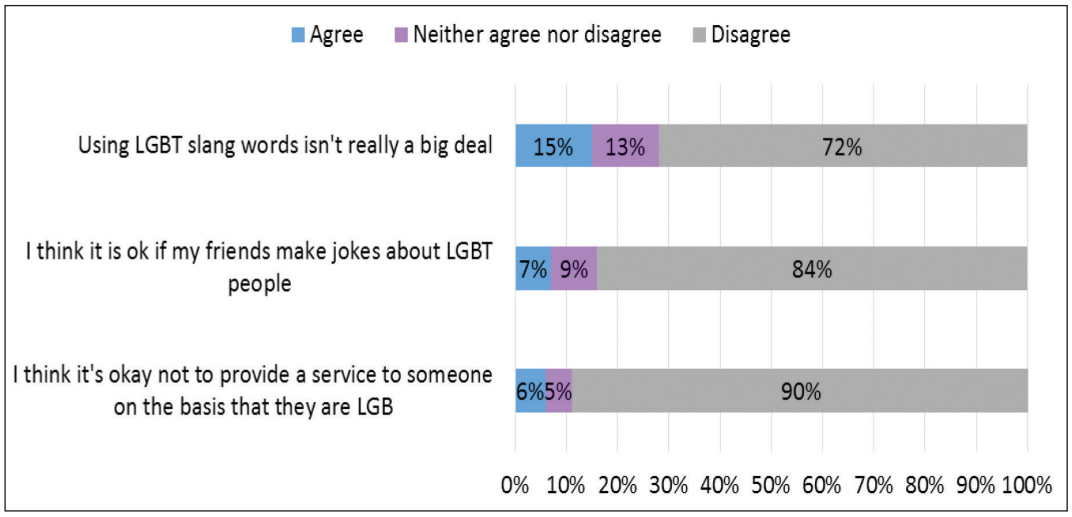
Female participants were more likely than male participants to disagree that people should keep their sexuality to themselves. Male participants were more likely than female participants to disagree that they are comfortable with a male couple kissing in public.

Participants who rarely/never interacted with LGB people were more likely to agree that people should keep their sexuality to themselves. Participants who frequently/occasionally interacted with LGB people were more likely to agree that they are comfortable with a man and woman couple, a female couple, and a male couple kissing in public. Those who frequently/occasionally interacted with transgender people were more likely to be comfortable with a same-sex couple, male or female, kissing.

Acceptance of discrimination against LGBT people

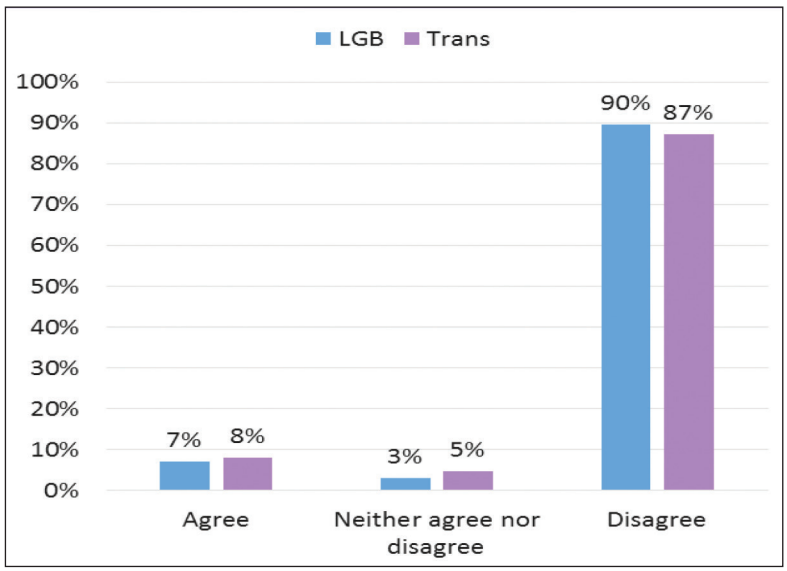
Positively, there were a large number of participants who did not believe that it was acceptable to discriminate against people on the basis of sexual orientation or gender identity. The vast majority (90%) did not think it was 'okay not to provide a service to someone on the basis that they are LGB', with just 6% of participants feeling it was ok. Similarly, there was a high level of non-acceptance around LGBT-focussed jokes, with just 7% of participants thinking it was 'okay if their friends make jokes about LGBT people' compared to 84% who disagreed. However, a slightly higher percentage (15%) thought that using LGBT slang words 'isn't really a big deal'; suggesting that there is a small cohort who may not be aware of the negative effects of such slang on LGBT people's identity and self-esteem (Figure 9.9).

Figure 9.9: Acceptance of discrimination against LGBT people



The vast majority of participants also disagreed with the statement that 'it is okay not to employ someone on the basis that they are LGBT.' Rates of agreement were found to be nearly identical for LGB and T, with slightly greater amounts of people disagreeing for LGB (90%) than transgender (87%) (Figure 9.10).

Figure 9.10: Views on whether it is okay not to employ someone on the basis that they are LGB or T



Age was a significant factor on 2 of the 5 statements. Interestingly, both the youngest (18-24 years: 11%) and oldest (65+ years: 13%) age groups were more than twice as likely as those in the middle (25-64) to agree that 'it's okay not to employ someone on the basis that they are LGB'. Those between 25-64 years agreed only 5-6% of the time. The older a participant was, the less likely they were to disagree that 'it's okay not to provide a service to someone on the basis that they are LGB'.

Female participants were significantly less likely to agree with two of the statements: 'I think it is okay if my friends make jokes about LGBT people' and 'using LGBT slang words isn't really a big deal.'

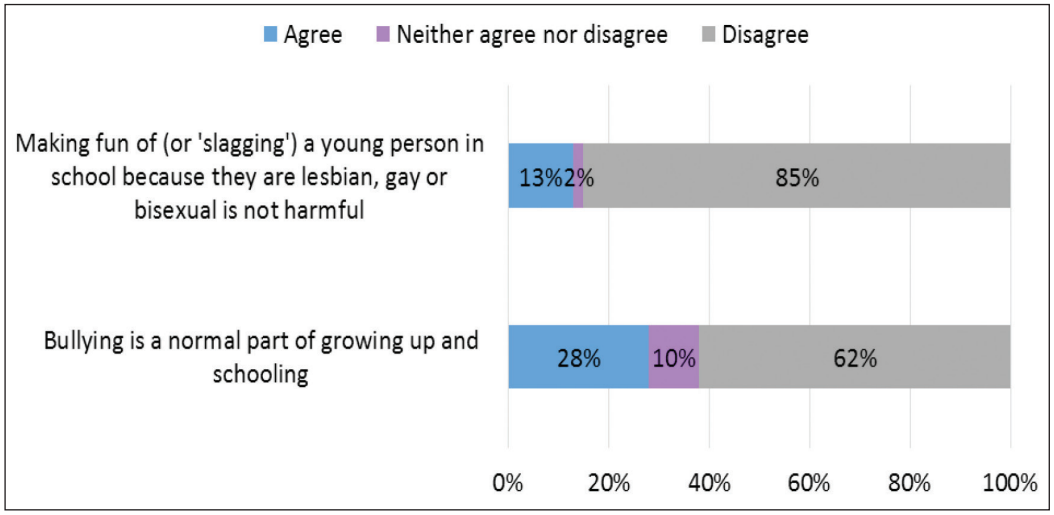
Frequency of interaction with LGB people was a significant factor on three of the five statements. Participants who never/rarely interacted with LGB people were two to three times more likely than those who frequently/occasionally interacted with LGB people to think that 'it is okay not to employ someone on the basis that they are LGB', 'it is okay not to provide a service to someone on the basis that they are LGB', and 'it is okay not to employ someone on the basis that they are transgender'.

There were no differences in responses by frequency of interaction with transgender people.

Tolerance of school bullying

Two questions were included that asked specifically about the school context. One in four participants felt that 'bullying is a normal part of growing up and schooling', while 62% disagreed, suggesting that some aspects of bullying has become normalised and expected as a part of growing up and of school life. Positively, 85% of participants disagreed that 'making fun of a young person in school because they are LGB is not harmful'; however, 13% did not agree that it is harmful (Figure 9.11).

Figure 9.11: Views on bullying



There were no age differences in terms of thinking 'bullying is a normal part of growing up and schooling' and cell counts were too small to analyse whether there were differences on the item 'making fun of (or slagging) a young person because they are LGB is not harmful'.

Male participants were more likely to think that bullying is a normal part of growing up and that 'making fun of a young person in school because they are LGB is not harmful'.

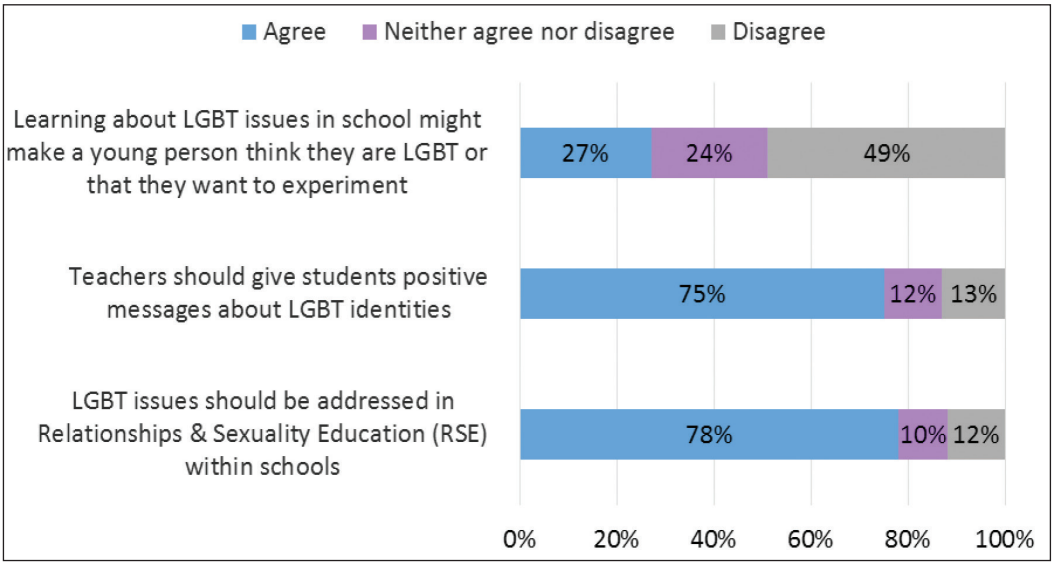
Those who only rarely/never interacted with LGB people were nearly 3 times more likely to think that 'making fun of (or slagging) a young person in school because they are LGBT is not harmful'.

Education about LGBT issues within school

Three questions were included on education about LGBT issues within school. While a small number of participants did not believe that LGBT issues should be included in the curriculum, positively, three-quarters (78%) of the sample believed that 'LGBT issues should be addressed in RSE within schools' and that 'teachers should give positive messages about LGBT identities' (75%). One in four participants (27%) believed that 'learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment' (See figure 9.12).

These responses showed significant though low correlations with beliefs that being LGB is a phase (r=.19), that being LGB is a choice (r=.15), and that someone can be convinced to be, or 'turn', LGB (r=.20). The Spearman's rho value indicates a positive relationships between the variables, meaning that the more likely a person was to think that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment, the more likely they were to believe that being LGB is a phase, choice, or something that someone can be convinced to be.

Figure 9.12: Views of sample on education about LGBT issues within school



Age was a significant factor on two of the statements. Those aged 18-44 were between 8%-15% more like than those aged 45+ to agree that 'teachers should give students positive messages about LGBT identities'. Interestingly, the youngest (18-24: 36%) and oldest (65+: 34%) age groups were more likely to agree that 'learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment' when compared to ages 25-64 (22%-26%).

Gender was a significant factor on all of the statements. Female participants were 10% more likely to think that 'LGBT issues should be addressed in RSE within schools' compared to male participants, and 9% more likely to think that 'teachers should give students positive messages about LGBT identities' compared to male participants. Female participants were nearly 12% more likely than male participants to disagree that 'learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment'.

Frequency of interaction with LGB people was a significant factor on two of the statements. Participants who had rarely/never interacted with LGB people were 3 times more likely than those who frequently/occasionally interacted with LGB people to think LGBT issues should not be included in the RSE curricula and 15% less likely to agree that 'teachers should give students positive messages about LGBT identities'.

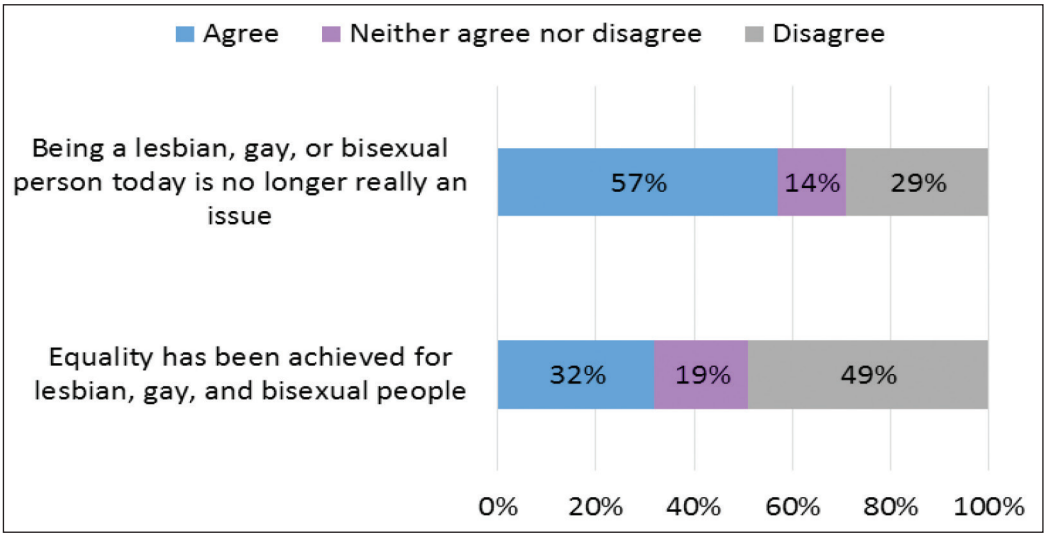
Frequency of interaction with transgender people was a significant factor on two of the statements. Participants who had rarely/never interacted with transgender people were 5 times more likely than those who frequently/occasionally interacted with transgender people to think LGBT issues should not be included in the RSE curricula. Those who interacted occasionally/frequently with transgender people were nearly 9% more likely to agree that 'teachers should give students positive messages about LGBT identities' than those who rarely/never interacted with transgender people.

Politics of being LGB and equality agenda

Two questions were asked about views on issues relating to the equality agenda. One in three participants (32%) believed that equality has been achieved for LGB people and over half (57%) believed that being LGB today is no longer really an issue (See figure 9.13), suggesting that a significant group of participants believe that equality has been achieved, that LGB people are accepted within society and as such that there is perhaps no need to continue to struggle for equality or to raise issues of discrimination and harassment.[16]

16 The survey took place prior to the Marriage Equality Referendum.

Figure 9.13: Views on the politics of being LGB and equality agenda



The only differences found for this category was that people who had never/rarely interacted with LGBT people were more likely to believe that equality has been achieved for LGB people compared to those who frequently/occasionally interacted with LGBT people. People who rarely/never interacted with LGBT people were 9-11% more likely to agree that equality has been achieved for LGB people and that being an LGB person today is no longer really an issue.

Discussion

The findings of this study suggest that the majority of the sample had positive attitudes towards LGBT people, with three out of four participants believing that LGB people's sexual orientation is 'normal'. In addition, the majority of the sample also disagreed with the statements that being LGB is a choice (64%), a sin (87%), a phase that the person is going through (78%), something that can be cured (88%), or something that someone can be convinced to be (71%). Importantly, the vast majority of the sample (87%-90%) did not believe it was okay to discriminate against LGBT in services or employment, and there was also a high level of non-acceptance around LGBT-focussed jokes. Such positive attitudes, which are theoretical in orientation, are also re-iterated in participants' beliefs about LGB individuals in close proximity to them. The majority of participants were comfortable working with (81%), and being friends with (84%) an LGB person, and having their child taught by an LGB teacher (75%). Similarly, three-quarters of the sample believed that LGBT issues should be addressed in RSE within schools (78%) and that teachers should give positive messages about LGBT identities (75%). This is a particularly positive finding in relation to module one of this study in which the need for reforms to the education system regarding

increased awareness and visibility of LGBTI identities in schools is an issue that the LGBTI participants strongly and repeatedly identified.

Recalling that only 35 years ago, 61% of Irish participants felt homosexuality was never justified (Kuyper *et al*. 2013), these findings suggest a significant shift in public attitudes in Ireland towards LGBT individuals. This evident shift is reflective of international trends which have also witnessed a steady progression of positive attitudes towards LGBT people over the last twenty years (Kuyper *et al*. 2013) and no doubt strongly facilitated the positive outcome of the recent referendum on same-sex marriage in Ireland. However, it must be acknowledged that module two's findings of positive attitudes towards the normalisation of, and levels of comfort with LGBT people, in addition to condemnation of harassment and discrimination, conflict somewhat with the findings presented in module one, where LGBTI participants reported experiencing or witnessing high levels of victimisation, discrimination and harassment from the general public.

Some areas for future development

While the findings suggest that Irish public attitudes are moving towards greater support for LGBT people and their civil rights, the findings also identify some areas of concern. These include, but are not limited to, beliefs about the source and development of sexual orientation, beliefs about the current status of LGBT civil rights, levels of discomfort in relation to having an LGBT child and to public displays of affection, and lastly levels of acceptance of name-calling and bullying of LGBT people.

Source and development of sexual orientation

A small, but significant minority, of participants seem to still believe that being LGB is a choice (25%), and something that someone can be convinced to be (17%). Such opinions may also be informing the perspectives of the 27% of participants who believed that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment. This study finding indicates that a significant proportion of people in Ireland may still believe that being LGB is voluntary, transitory and, most pertinently, controllable. The delegitimising of LGB identities by such a significant proportion of the general population is concerning, given the participant narratives in module one where the normalisation and acceptance of LGBTI identities was seen as paramount to facilitating LGBTI people's feelings of safety and belonging, and to promoting their positive mental health.

Similarly, bisexuality was also delegitimised by one in five participants, with 19% believing that bisexual people are just confused about their sexual orientation.

This is not an unusual finding as it reflects previous international and Irish studies examining public attitudes towards bisexual people. Morrison *et al*. (2010) found that explicit bi-negativity is still somewhat prevalent in Ireland. In their study, 34.3% of Irish men and women surveyed agreed or strongly agreed that lesbian women are less confused about their sexuality than bisexual women; 24.1% agreed or strongly agreed that most women who call themselves bisexual are temporarily experimenting with their sexuality; and 12.5% agreed or strongly agreed that male bisexuals are afraid to commit to one lifestyle. The opinion that bisexual people are merely confused about their sexual orientation is one way in which Yoshino (2000) claims monosexuals (individuals who are attracted to only one gender) delegitimise bisexuality as a valid sexual orientation and, therefore, actively contribute to bisexual erasure or bisexual invisibility in society (Yoshino 2000). The reasons for bisexual erasure, Yoshino argues, are to protect the stability of sexual orientation categories, the primacy of sex as a diacritical characteristic, and the preservation of monogamy (Yoshino 2000). Overall, these findings have important implications for public education and understanding, as the attributions for the causes of sexual orientation have been shown to relate to one's attitudes and behaviour toward LGB people (Altemeyer 2002; Furnham and Taylor 1990; Hewitt and Moore 2002), as well as informing their level of support for LGB civil rights. Previous research has found that adults who believe that homosexuality and bisexuality are lifestyle choices are less likely to support LGB rights as compared with those who believed in the biological explanation of homosexuality (Wood and Bartkowski 2004). In addition, several authors have linked bisexual invisibility to the high rates of mental health problems reported amongst bi-identified people relative to heterosexual, lesbian and gay identified people (Barker & Landridge 2008, Jorm *et al*. 2002; Oxley *et al*. 2000).

Interestingly, whilst one in five participants believed bisexual people were just confused about their orientation, participants' level of tolerance toward bisexual people was significantly greater than their perception of bisexuality as a stable sexual orientation. Similarly, despite some participants' difficulty in accepting transgender people as 'normal' (57%), and their evident reservations in having their child taught by a transgender teacher (participants were 12% more comfortable with their child having an LGB teacher as compared to a transgender teacher), the majority of participants still reported that they would support a family member who wanted a sex change (70%) and support transgender people's rights to legal recognition (74%). This indicates that, while participants held the view that bisexual people are just confused about their orientation, are unsure how to view transgender people, and may have difficulty accepting transgender people as 'normal', they still hypothetically support their civil rights, even in a setting as intimate as family. Once again these findings indicate

support for participants' desires for further advancement of civil right issues for LGBTI people, as articulated in module one.

Beliefs about the current status of LGBT civil rights

It is noteworthy that the public's perception of what equates to equal rights may be different to the views of the LGBT community. In this study, one in three participants (32%) believed that equality has already been achieved for LGB people and over half (57%) believed that being LGBT today is no longer really an issue. These figures raise concern as they indicate that a significant group of participants believe that equality has been achieved, that LGBT people are fully accepted within society, and thus there is perhaps no need to continue to fight for equality or to raise issues of discrimination and harassment; all issues which were strongly identified in module one by LGBTI participants as needing immediate attention. Mediating factors provide illumination for future action in this regard, in that it was people who had never/rarely interacted with LGBT people who were more likely to believe that equality has been achieved for LGBT people compared to those who frequently/occasionally interact with LGBT people. People who rarely/never interacted with LGBT people were 9-11% more likely to agree that equality has been achieved for LGBT people and that being a LGBT person today is no longer really an issue. This suggests that more concerted efforts need to be directed towards cohorts of the population who rarely or never interact with LGBT people and so are not exposed to the issues and concerns of the LGBT community.

Attitudes towards LGBT family members

Whilst rates of comfort with LGBT individuals were relatively high in relation to feeling comfortable working with (81%) and being friends with (84%), and having their child taught by an LGB teacher (75%), these rates shifted when it came to having a son or daughter who is LGB (68%) or transgender (56%). This highlights that levels of acceptance of LGBT individuals decrease when the participant's own nuclear family is involved. Whilst the survey did not explore possible reasons why participants reported lower levels of comfort in this regard, some tentative suggestions may be offered. Perhaps this finding is not surprising given that overwhelmingly, previous research has found that parental reactions to learning that their child is LGBT tend to be initially negative (Conley 2011; Whittle *et al*. 2007; McBride 2013). The sources of participants' parental discomfort with the hypothetical proposition that their child is LGBT may be varied, and include both parent and child-oriented reactions. Parents' levels of discomfort may be informed by a fear that their child may face many injustices in life,

including social marginalisation, discrimination, bullying, and unequal civil rights (Conley 2011; Rooney 2015), as evident in the findings of module one. This may be particularly the case for parents of transgender children, as transphobic hate crime has been shown to be prevalent across Europe, the UK and Ireland (McBride and Hansson 2010; McIlroy 2009; Turner *et al*. 2009; Whittle *et al*. 2007). Alternatively, parents may worry that their long-held expectations of marriages, daughters/sons-in-law, and grandchildren may be put in jeopardy (Saltzburg 2004; Broad 2011). In addition, some research has shown that particular aspects of family dynamics, such as religiosity, family cohesion, concerns about conformity, pre-existing beliefs about sex and sexuality, social conformity, and family values, influence parental reactions to learning that a child is gay or lesbian (Cramer & Roach 1988; Savin-Williams and Dube 1998; Ben-Ari 1995; Willoughby *et al*. 2006). Parents may also view the disclosure as reflecting back on the family and may struggle with marginalisation and stigma in their own daily lives (Beeler and DiProva 1999; Saltzburg 2009). Whatever the source of parental discomfort, parental display of non-acceptance towards their children's sexual orientation has a detrimental impact on their children's psychological well-being and has been associated with an increased likelihood of an LGBT individual developing negative LGBT identity, depression, suicidal ideation, illicit substance misuse, and unprotected sex with casual partners (Ryan *et al*. 2009, 2010). It is thus imperative that future educational and public initiatives target the potential discomfort Irish families may feel in relation to a family member's sexual orientation or gender identity, and provide Irish families with the knowledge and skills necessary to negotiate this new, and for some people challenging, family dynamic.

Public display of affection

Module one's finding that LGBTI people strongly desire increased normalisation and visibility of LGBTI relationships is again challenged by module two's findings, as the general population's levels of discomfort rose in relation to public displays of affection between LGBT people. The sample was effectively split between those who agreed (38%) and disagreed (41%) with the statement that 'people should keep their sexuality to themselves'. Findings indicate that comfort levels decrease around displays of same-sex affection, with a greater percentage of participants indicating discomfort with a male couple kissing (39%), compared with a female couple kissing (30%) or a heterosexual couple (17%) kissing in public. These findings reflect previous research conducted in Ireland (Morrison *et al*. 2005). Qualitative studies confirm these findings by revealing that lesbians and gays are often denied public visibility and recognition through others' rejection of their public displays of affection (Donovan *et al*. 1999; Johnson 2002; Steinbugler 2005). The reasons for public discomfort were not explored in this survey and have rarely been examined internationally, but Ferreira (2014: 98)

suggests that 'public visibility of these sexualities disrupts and therefore exposes the way in which the street is commonly produced as "naturally" or "normally" a heterosexual space'. The findings indicate then that although the participants may be supportive of private and formal rights for LGBT people, over one-third of the sample do not feel comfortable with public displays of 'informal privileges' (Doan *et al*. 2014), such as displays of same-sex affection. It is important to consider how to address these disparities.

Age of awareness of LGBT orientation

The study findings also suggest that there may be misinformation in the public domain about age of awareness of LGBT orientation. For example, 34% of participants did not believe that a person could know their sexual orientation at a young age like 12. This belief is at variance with module one's finding that the most common age of knowing was 12 years of age. A considerable body of international research has also argued that contemporary sexual minority youth are self-identifying as LGB and coming out at younger ages than previous generations of sexual minorities (Calzo *et al*. 2011; Kennedy and Hellen 2010). However, whilst contemporary sexual minority youth may be publicly coming out at earlier ages than their older counterparts once did, early development of self-identification as LGB is not a new phenomenon and has consistently occurred, with and without public disclosure (Calzo *et al*. 2011). The belief that an individual is too young to know their sexual orientation at the age of 12 may contribute to negative and identity disconfirming attitudes towards young LGBT people when they publicly disclose their sexual orientation. This is especially pertinent given that LGBT people publicly coming out during early adolescence are exposed to increased levels of discrimination and victimisation, particularly from peers in school (Minton *et al*. 2008; Mayock *et al*. 2009)

Name-calling and bullying of LGBT people

Bullying is a pertinent issue for the LGBT community. In Ireland, Mayock *et al*. (2009) reported that 58% of participants in their study reported homophobic bullying in their schools, 50% had been called abusive names related to their LGBT identity by fellow students, and 80% had been verbally abused because of their LGBT identity. In module one of this study, a slightly lower rate than Mayock *et al*.'s (2009) study was recorded, with 47.5% of the participants who are or had been in school within the past five years reporting an experience of bullying due to their LGBT identity. Module two's findings however suggest that there is a small cohort in Ireland who may not be aware of the prevalence and negative effects of bullying; 15% of the sample thought that using LGBT slang words 'isn't really a big deal', 13% did not think that making fun of a young person in school because they are LGB is harmful, and 28% of participants felt that bullying

is a normal part of growing up and school life. Whilst these were the minority, this finding is still of particular concern in light of findings from module one, and other research, which suggests that homophobic bullying has considerable short and long term implications on the emotional and psychological well-being of LGBT people (Bontempo & D'Augelli 2002; Duong and Bradshaw 2014; Burton *et al.* 2013; Patrick *et al.* 2013; O'Shaughnessy *et al.* 2004; Rivers, 2000, 2001, 2004).

A number of studies have highlighted the invisibility of sexual orientation within schools' curricula. O'Higgins-Norman (2008, 2009b) suggests that Irish schools' silencing of sexual orientations outside of the heterosexual domain contributes to homophobic bullying. He suggests that a revision of the RSE syllabus to include LGBT issues may help to build awareness about LGBT people, and their sexual orientation and gender identity, which may in turn increase levels of tolerance and decrease incidences of LGBT bullying. Similarly, anti-bullying campaigns and programmes in workplaces may produce the same potential outcomes (Einarsdóttir *et al.* 2015) in the Irish adult population.

Mediating factors which appeared to influence participants' attitudes

The mediating factors which appeared to influence participants' attitudes may provide helpful insight by identifying cohorts of the Irish population that future educational and awareness campaigns might specifically target. In general, the way in which mediating factors (gender, age, and frequency of interaction) positively influenced participants' attitudes was largely reflective of international findings. Female participants and participants who frequently interacted with LGBT people held more positive attitudes to LGBT people and their rights compared to male participants and participants who rarely/never interacted with LGBT people.

The mediating role of age was less consistent and appears to disagree with international trends. The youngest age cohort of participants (18-24) were between 22-24% more likely to agree that they would feel comfortable if their child were LGB or T when compared to the oldest age group (65+), and were between 14-15% more likely to agree that they would feel comfortable with their child having a LGB or T teacher when compared to the oldest age group (65+). However, their attitudes with regards to certain topics actually aligned strongly with the oldest age cohort (65+). For example, the youngest (18-24: 36%) and oldest (65+: 34%) age groups were more likely to agree that 'learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment' when compared to ages 25-64 (22%-26%). In addition, both the youngest (18-24 years: 11%) and oldest (65+ years: 13%) age groups

were more than twice as likely as those in the middle (25-54) to agree that it's okay not to employ someone on the basis that they are LGB. The youngest age group (18-24), were also less likely to agree with the statement that 'being transgender is something you are born with' (46%), as compared to over 70% of those aged 55+ who agreed with the statement. These are surprising findings given that younger age groups are consistently cited as holding supportive perceptions of LGBT people and of being supportive of their rights (Hayes and Dowds 2014; Jarman 2010; McAlister *et al.* 2014; Perry 2013; Pew Research Center 2006; ECNI 2012; Ellison *et al.* 2011; Loftus 2001). These study findings suggest that it is actually the population of 25-64 year olds which hold more consistently supportive and tolerant attitudes towards LGBT people than their younger and older counterparts. Future efforts to advance LGBT issues and concerns will need to consider why the younger population express more conservative attitudes towards LGBT people in these areas, and to design initiatives which specifically target the 18-24 year and 65+ cohort's knowledge about sexual orientation and gender identity, as well as the impact of discriminatory employment practices on LGBT people.

KEY ISSUES EMERGING FROM BOTH STUDIES AND RECOMMENDATIONS FOR THE FUTURE

Introduction

This chapter summarises the key findings emerging from both module one and module two and identifies recommendations for future developments.

Key Findings from Module One

The findings from module one suggest that similar to the general population a large proportion of LGBTI participants (approximately 70%) are experiencing positive well-being. Across LGBTI groups and age groups, most mean scores for happiness and life satisfaction were above the midpoint of the scales. An overwhelming majority of participants in this study had told somebody that they were LGBTI, with only 3.1% disclosing that they had not told anybody. These are encouraging findings as they indicate that a large proportion of the sample appraise their overall well-being in a positive light, which in turn may mean that they are experiencing many of the positive outcomes that high levels of well-being can induce.

While between 50-60% of the sample recorded no or very few indicators of depression, anxiety or stress on the DASS-scale, the findings still support the dominant narrative, both internationally and in Ireland, that a significant proportion of LGBTI people experience mental health difficulties. Across LGBTI groups between 12-35% of participants recorded scores indicating severe or extremely severe depression, anxiety, and stress. On all scales of DASS, the youngest age group (14-18 years) had the highest mean scores, followed by the 19-25 year olds. Rates of severe or extremely severe depression, anxiety and stress for the adolescent cohort (14-18 year) was four times higher than the rates reported for the 12-19 year old cohort in the *My World* survey of Irish adolescent and young people (Dooley and Fitzgerald 2012). The youngest age group (14-18 years) had significantly lower scores on satisfaction, happiness and self-esteem, followed by the 19-25 age group. Self-esteem scores were also lower than those reported in the *My World* survey. Alongside differences in mental health difficulties according to age, participants' DASS-scores were also mediated by LGBTI identity, clearly indicating that LGBTI people are not a homogenous group. Intersex had the

highest mean scores for depression, anxiety and stress followed by transgender and bisexual participants. The mean scores on the satisfaction, happiness and self-esteem scales were also lowest among transgender and intersex participants.

In relation to self-harm, a lifetime history of self-harm was reported by a third (34%) of participants, which represents an increase on the 27% previously reported in the LGBT population in Ireland (Mayock *et al*. 2009). Nearly half of these (45.6%) reported that they had self-harmed within the past year, with nearly 60% relating their self-harm to their LGBTI identity and their struggle to be accepted by others and society. Over half (55.7%) of the sample aged 14-18 had a history of self-harm, with just over 75% of these having self-harmed in the previous year. Similar to other mental health issues, the findings in relation to self-harm again demonstrate that LGBTI people are not a homogeneous group, as bisexual (54.5%) and transgender participants (48.8%) were more likely to have self-harmed compared to gay males (19.5%). However, both lesbian/gay females and intersex participants also had relatively high levels of self-harm (37.4%, 42.1% respectively). A significant majority (63%) of participants who had self-harmed had thought about it for less than 24 hours.

Almost 60% of the sample had seriously thought of ending their own life, with approximately 45% having thought of doing so within the past year. 60% reported that their suicidal thoughts were at least somewhat related to their LGBTI identity. Of those aged 14-18, over two-thirds (69.4%) had seriously thought of ending their own life, with over two thirds having considered ending their own life within the past year. A hierarchy of risk was also evident, with intersex (84.2%), transgender (75.6%) and bisexual (65.3%) participants being more likely to have considered ending their life compared to lesbian/gay females (56.4%) and gay males (52.4%). Of those who had seriously considered ending their own life, four in ten (39.9%) did not seek any help for the problems that led them to seriously consider ending their life.

Over one in five of the sample (21.4%) had seriously tried to take their own life. Of these, 26.3% had tried to take their life within the past year. Approximately two-thirds (66.8%) reported that their suicide attempt(s) was at least somewhat related to being LGBTI. Of those aged 14-18, nearly one third (31.9%) had seriously tried to take their own life, with over half (52.5%) having tried to do so within the last year. Of those aged 19-25, over a fifth (21.1%; n=110) had seriously tried to take their own life, with a quarter (25%; n=27) having tried to do so within the last year. Of the 407 participants who had tried to take their own life the mean age was 18.52 (SD=7.31), and the most common age was 15 years. Transgender (35.1%) and intersex participants (57.9%) were more likely to have attempted to take their own life compared to lesbian/gay females, gay males and bisexuals (17-24%). Of those who had seriously tried to take their own lives 30% did not

seek help or support for their problems.

In relation to substance misuse, just over 40% of the participants' AUDIT scores indicated some level of alcohol problem. In terms of illegal drug-use, whilst 27% of the general population have reported using any illegal drugs in their lifetime (National Advisory Committee on Drugs 2011), just over half of the *LGBTIreland* study sample had taken drugs recreationally during their life (55.9%; n=1,095). In the general population the lifetime prevalence rate for any illegal drugs was lowest amongst the younger age cohort of 15-24 (27%) (National Advisory Committee on Drugs 2011), whereas, in this study, 49.9% of participants aged 14-25 had taken drugs recreationally.

Findings indicated that being bullied in school because of LGBTI identity exerted a strong influence on the onset of mental health difficulties for young people. Study participants (14-25 year olds) who experienced LGBTI bullying in school had significantly higher scores on the depression, anxiety, stress, and alcohol use scales indicating more problematic alcohol use. They also had significantly lower scores on the self-esteem scale. In addition they were more likely to self-harm, more likely to have seriously considered ending their life, and more likely to have attempted to take their own life than those who had not experienced LGBTI bullying in school. These findings are of concern as approximately a quarter of the 14-18 year old (23.6%) and 19-25 year old (23.2%) participants reported having missed or skipped school to avoid negative treatment related to being LGBTI.

Study findings suggest that LGBTI people continue to experience incidents of victimisation, discrimination and harassment outside of school: 75.2% reported that over their lifetime they had experienced being verbally hurt, with approximately one fifth of participants having experienced physical attacks due to being LGBTI. Gay male, transgender, and intersex participants appeared particularly at risk in this regard. Gay males reported the highest incidence of being physically attacked (29.3%), whilst transgender persons had comparatively high levels of having hurtful things written about them on social media (34.3%), high incidences of being threatened with being outed (40.6%), and the highest incidence of being attacked with a weapon (12.2%). Over a fifth of transgender people (22.1%) also reported being sexually attacked. Given the high incidences of harassment across the board it is not surprising that participants felt unsafe or very unsafe when showing public affection (53%) or holding hands with their partner (47.1%), with between 25% and 33% having some level of fear around being seen going to or leaving an LGBTI club or venue; reading an LGBTI publication in a public space, or checking an LGBTI website on a public computer. Approximately 60%

of the transgender participants reported feeling unsafe to express their gender identity in public.

LGBTI people's experiences of college/university and work appear to be largely positive; participants' most common rating of LGBTI friendliness of work and college/university was 10 meaning 'completely LGBTI-friendly', which suggests that there have been many positive advances in colleges and universities, and workplace culture. Compared to both school and the workplace, college/university rated highest in terms of LGBTI friendliness, suggesting that college/university is a vastly improved experience for students who identity as LGBTI. The lowest incidence of bullying was also found for college/university (15.2% compared to 17.4% for workplace and 47.5% for school).

Despite LGBTI people's increased risk to mental health problems, the vast majority of participants identified a number of both systemic and psychosocial inhibitors to access to mental health care. Whilst some of the barriers cited were specific to all people (lack of services, stigma, fear of being medicated), some LGBTI-specific barriers were cited, including fear that their sexual orientation or gender identity would be pathologised, and a lack of knowledge and skill among staff to respond to the needs of LGBTI people in a non-discriminatory fashion.

Participants were asked for their recommendations for future development. Interestingly, there was a consistency in the themes proffered by participants across all groups and ages, and these included recommendations for: increased visibility and normalisation of LGBTI identities; enhanced education on, and awareness and positive affirmation of, LGBTI identities, including increasing awareness and visibility of LGBTI identities in schools; and enhancing protection and support for LGBTI identities. Recommendations explicitly reiterated the strong mediating role experiences of heteronormativity, rejection, victimisation, and harassment have on LGBTI people's feelings of societal acceptance, sense of belonging, mental health outcomes and willingness to publicly disclose LGBTI identity.

Key Findings from Module two: Public attitudes towards LGBT people

Module two focused on measuring the attitudes of a representative sample of the Irish public about LGBT people. Importantly, the vast majority of the sample (87%-90%) did not believe it was okay to discriminate against LGBT people in services or employment, and there was also a high level of non-acceptance around discrimination and bullying behaviour towards LGBT people. However, 15% of the sample thought that using LGBT slang words 'isn't really a big deal', 13% did not think that making fun of a young person in school because they are LGB is harmful, and 28% of participants felt that bullying is

a normal part of growing up and school life. Whilst these views were in the minority, this finding is still of particular concern in light of findings from module one, and other research, which suggest that homophobic bullying in schools has considerable implications on the emotional and psychological well-being of young LGBT people.

The majority of participants demonstrated high levels of comfort in relation to working with (81%) and being friends with (84%) an LGB person, and having their child taught by an LGB teacher (75%). Participants' comfort levels decrease around public displays of same-sex affection, with a greater percentage of participants indicating discomfort with a male couple kissing (39%) and a female couple kissing (30%) compared to a heterosexual couple (17%) kissing in public. This finding also resonated with findings from module one where approximately half of the LGBTI participants reported feeling unsafe or very unsafe showing affection with a same-sex partner in public or holding hands with a same-sex partner in public.

The study findings suggest that there may be misinformation in the public domain about LGBT orientation. Over a third of participants (34%) did not believe that you could know your sexual orientation at a young age like 12, which is at variance with module one's finding where the most common age of knowing was indeed 12 years of age. In addition, a small but significant proportion appear to still believe that being LGB is voluntary, transitory, and controllable, as 25% of participants believed that being LGBT is a choice, something that someone can be convinced to become (17%), and that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment (27%). The delegitimising of bisexuality is also evident with 19% of participants believing that bisexual people are just confused about their sexual orientation.

Despite some participants' reservations in having their child taught by a transgender teacher (participants were 12% more comfortable with their child having a LGB teacher as compared to a transgender teacher), the majority of participants still reported that they would support a family member who wanted a sex change (70%) and support transgender people's rights to legal recognition (74%).

Three-quarters (78%) of the sample believed that LGBT issues should be addressed in RSE within schools and that teachers should give positive messages about LGBT identities (75%). This is a particularly positive finding in relation to module one of this study given that the need for reforms to the education system regarding increased awareness and visibility of LGBTI identities in schools is an issue that the LGBTI participants strongly and repeatedly identified.

One in three respondents (32%) believed that equality has already been achieved for LGBT people and over half (57%) believed that being LGBT today is no longer really an issue, with people who rarely/never interacted with LGBT people being 9-11% more likely to agree that equality has been achieved for LGBT people and that being a LGBT person today is no longer really an issue.

Recommendations

Based on the findings of module one and module two, and bearing in mind the recommendations made by the participants and the limitations outlined, the following seven strategies are recommended for achieving positive change for LGBTI people in Ireland:

- Reduce mental health risks and build resilience among LGBTI people
- Support the LGBTI community to flourish
- Protect and support LGBTI children and young people in schools
- Increase public understanding and change attitudes and behaviours
- Recognise the diverse needs within the LGBTI community
- Build the knowledge and skills of professionals and service providers
- Conduct further research and assess progress

1. Reduce mental health risks and build resilience among LGBTI people

- Future national mental health policies must give full consideration to LGBTI mental health. This is particularly pertinent for the mental health policy that follows on from *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Department of Health and Children 2006).

- In view of the findings on self-harm and suicide, and the identification of LGBT people within *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020* (Department of Health 2015) as one of the groups most vulnerable to suicide in Ireland, a cross-sectoral approach is needed to address the problem of LGBTI self-harm and suicidal behaviour.

- Specific initiatives targeting self-harm, suicidal behaviour, anxiety, depression and substance misuse among young LGBTI people should be established as a matter of priority. It is recommended that such initiatives would be best realised through a partnership approach between LGBTI organisations and, statutory and

voluntary agencies in the mental health, health promotion, addiction and youth sectors.

- Continued efforts are needed within the LGBTI community to reduce stigma associated with mental health problems and accessing mental health services. In addition, the LGBTI community also need to highlight to young LGBTI people the existing mental health services available, including statutory, voluntary and community services, and how to access them.

- National and regional structures emerging from Connecting for Life and other mental health policies should include the identification of LGBTI people and identify actions for targeting the LGBTI population.

- The implementation of current and future health and wellbeing policies should pay particular attention to the needs of LGBTI people (e.g. *Healthy Ireland: A Framework for Improving Health and Wellbeing*; Department of Health 2013).

- A comprehensive approach to building resilience and supporting positive mental health among the LGBTI population is needed in Ireland. As such, it is recommended that initiatives be established to address:
  - » Increasing mental health awareness
  - » Promoting positive mental health
  - » Building mental health resilience and coping skills.
  - » Promoting help-seeking when experiencing distress.

  It is recommended that such initiatives would be best realised through a partnership approach between LGBTI organisations and, statutory and voluntary agencies in the mental health and health promotion sectors. Schools and youth services will be key settings for the implementation of such initiatives.

- Given the findings on the elevated levels of psychological distress among LGBTI people in Ireland (and in particular young LGBTI people), further efforts are needed to address the harmful effects of stigmatisation of LGBTI identities and the associated experiences of rejection and discrimination. To address this there is a need to promote mental health protective factors through the continued building of an LGBTI-affirmative society that embraces the diversity of sexual orientation, gender identity and sex characteristics.

2. Support the LGBTI community to flourish

- Building on progress achieved to date, a Government strategy should be developed to promote LGBTI inclusion and wellbeing in Ireland, incorporating among other things a range of cross-departmental actions, and national and regional initiatives to make Ireland the best place in the world for LGBTI people to live. Such a strategy should take cognisance of LGBTI specific issues and wider issues that can compound already challenging LGBTI experiences, such as gender inequality, socio-economic category, ethnicity and disability.

- Given the findings on harassment and violence against LGBTI people and the continuing high levels of LGBTI people feeling unsafe in public spaces, efforts are needed to eliminate these problems in Irish society, with particular emphasis on gay men, transgender and intersex people. To address this need, a partnership approach between LGBTI organisations and, voluntary and statutory agencies, such as An Garda Síochána, is recommended.

- This research demonstrates that there is a hierarchy of risk within the LGBTI population reflecting the hierarchy of progress for gay men, lesbian women, bisexual people, transgender people and intersex people respectively. LGBTI community organisations should take further steps in their advocacy work to advance equality for bisexual, transgender and intersex people, and be supported to continue to advocate for and provide services to LGBTI people.

- An information campaign on legal and civil protections needs to be specifically directed at the LGBTI community to increase their understanding of current protections and rights within the law. It is recommended that this be developed as a partnership between LGBTI organisations and the relevant state agencies.

- Ireland is the only remaining western democracy without hate crime legislation. Hate crime legislation should be introduced imminently so that discriminatory acts toward LGBTI people are considered a crime in their own right, and the prejudicial motives informing such acts are therefore considered in the determination of sentencing. In addition, Ireland's current equality legislation must be further expanded to explicitly protect individuals on the basis of their gender identity, gender expression and sex characteristics.

- It is recommended that further resources on the coming out process be developed for young LGBTI people and be made available through the internet and social media.

3. Protect LGBTI children and young people in schools

- In keeping with the many positive initiatives currently in operation within schools, as outlined in chapter 4, and in view of the link identified in this study between the experience of bullying in school and suicidal behaviour among young LGBTI people, continued efforts must be made to enable primary and post-primary schools to ensure that:
  - » Further to the valuable work already conducted by the Professional Development Service for Teachers (PDST), school staff are continually educated and informed on sexual orientation and gender identity issues, including the challenges LGBTI students face in school.
  - » Homophobic, biphobic and transphobic bullying are eliminated in schools by the continuing implementation of the Department of Education and Skills' *Action Plan on Bullying* and their *Anti-bullying Procedures for Primary and Post-Primary schools*.
  - » Schools continue to implement initiatives such as BeLonG To's *Stand Up Awareness Week* and guidance such as the GLEN *Being LGBT in School* guidelines.
  - » Schools continue to show they are LGBTI friendly, while validating and affirming LGBTI students' identities. Thus, age-appropriate and affirming discussions of lesbian, gay, bisexual, transgender and intersex identities should be facilitated which challenge stereotypes and negative attitudes towards LGBTI people.
  - » The curriculum on LGBTI issues is expanded to address both sexual orientation and gender identity beyond what is included in Relationships and Sexuality Education (RSE) or Social Personal Health Education (SPHE) classes.

- The findings of this study highlight the urgent need to address the issues that may be putting 14 to 18 year old LGBTI people at risk. Given that this coincides with post-primary school-going years, ongoing engagement by the Department of Education and Skill is needed, to continue building on the significant progress achieved under the DES Action Plan on Bullying (2013).

4. Increase public understanding and change attitudes

- Given the finding that some negative attitudes and misinformation towards LGBT people persists in Ireland, it is recommended that public awareness and behaviour change campaigns are undertaken to promote a better understanding of sexual orientation, gender identity and the realities of what it means to be a LGBTI person.

- Awareness campaigns and information resources also need to be developed for parents, family members, teachers and others who work with young LGBTI people to alert them to:
  - The critical importance of supporting and affirming children, adolescents and adults who are LGBTI
  - Accurate information about LGBTI identities and the coming out process, including strategies to support people during this time; and the factors that make it harder for people to come out, such as fear of rejection by family and friends and fear of discrimination, or easier to come out, such as knowing people would be supportive.
  - The impact negative language, attitudes and behaviours have on the mental health and wellbeing of LGBTI people.

  It is recommended that such information campaigns would be best realised through a partnership between LGBTI organisations and, statutory and voluntary agencies, including parent groups.

5. Recognise the diverse needs within the LGBTI community

Lesbian and bisexual women

- Continued action is needed to address the specific needs of lesbian and bisexual women and girls within the LGBTI population and to ensure structures and services exist and are resourced to meet their needs.

Gay and bisexual men

- Continued action is needed to address the specific needs of gay and bisexual men and boys within the LGBTI population and to ensure structures and services exist and are resourced to meet their needs.

Bisexual people

- There is a need to address misunderstandings about bisexuality among both the general population and the LGTI population, and to eliminate biphobic attitudes and discrimination against bisexual people in Ireland.

- In light of the finding that bisexual people are an at risk group to higher levels of mental distress, services and interventions need to specifically focus on this group.

Transgender people

- There is a need to address misunderstandings about transgender people among the general population and to eliminate transphobic attitudes and discrimination against transgender people in Ireland.

- Continued action is needed to address the specific needs of transgender people and to ensure suitable structures and services exist and are resourced to meet their needs.

- As transgender people face particularly high levels of victimisation and violence, including sexual violence, services that support victims of sexual abuse and harassment need to build their capacity on transgender people's needs and focus on them within service provision.

- As transgender people face higher levels of bullying and harassment in the workplace, there is a need for further training for employers on transgender issues, including how to support transgender people who are transitioning in the workplace.

Intersex people

- As this was the first study in Ireland to gather data on intersex people and the sample size, relative to the size of the lesbian, gay, bisexual and transgender samples, was small, more in-depth research on intersex people is needed to further explore their lived experiences and the challenges and barriers they encounter. In addition, specific research on gender assignment is recommended including the identification of surgical and medical interventions carried out in Ireland.

- Greater understanding and awareness of intersex people is needed in Ireland among both the general public and professionals.

- New action is needed to address the specific needs of intersex people and to ensure suitable structures and services exist and are resourced to meet their needs.

Young LGBTI people

- LGBTI issues should be considered and reviewed when policy and services are being developed for young people in all settings that impact on their lives.

- Continued action is needed to address the specific needs of young people within the LGBTI population and to ensure structures and services exist and are resourced to meet their needs.

6. Build the knowledge and skills of professionals and service providers

- LGBTI capacity-building and training for practitioners and service providers is an urgent requirement for medical, nursing, health, social care and psychological therapy professionals as well as teachers and guidance counsellors. Education and training should include the following content:
  - » Sexual orientation, gender identity and LGBTI terminology
  - » Research findings on LGBTI mental health and wellbeing
  - » Specific risks for lesbian, gay, bisexual, transgender and intersex people
  - » Specific needs of transgender and intersex people
  - » LGBTI-inclusive practice guidelines
  - » Importance of ensuring sexual orientation and gender identity are included as part of routine assessment

- Regulation Bodies with responsibility for approval and accreditation of professional education programmes need to ensure that LGBTI content is part of the curricula for all health, social care, and education practitioners.

7. Conduct further research and assess progress

- The *LGBTIreland* study should be repeated in three to five years in order to provide a comparative sample to assess progress in LGBTI mental health and wellbeing, and public attitudes towards LGBT people in Ireland.

- In addition, the prevalence of LGBTI bullying and discriminatory experiences across the lifespan must be collated in order to ascertain the scale of such incidences in Ireland and thus inform appropriate responses and interventions.

- A review of international experiences of routinely collecting demographic data on sexual orientation and gender identity should be undertaken with a view to including this data in a number of health reporting systems, including the National In-Patient Reporting System and the National Self-Harm Registry.

- Initiatives and interventions arising from the recommendations of this report should be evaluated using robust methods to assess their impact and long-term effectiveness and outcomes, particularly interventions designed and implemented to address mental health issues, to reduce self-harm and suicide, and to enhance school environments.

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APPENDICES

Appendix 1: Organisations involved with promoting the study

2gether Counselling Services	Bear Féile
A Brighter Day For Mums	BeLonG To Youth Services
Abbey School of Theatre	Beyond the Binary
Acting Out	Bi+ Ireland
ActionAid Ireland	Bisexual Ireland
Active Retirement Ireland	Border Area Group
Activelink	BreakOUT Donegal
Age & Opportunity	Burren College of Art
Age Action	Canoodle Ireland
Agenda LGBT A.C.	Carlow College
AIDS West	CDYS Youth Work Ireland
All Hallows College	Centre for Ageing Research and Development (CARDI)
ALONE	ChillOUT Youth Project
Amach LGBT Galway	Church of Ireland College of Education
American College Dublin	CKB Gifts
Association of Secondary Teachers, Ireland (ASTI)	College of Computer Training
Asylum seekers and refugees	College of Psychiatrists Ireland
Aurora	Community Foundation
Aware	Complete Accounting Solutions
Awareness	Console
BCM Northern Ireland	Cork College of Commerce

Cork Institute of Technology

Cork LGBT Pride

Cork Rebel Awards

Cork Women's Fun Weekend

Crosscare

CrowdTAssoc

CRY 104 FM

Day Break Programme

Defence Forces Colleges

Development Studies Centre

Digital Marketing Institute

Discover It Online

Domestic & Sexual Violence Helpline

Donegal Youth Council

Donegal Youth Reach

Donegal Youth Service

Drugs.ie

Dublin Aids Alliance

Dublin Art Therapy

Dublin Bins

Dublin Business School

Dublin City Council (DCC) LGBT Staff Network

Dublin City University

Dublin Devils Football Club

Dublin Gay Theatre Festival

Dublin Institute for Advanced Studies

Dublin Institute of Design

Dublin Institute of Technology

Dublin LGBTQ Pride Festival

Dublin University History

Dún Laoghaire Institute of Art, Design and Technology

Dundalk Institute of Technology

Equality Depot

Erich Keller Counselling

ESB Group of Unions (ESBGOU)

Fallopian Tunes Fest

Fianna Fáil

Fine Gael LGBT

Free Legal Advice Centres

Friends of the Elderly

GAA Inclusion Office

GAA Marketing and PR

Gaelick

Gaiety School of Acting

Gaire

Galas LGBT Awards

Galway Pride

Garda Press Office

Garda Racial, Intercultural, and Diversity Office

- Garda Síochána College
- Gay & Lesbian Equality Network (GLEN)
- Gay Community News
- Gay Cork
- Gay Health Network Newsletter
- Gay Life (UK and IE)
- Gay Star News
- Gay Switchboard Ireland
- GAZE Film Festival
- Gender Identity Watch Exposed (GIWE)
- Gender Orientation Sexual Health HIV (GOSHH)
- G-Force
- Girls Night In
- GLEN Diversity Champions
- GLEN E-Zine
- Griffith College Cork
- Griffith College Dublin
- Griffith College Limerick
- Headstrong
- Health and Social Care Service LGBT Staff (NI)
- Hibernia College
- Himerus Health
- HIV Big Deal
- HIV Disclosure Study
- HIV Molecular Research Group
- Honorable Society of King's Inns
- Hospital Family Resource Centre
- HSE
- Imagine Peace
- Impact Trade Union
- Insight Matters
- Instagramers Dublin
- Institute of Public Administration
- Institute of Technology, Athlone
- Institute of Technology, Blanchardstown
- Institute of Technology, Carlow
- Institute of Technology, Galway-Mayo
- Institute of Technology, Limerick
- Institute of Technology, Sligo
- Institute of Technology, Tallaght
- Institute of Technology, Tralee
- Involve
- Irish Association for the Social Integration of Offenders
- Irish Association of Older People (IAOP)
- Irish Association of Suicidology
- Irish Bible Institute
- Irish Defence Forces

Irish Federation of University Teachers (IFUT)

Irish Management Institute

Irish National Teachers' Organisation (INTO)

Irish Nurses and Midwives Organisation (INMO)

Irish Prison Service

Irish Rugby

Irish Student Movement Research Project

Irish Times

Irish Traveller Movement

IT Dublin

Kerry Volunteer Centre

Kimmage Development Studies Centre

Labour LGBT

Late Debate

LEO Waterford

LetsGetChecked

Letterkenny Institute of Technology

LGBT CyberHate Project

LGBT Helpline

LGBT Labour Northern Ireland

lgbt NOISE

LGBTmentalhealth.ie

LGBTogether

Limerick LGBT

Limerick Pride

LINC

Living with HIV

Longford LGBT

Macra na Feirme Newsletter

Macro Centre

Mallow College of Further Education

Maman Poulet

Man2Man.ie

Marino Institute of Education

Mary Immaculate College, Limerick

Mental Health Ireland

Mental Health Reform

Midlands Zone

Milltown Institute of Theology and Philosophy

Minceirs Whiden

MirrorMe Dramatherapy

Mr Gay Ireland

Ms Gay Cork

Muskelimies

MyMind

National Ambulance Service College

National College of Ireland

National LGBT Federation

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- National Traveller Money and Budgeting Services
- National Traveller Women's Forum
- National University of Ireland Maynooth
- News Talk FM
- No Hate Speech Movement Ireland
- Northwest LGBT Pride
- Nurture
- Obesity Awareness Ireland
- Office of the Pensions Ombudsman
- One Family Ireland
- Out Aloud
- OUT for the Weekend
- Out in the UK
- Out Loud Show Dublin
- Outcast Magazine
- Outhouse
- Outrage
- Outwest
- Parish of the Travelling People
- Patients First
- Pavee Point
- Personal Development - LIT
- Phoenix Handfasting
- Pink Families
- Pink Latino
- Pitman Training Ireland
- Pop Rox
- Portobello Institute
- Pride Time @ Near90FM
- Pulso Gay Magazine
- Quality Matters
- Rainbow Biz Radio
- Rainbow Fest
- Rainbow Revolution United
- Rape Crisis Network
- Reach Out Ireland
- Rehab Recycling
- Resources for Positive Mental Health
- Retirement Planning Council
- Roscrea Youth Café
- Royal College of Physicians of Ireland
- Royal College of Surgeons in Ireland
- Royal Irish Academy of Music
- Sallynoggin College of Further Education
- Samaritans Ireland
- Scouting Ireland
- See Change
- Setanta College
- Shadow Box Theatre
- Shock World Service

ShoutOUT

Sinn Féin

SIPTU LGBTQ Network

Social Computing

Socialist Party

Soulful Bistro

Space Camp

St Michael's House

St Nicholas Montessori College

St Patrick's College, Maynooth

St. John's Central College, Cork

Stress Skills

Suicide or Survive

Sunrise LGBT Kildare

Sweatbox

Tallaght Trialogue

The Balance Authority of Ireland (BAI)

The Big Gay Sing Dublin

The Carers Association

The Garda Representative Association (GRA)

The Irish Congress of Trade Unions (ICTU)

The Irish National Organisation of the Unemployed

The Open Minds

The Other Place Cork

The Outing, Lisdoonvarna

The Psychiatric Nurses Association (PNA)

The Queen of Ireland Documentary

The Services, Industrial, Professional and Technical Union

The Stress Management Institute

The Teacher's Union of Ireland (TUI)

The Treasure Chest

The Wheel

Third Age Ireland

Thomas McCann

Today South Dublin

TOST (Breaking the Silence) - Mayo

Transgender Equality Network Ireland (TENI)

TransParenCI

Traveller & Gypsy Network NI

Traveller Heritage

Trinity College Dublin

Turning Point

Union of Students Ireland

University College Cork

University College Dublin

University of Galway

University of Limerick

University Times

USDAW LGBT

Various Voices Dublin

VendFind
VEX Ireland
Victorian AIDS Council
Volunteer Galway
Volunteer Ireland
Waterford Diversity
Waterford Institute of Technology
Waterford Pride
West Training & Development
Westport Family Resource Center
Women's Aid Ireland
Women's Health Project
YesEquality Wicklow
Youth Reach Buncrana
Youth Work Galway
Youth Work Ireland

Appendix 2: Nationality and ethnicity of survey sample compared to general population

	Nationality of study sample LGBTIreland (N=2,218)*	**Nationality of population CSO 2011** (N=4,471,500)
Irish	89.4% (1,982)	87.8% (3,927,143)
Non-Irish	10.6% (236)	12.2% (544,357)
	Ethnicity of study sample LGBTIreland (N=2,221)*	**Ethnicity of population CSO 2011 (N=4,454,957)**
White (Irish)	87.5% (1,944)	85.8% (3,821,995)
White (Irish Traveller)	.6% (13)	.7% (29,495)
White (Non-Irish; any other White background)	8.8% (196)	9.3% (412,975)
Black or Black Irish (African; any other Black background)	.2% (4)	1.5% (65,078)
Asian or Asian Irish (Chinese; any other Asian background)	1.0% (22)	1.9% (84,690)
Other, including mixed background	1.9% (42)	.9% (40,724)

**Only includes participants 15+ years of age.*

Appendix 3: County and area living of survey sample

County (n=2,249)	Sample by County (N=2,249) % (n)	Population By County (N=4,558,252) %
Carlow	.8% (18)	1.2 (54612)
Cavan	.9% (21)	1.6 (73183)
Clare	1.1% (24)	2.6 (117196)
Cork	10.7% (239)	11.3 (519032)
Donegal	1.5% (33)	3.5 (161137)
Dublin	49.6% (1,116)	27.7 (1273069)
Galway	4.9% (110)	5.5 (250653)
Kerry	1.6% (36)	5.5 (145502)
Kildare	3.7% (83)	4.6 (210312)
Kilkenny	.8% (18)	2.1 (95419)
Laois	1.0% (22)	1.8 (80559)
Leitrim	.6% (13)	0.7 (31798)
Limerick	3.0% (67)	4.2 (191809)
Longford	.3% (6)	0.8 (39000)
Louth	2.8% (63)	2.7 (122897)
Mayo	1.5% (34)	2.8 (130638)
Meath	2.3% (51)	4.0 (184135)
Monaghan	.4% (9)	1.3 (60483)
Offaly	1.3% (29)	1.7 (158754)
Roscommon	.6% (14)	1.4 (76687)
Sligo	.7% (16)	1.4 (64065)

Tipperary	1.2% (27)	3.5 (65393)
Waterford	2.6% (58)	2.5 (113795)
Westmeath	1.5% (33)	1.9 (86164)
Wexford	1.7% (39)	3.2 (145320)
Wicklow	3.1% (70)	3.0 (136640)
Area living (n=2,259)		
Rural/country area	15.7% (354)	
Village	7.8% (176)	
Town	18.6% (419)	
Suburb of a city	30.1% (680)	
City	27.9% (630)	

Appendix 4: Employment status, education level, and religion of survey sample

Current employment status (n=2,256)	**% (n)**
Working for payment or profit	47.6% (1,074)
Student or pupil	34.6% (780)
CE Scheme; JobBridge; Back to Work; Internship	2.3% (51)
Looking for first regular job	2.8% (64)
Looking after home/family	1.3% (30)
Unemployed	8.5% (192)
Unable to work due to permanent sickness or disability	.6% (14)
Retired from employment	1.4% (31)
Other	.9% (20)
Highest level of education to date (n=2,260)	
Some primary education or less	.3% (6)
Completed primary education	1.9% (44)
Completed lower secondary level (Intermediate/Group/Junior Certificate, GCSEs)	13.8% (312)
Completed upper secondary level (Leaving Certificate, A Levels)	26.7% (604)
Completed third level education (Diploma, Degree, Postgraduate Degree)	55.9% (1,264)
Other	1.3% (30)
Religion (n=2,256)	
No religion	57.7% (1,301)
Roman Catholic	28.9% (653)
Church of Ireland	2.6% (59)
Other	10.8% (243)

Appendix 5: Employment status, education level, and religion of survey sample compared to general population

	Employment status of sample LGBTIreland (N=2,218)*	**Employment status of population CSO** (N=3,608,662)
Working for payment or profit	48.3% (1,072)	50.1% (1,807,360)
Student or pupil	33.7% (747)	11.3% (408,838)
Looking for first regular job	2.9% (64)	.9% (34,166)
Looking after home/ family	1.4% (30)	9.4% (339,918)
Unemployed	8.6% (191)	10.8% (390,677)
Unable to work due to permanent sickness or disability	.6% (14)	4.4% (156,993)
Retired from employment	1.4% (30)	12.7% (457,394)
Other**	3.2% (70)	.4% (13,316)
	Education of study sample LGBTIreland (N=2,260)	**Education of population CSO (N=2,863,619)**
Some primary education or less / Completed primary education	2.2% (50)	16.0% (456,896)
Completed lower secondary level	13.8% (312)	17.4% (499,489)
Completed upper secondary level	26.7% (604)	21.0% (601,498)

Completed education higher than upper secondary (diploma, technical courses, PhD, Masters, etc.)	57.2% (1,294)	45.6% (1,305,736)
	Religion of study sample LGBTIreland (N=2,218)*	**Religion of population CSO (N=4,515,338)**
Roman Catholic	28.9% (653)	85.5% (3,861,335)
Church of Ireland	2.6% (59)	3.0% (134,365)
No religion	57.7% (1,301)	6.0% (269,811)
Other	10.8% (243)	5.5% (249,827)

**Only includes participants 15+ years of age*

***Includes CE Scheme; JobBridge; Back to Work; Internship*

Appendix 6: LGBTI identity and relationship status of participant who identified as parents

LGBTI identity (n=221)	**% (n)**
Lesbian/gay female	42.5% (94)
Gay male	12.2% (27)
Bisexual (not trans or intersex)	16.7% (37)
Transgender	19.5% (43)
Intersex	4.5% (10)
Other identity	4.5% (10)
Relationship status (n=219)	
Relationship (monogamous)	58.4% (128)
Single and not dating	22.4% (49)
Single and dating	8.7% (19)
Relationship (non-monogamous)	5.9% (13)
Other	4.6% (10)

Appendix 7: Instruments considered in development of the module two survey

In designing the survey for module two, a number of previously developed instruments were reviewed and considered.
These included:

- Homophobia Scale (Wright, Adams, & Bernat 1999)
- Index of Attitudes toward Homosexuals (IAH) / Index of Homophobia (IHP) (Hudson & Ricketts 1980)
- Attitudes Toward Lesbians and Gays Scale (ATLG) (Herek 1984)
- The Riddle Scale / Riddle Homophobia Scale (Riddle 1984)
- Implicit Association Test (IAT) (Banse, Seise, & Zerbes 2001)
- Modern Homonegativity Scale – Gay Men / Lesbian Women (Morrison & Morrison 2002)
- PRRI Religion and Politics Tracking Survey (Public Religion Research Institute 2013)
- Genderism and Transphobia Scale (Hill & Willoughby 2005)
- European Social Survey (European Social Survey Team 2006)
- European Values Study (European Values Study 2008)

Appendix 8: Crosstabulations of public attitudes by gender and age

Frequency of interaction

	Frequency of interaction with LGB people	Summary of findings
Age	X(5)=18.961, p=.002	People between the ages of 18-34 interacted frequently/occasionally with LGB people between 81%-82% of the time compared to 63%-70% for those aged 35+. Younger participants (18-34) were more likely to have frequent/occasional interaction with LGB people compared to older participants (65+).
Gender	X(1)=6.647, p.006	Female participants were 7% more likely than male participants to have frequent/occasional interaction with LGB people.
	Frequency of interaction with trans people	Summary of findings
Age	X(10)=9.030, p=.529	No statistically significant differences.
Gender	X(2)=.558, p=.757	No statistically significant differences.

Belief system about being LGB

	Being lesbian, gay or bisexual is a sin	Summary of findings
Age	X(10)=18.371, p=.049	Slightly lower proportions of older people disagreed that being LGB is a sin, with 87% of those aged 18-24 disagreeing, and 85% of those aged 65+ disagreeing. 25-34 year olds agreed most often with the statement (13%) compared to the other age groups which ranged between 6%-10% in agreement.
Gender	X(2)=.502, p=.778	No statistically significant differences.

Frequency of interaction with LGB	X(2)=37.096, p=.000	Participants who rarely/never interacted with LGB people were 3x more likely to agree that being LGB is a sin compared to those who frequently/occasionally interacted with LGB people.
Frequency of interaction with trans	X(2)=6.875, p=.032	Participants who rarely/never interacted with transgender people were 2x more likely to agree that being LGB is a sin compared to those who frequently/occasionally interacted with transgender people.

	Lesbian, gay or bisexual people can be cured	**Summary of findings**
Age	x(10)=11.944, p=.289	No statistically significant differences.
Gender	X(2)=11.853, p=.003	Male participants were 2x more likely than female participants to agree that LGB people can be cured.
Frequency of interaction with LGB	X(2)=49.532, p=.000	Participants who rarely/never interacted with LGB people were nearly 4x as likely to agree that LGB people can be cured as those who frequently/occasionally interacted with LGB people. Those who frequently/occasionally interacted with LGB people were more than 15% more likely to disagree that LGB people can be cured than those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=1.799, p-.407	No statistically significant differences.
	Being lesbian, gay or bisexual is a choice	**Summary of findings**
Age	X(10)=7.915, p=.637	No statistically significant differences.
Gender	X(2)=20.846, p=.000	Male participants were more than 13% more likely than female participants to believe that being LGB is a choice.
Frequency of interaction with LGB	X(2)=7.803, p=.020	Participants who rarely/never interacted with LGB people were 8% more likely to believe that being LGB is a choice compared to those who frequently/occasionally interacted with LGB people.
Frequency of interaction with trans	X(2)=1.212, p=.545	No statistically significant differences.

	Being lesbian, gay or bisexual is just a phase that people can grow out of	Summary of findings
Age	X(10)=15.776, p=.106	No statistically significant differences.
Gender	X(2)=19.333, p=.000	Male participants were 2x more likely than female participants to agree that being LGB is a phase that people grow of.
Frequency of interaction with LGB	X(2)=37.934, p=.000	Those who rarely/never interacted with LGB people were nearly 2.5x more likely to agree that being LGB is just a phase that people can grow out of than those who frequent/occasionally interacted with LGB people. Those who occasionally/frequently interacted with LGB people were 18% more likely to disagree that being LGB is just a phase that people can grow out of compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=6.890, p=.032	Those who rarely/never interacted with transgender people were 5% more likely to disagree that being LGB is just a phase that people can grow out of compared to those who frequently/occasionally interacted with transgender people.
	Someone can be convinced to be or 'turn' lesbian, gay or bisexual	**Summary of findings**
Age	X(10)=13.181, p=.214	No statistically significant differences.
Gender	X(2)=6.304, p=.043	Female participants were 7% more likely than male participants to disagree that someone can be convinced to be or 'turn' LGB.
Frequency of interaction with LGB	X(2)=16.004, p=.000	Those who frequently/occasionally interacted with LGB people were nearly 13% more likely to disagree that someone can be convinced to be or 'turn' LGB than those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=.990, p=.609	No statistically significant differences.
	You can't possibly know your sexual orientation at a young age like 12	Summary of findings

Age	X(10)=18.260, p=.051	No statistically significant differences.
Gender	X(2)=23.047, p=.000	Female participants were nearly 15% more likely than male participants to disagree with the statement.
Frequency of interaction with LGB	X(2)=2.740, p-.254	No statistically significant differences.
Frequency of interaction with trans	X(2)=3.290, p=.193	No statistically significant differences.
	People who say they are bisexual are just confused about their sexual orientation	**Summary of findings**
Age	X(10)=11.048, p=.354	No statistically significant differences.
Gender	X(2)=5.236, p=.073	No statistically significant differences.
Frequency of interaction with LGB	X(2)=24.187, p=.000	Participants who rarely/never interacted with LGB people were 10% more likely to agree. Those who frequently/occasionally interacted with LGB people were 17% more likely to disagree.
Frequency of interaction with trans	X(2)=1.365, p=.505	No statistically significant differences.

	Lesbian, gay or bisexual people's sexual orientation is not normal	Summary of findings
Age	X(10)=32.014, p=.000	Older age groups tended to agree with this statement more than younger age groups. Participants 55 and older were more likely to agree, with 22% of those 65+ likely to agree compared to just 10% of those aged 18-24.
Gender	X(2)=7.517, p=.023	Female participants were 5% more likely than male participants to disagree.
Frequency of interaction with LGB	X(2)=52.497, p=.000	Participants who rarely/never interacted with LGB people were more than 2.5 times as likely to think that LGB people's sexual orientation is not normal.
Frequency of interaction with trans	X(2)=1.467, p=.480	No statistically significant differences.
	I fear that gay, lesbian or bisexual people will make advances towards me	**Summary of findings**
Age	X(10)=3.168, p=.977	No statistically significant differences.
Gender	X(2)=25.678, p=.000	Female participants were 10% more likely than male participants to report that they do not fear LGB people will make sexual advances towards them.
Frequency of interaction with LGB	X(2)=10.615, p=.005	Participants who rarely/never interacted with LGB people were 2x more likely to report that they fear LGB people will make sexual advances towards them compared to those who frequently/occasionally interact with LGB people.
Frequency of interaction with trans	X(2)=1.755, p=.416	No statistically significant differences.

Belief system about being transgender

	Being transgender is something you are born with	Summary of findings
Age	X(10)=37.038, p=.000	Interestingly, those 55+ were more likely to agree that being transgender is something you are both with. In the youngest age group (18-24), just 46% of people agreed with the statement compared to over 70% of those aged 55+.
Gender	X(2)=24.939, p=.000	Female participants were nearly 15% more likely than male participants to agree that being transgender is something you are both with.
Frequency of interaction with LGB	X(2)=17.530, p=.000	Participants who frequently/occasionally interacted with LGB people were over 10% more likely to agree that being transgender is something you are both with compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=5.028, p=.081	No statistically significant differences.
	It is difficult to accept transgender people as normal	**Summary of findings**
Age	X(10)=16.625, p=.083	No statistically significant differences.
Gender	X(2)=7.295, p=.026	Female participants were over 5% more likely than male participants to disagree that it is difficult to accept transgender people as normal.
Frequency of interaction with LGB	X(2)=33.940, p=.000	Participants who frequently/occasionally interacted with LGB people were over 20% more likely to disagree compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=17.397, p=.000	Participants who frequently/occasionally interacted with transgender people were 15% more likely to disagree compared to those who rarely/never interacted with transgender people.
	Transgender people should be able to change their legal documents (such as their birth certificate) to match their preferred gender	**Summary of findings**

Age	X(10)=12.276, p=.267	No statistically significant differences.
Gender	X(2)=11.743, p=.003	Female participants were 9% more likely than male participants to agree.
Frequency of interaction with LGB	X(2)=16.757, p=.000	Participants who frequently/occasionally interact with LGB people were 13% more likely to agree compared to those who rarely/never interact with LGB people.
Frequency of interaction with trans	X(2)=12.611, p=.002	Participants who rarely/never interact with transgender people were 2.5x more likely to disagree compared to those who occasionally/frequently interact with transgender people.

	If a family member decided to have a sex change, I would support their decision	**Summary of findings**
Age	X(10)=15.850, p=.104	No statistically significant differences.
Gender	X(2)=33.715, p=.000	Female participants were 15% more likely than male participants to agree.
Frequency of interaction with LGB	X(2)=62.469, p=.000	Participants who frequently/occasionally interacted with LGB people were nearly 25% more likely to compared to those who rarely/never interact with LGB people. Those who rarely/never interact with LGB people nearly 3x more likely to report that they would not support their family member's decision for a sex change.
Frequency of interaction with trans	X(2)=18.357, p=.000	Participants who frequently/occasionally interacted with transgender people were 13% more likely to agree compared to those who rarely/never interact with transgender people. Those who rarely/never interact with transgender people nearly 3x more likely to report that they would not support their family member's decision for a sex change.

Comfort with contact / proximity

	I would feel comfortable working closely with someone who is lesbian, gay or bisexual	Summary of findings
Age	X(10)=20.407, p=.026	Just 4% of those aged 55-64 felt that they would not be comfortable working with someone who is LGB compared to 6%-11% of those aged 18-44. 14% of those aged 45-54 and 65+ felt that they would not feel comfortable closely with someone who is LGB.
Gender	X(2)=17.751, p=.000	Females were almost 10% more likely than males to agree that they would feel comfortable working closely with someone who is LGB.
Frequency of interaction with LGB	X(2)=67.518, p=.000	Participants who frequently/occasionally interacted with LGB people were 22% more likely to agree that they would feel comfortable working closely with LGB people compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=6.519, =.038	Participants who rarely/never interacted with transgender people were nearly 2x as likely to report that they would not feel comfortable working closely with LGB people compared to those who frequently/occasionally interacted with transgender people.

	It wouldn't bother me if a close friend told me they were lesbian, gay or bisexual	Summary of findings
Age	X(10)=5.607, p=.847	No statistically significant differences.
Gender	X(2)=32.828, p=.000	Female participants were nearly 10% more likely than male participants to report that it would not bother them if a close friend told them they were LGB.
Frequency of interaction with LGB	X(2)=46.940, p=.000	Those who frequently/occasionally interacted with LGB people were 18% more likely to agree that it would not bother them if a close friend told them they were LGB compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=3.535, p=.171	No statistically significant differences.
	I would feel comfortable if my son/daughter were lesbian/gay/ bisexual	**Summary of findings**
Age	X(10)=37.834, p=.000	Those aged 65+ were 20% less likely to agree that they would feel comfortable if their son/daughter were LGB compared to those aged 18-34. 12% of those aged 55-64 were reported that they would not feel comfortable if their son/daughter were LGB compared to 20% of those aged 45-54 and 23% of those aged 65+.
Gender	X(2)=12.138, p=.002	Female participants were nearly 10% more likely than male participants to agree that they would feel comfortable if they son/daughter were LGB.
Frequency of interaction with LGB	X(2)=90.866, p=.000	Those who interacted frequently/occasionally with LGB people were over 30% more likely to agree that they would feel comfortable if their son/daughter were LGB compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=14.878, p=.001	Those who interacted frequently/occasionally with trans-gender people were nearly 15% more likely to agree that they would feel comfortable if their son/daughter were LGB compared to those who rarely/never interacted with transgender people.

	I can't help but feel uncomfortable in the company of lesbian, gay or bisexual people	Summary of findings
Age	X(10)=14.316, p=.159	No statistically significant differences.
Gender	X(2)=1.629, p=.443	No statistically significant differences.
Frequency of interaction with LGB	X(2)=54.850, p-.000	Those who rarely/never interacted with LGB people were more than 2x as likely to agree that they can't help but feel uncomfortable in the company of LGB people compared to those who frequently/occasionally interacted with LGB people.
Frequency of interaction with trans	X(2)=2.927, p=.231	No statistically significant differences.

	I would feel comfortable working closely with someone who is transgender	Summary of findings
Age	X(10)=7.736, p=.655	No statistically significant differences.
Gender	X(2)=19.938, p=.000	Female participants were over 10% more likely than male participants to report that they would feel comfortable working closely with someone who is transgender.
Frequency of interaction with LGB	X(2)=71.343, p=.000	Participants who frequently/occasionally interacted with LGB people were 25% more likely to report that they would feel comfortable working closely with someone who is transgender compared to those who interact rarely/never with LGB people.
Frequency of interaction with trans	X(2)=23.438, p=.000	Participants who never/rarely interacted with transgender people were more than 6.5x as likely to report that they would not feel comfortable working closely with someone who is transgender.
	I would feel comfortable with my child having a lesbian, gay or bisexual teacher	**Summary of findings**
Age	X(10)=21.226, p=.020	Those aged 18-24 were between 7-14% more likely to agree that they would feel comfortable with their child having a LGB teacher.

Gender	X(2)=19.331, p=.000	Female participants were more than 11% more likely than male participants to report that they would feel comfortable with their child having a LGB teacher.
Frequency of interaction with LGB	X(2)=99.935, p=.000	Those who frequently/occasionally interacted with LGB people were 29% more likely to report that they would feel comfortable with their child having a LGB teacher.
Frequency of interaction with trans	X(2)=14.678, p=.001	Those who frequently/occasionally interacted with trans people were 12% more likely to report that they would feel comfortable with their child having a LGB teacher.

	I would feel comfortable with my child having a transgender teacher	**Summary of findings**
Age	X(10)=20.375, p=.026	Those aged 35 and over were less likely to agree that they would feel comfortable with their child having a transgender teacher, with between 57%-60% feeling comfortable compared to 68%-75% of those aged 18-34. A marked exception was 65% of those in the age range of 55-64 who would feel comfortable.
Gender	X(2)=23.055, p=.000	Female participants were 14% more likely than male participants to agree that they would feel comfortable with their child having a transgender teacher.
Frequency of interaction with LGB	X(2)=50.924, p=.000	Participants who frequently/occasionally interacted with LGB people were over 20% more likely than those who never/rarely interacted with LGB people to agree that they would feel comfortable with their child having a transgender teacher. Those who rarely/never interacted with LGB people were more than 2x as likely to disagree.
Frequency of interaction with trans	X(2)=26.515, p=.000	Participants who frequently/occasionally interacted with transgender people were over 18% more likely than those who never/rarely interacted with transgender people to agree that they would feel comfortable with their child having a transgender teacher. Those who rarely/never interacted with LGB people were more than 3x as likely to disagree.

	It wouldn't bother me if a close friend told me they were transgender	Summary of findings
Age	X(10)=16.178, p=.095	No statistically significant differences.
Gender	X(2)=15.127, p=.001	Female participants were 10% more likely than male participants to agree that it wouldn't bother them if a close friend told them they were transgender.
Frequency of interaction with LGB	X(2)=61.096, p=.000	Participants who frequently/occasionally interacted with LGB people were nearly 30% more likely to agree that it wouldn't bother them if a close friend told them they were transgender compared to those who rarely/never interact with LGB people. Those who rarely/never interact with LGB people were nearly 3x more likely to disagree.
Frequency of interaction with trans	X(2)=23.503, p=.000	Participants who frequently/occasionally interacted with transgender people were 14% more likely to agree that it wouldn't bother them if a close friend told them they were transgender compared to those who rarely/never interact with transgender people. Those who rarely/never interact with transgender people were more than 5x more likely to disagree.

	I would feel comfortable if my son or daughter was transgender	Summary of findings
Age	X(10)=20.092, p=.028	Those in the youngest age group of 18-24 were more likely to agree (70%) that they would feel comfortable if their son or daughter was transgender. Those aged 45-54 (48%) and 65% (49%) were least likely to agree. Those aged 25-44 (57%-60%) and 55-64 (57%) fell somewhere in between.
Gender	X(2)=14.859, p=.001	Female participants were nearly 12% more likely than male participants to agree that they would they feel comfortable if their son or daughter were transgender.

Frequency of interaction with LGB	X(2)=81.767, p=.000	Participants who frequently/occasionally interacted with LGB people were nearly 30% more likely to agree that they would they feel comfortable if their son or daughter were transgender compared to those who interact rarely/never with LGB people. Those who rarely/never interact with LGB people were nearly 2.5x as likely to report that they would not feel comfortable if their son or daughter was transgender.
Frequency of interaction with trans	X(2)=13.572, p=.001	Participants who frequently/occasionally interacted with transgender people were nearly 13% more likely to agree that they would they feel comfortable if their son or daughter were transgender compared to those who interact rarely/never with transgender people. Those who rarely/never interact with transgender people were nearly 2x as likely to report that they would not feel comfortable if their son or daughter was transgender.

Sexual expression / affection of LGB people

	People should keep their sexuality to themselves.	**Summary of findings**
Age	X(10)=88.596, p=.000	The older a participant, the more likely they were to agree that people should keep their sexuality to themselves. Participants aged 65+ were between 38%-41% more likely than those aged 18-34 to agree that people should keep their sexuality to themselves.
Gender	X(2)=24.045, p=.000	Female participants were 15% more likely than male participants to disagree that people should keep their sexuality to themselves.
Frequency of interaction with LGB	X(2)=24.078, p=.000	Participants who rarely/never interacted with LGB people were 15% more likely to agree that people should keep their sexuality to themselves when compared to those who frequently/occasionally interacted with LGB people.
Frequency of interaction with trans	X(2)=1.665, p=.435	No statistically significant differences.

	I am comfortable with a man and woman couple kissing in public.	Summary of findings
Age	X(10)=62.843, p=.000	The younger a participant, the more likely they were to agree that they are comfortable with a man and woman couple kissing in public. Those aged 65+ were between 26%-29% less likely to agree that they are comfortable with a man and woman couple kissing in public compared to those aged 18-34.
Gender	X(2)=4.061, p=.131	No statistically significant differences.
Frequency of interaction with LGB	X(2)=21.295, p=.000	Participants who frequently/occasionally interacted with LGB people were 15% more likely to agree that they are comfortable with a man and woman couples kissing in public compared to those who rarely/never interacted with LGB people.
Frequency of interaction with trans	X(2)=1.959, p=.376	No statistically significant differences.
	I am comfortable with a female couple (two women) kissing in public.	**Summary of findings**
Age	X(10)=109.997, p=.000	Younger age groups were more likely than older age groups to agree that they feel comfortable with a female couple kissing in public. Those aged 65+ were between 35%-43% more likely than those aged 18-34 to disagree that they feel comfortable with a female couple kissing in public.
Gender	X(2)=.771, p=.680	No statistically significant differences.
Frequency of interaction with LGB	X(2)=57.558, p=.000	Those who frequently/occasionally interacted with LGB people were 23% more likely to report that they are comfortable with a female couple kissing in public than those who rarely/never interact with LGB people.
Frequency of interaction with trans	X(2)=17.517, p=.000	Those who frequently/occasionally interact with transgender people were 16% more likely to report that they are comfortable with a female couple kissing in public than those who rarely/never interact with transgender people.

	I am comfortable with a male couple (two men) kissing in public.	Summary of findings
Age	X(10)=103.088, p=.000	Younger age groups were more likely than older age groups to agree that they feel comfortable with a male couple kissing in public. Those aged 65+ were between 36%-42% more likely than those aged 18-34 to disagree that they feel comfortable with a male couple kissing in public.
Gender	X(2)=7.620, p=.022	Male participants were 9% more likely than to female participants to disagree that they are comfortable with a male couple kissing in public.
Frequency of interaction with LGB	X(2)=65.296, p=.000	Those who frequently/occasionally interacted with LGB people were more than 25% more likely to report that they are comfortable with a male couple kissing in public than those who rarely/never interact with LGB people.
Frequency of interaction with trans	X(2)=16.272, p=.000	Those who frequently/occasionally interacted with transgender people were nearly 15% more likely to report that they are comfortable with a male couple kissing in public than those who rarely/never interact with transgender people.

Acceptance of discrimination of LGBT people

	I think it's okay not to employ someone on the basis that they are lesbian, gay or bisexual	Summary of findings
Age	X(10)=18.882, p=.042	Interestingly, both the youngest (18-24 years: 11%) and oldest (65+ years: 13%) age groups were more than 2x as likely as those in the middle (25-54) to agree that it's okay not to employ someone on the basis that they are LGB. Those between 25-64 years agreed only 5-6% of the time.
Gender	X(2)=1.918, p=.383	No statistically significant differences.
Frequency of interaction with LGB	X(2)=28.184, p=.000	Participants who never/rarely interacted with LGB people were nearly 3x more likely to think it is okay not to employ someone on the basis that they are LGB compared to those who frequently/occasionally interact with LGB people.

Frequency of interaction with trans	X(2)=.095, p=.953	No statistically significant differences.
	I think it's okay not to provide a service (e.g. a hotel, a photographer or a Bed &Breakfast) to someone on the basis that they are lesbian, gay or bisexual	**Summary of findings**
Age	X(10)=25.085, p=.005	The older a participant was, the less likely they were to disagree with that it's okay not to provide a service to someone on the basis that they are LGB. Participants aged 18-24 were more than 10% more likely to disagree that it's okay not to provide a service to someone on the basis that they are LGB.
Gender	X(2)=3.852, p=.146	No statistically significant differences.
Frequency of interaction with LGB	X(2)=19.338, p=.000	Participants who rarely/never interacted with LGB people were 2.5x more likely to think it's okay not to provide a service to someone on the basis that they are LGB compared to those who frequently/occasionally interact with LGB people.
Frequency of interaction with trans	X(2)=4.132, p=.127	No statistically significant differences.
	I think it's okay not to employ someone on the basis that they are transgender	**Summary of findings**
Age	X(10)=13.545, p=.195	No statistically significant differences.
Gender	X(2)=3.213, p=.201	No statistically significant differences.
Frequency of interaction with LGB	X(2)=17.518, p=.000	Participants who never/rarely interact with LGB people were nearly two times more likely to agree that it's okay not to employ someone on the basis that they are transgender when compared to those who frequently/occasionally interact with LGB people.

Frequency of interaction with trans	X(2)=3.660, p=.160	No statistically significant differences.

Tolerance of school bullying

	Bullying is a normal part of growing up and schooling	**Summary of findings**
Age	X(10)=8.021, p=.627	No statistically significant differences.
Gender	X(2)=7.833, p.020	Female participants were 8% more likely than male participants to disagree that bullying is a normal part of growing up and schooling.
Frequency of interaction with LGB	x(2)=.250, p=.882	No statistically significant differences.
Frequency of interaction with trans	X(2)=.735, p=.693	No statistically significant differences.
	Making fun of (or 'slagging') a young person in school because they are lesbian, gay or bisexual is not harmful	**Summary of findings**
Age	**Expected cell counts too small in 6 cells.	
Gender	X(2)=24.087, p=.000	Male participants were 7% more likely than female participants to think that slagging a young person in school because they are LGBT is not harmful. Female participants were 10% more likely than male participants to think it is harmful.
Frequency of interaction with LGB	X(2)=54.902, p=.000	Those who only rarely/never interacted with LGB people were nearly 3x more likely to think that slagging a young person in school because they are LGBT is not harmful.
Frequency of interaction with trans	X(2)=4.909, p=.086	No statistically significant differences.

Education about LGBT issues in school

	LGBT issues should be addressed in Relationships & Sexuality Education (RSE) within schools	Summary of findings
Age	X(10)=5.577, p=.849	No statistically significant differences.
Gender	X(2)=12.957, p=.002	Female participants were 9% more likely to think that LGBT issues should be addressed in RSE within schools compared to male participants.
Frequency of interaction with LGB	X(2)=56.166, p=.000	Participants who had rarely/never interacted with LGB people were 3x more likely than those who frequently/occasionally interacted with LGB people to think LGBT issues should not be included in the RSE curricula.
Frequency of interaction with trans	x(2)=20.940, p=.000	Participants who had rarely/never interacted with trans people were 5x more likely than those who frequently/occasionally interacted with trans people to think LGBT issues should not included in the RSE curricula.
	Teachers should give students positive messages about LGBT identities	**Summary of findings**
Age	X(10)=19.367, p=.036	Those aged 18-44 were between 8%-15% more likely than those aged 45+ to agree that teachers should give students positive messages about LGBT identities.
Gender	X(2)=21.356, p=.000	Female participants were 10% more likely than male participants to agree that teachers should give students positive messages about LGBT identities.
Frequency of interaction with LGB	X(2)=23.323, =.000	Those who interacted occasionally/frequently with LGB people were nearly 15% more likely to agree that teachers should give students positive messages about LGBT identities.
Frequency of interaction with trans	X(2)=6.863, p=.032	Those who interacted occasionally/frequently with trans people were nearly 9% more likely to agree that teachers should give students positive messages about LGBT identities.
	Learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment	**Summary of findings**
Age	X(10)=19.367, p=.036	Interestingly, the youngest (18-24: 36%) and oldest (65+: 34%) age groups were more likely to agree with this statement when compared to age ages 25-64 (22%-26%).

Gender	X(2)=14.681, p=.001	Female participants were nearly 12% more likely than male participants to disagree that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment.
Frequency of interaction with LGB	X(2)=.377, p=.828	No statistically significant differences.
Frequency of interaction with trans	X(2)=1.897, p=.387	No statistically significant differences.

Politics of being LGB

	Equality has been achieved for lesbian, gay, and bisexual people	**Summary of findings**
Age	X(10)=11.528, p=.318	No statistically significant differences.
Gender	X(2)=.414, p=.813	No statistically significant differences.
Frequency of interaction with LGB	X(2)=16.329, p=.000	Participants who never/rarely interact with LGB people were 11% more likely to believe that equality has been achieved for LGB people compared to those who frequently/occasionally interact with LGB people.
Frequency of interaction with trans	X(2)=7.163, p=.028	Participants who never/rarely interact with transgender people were 9% more likely to believe that equality has been achieved for LGB people compared to those who frequently/occasionally interact with transgender people.
	Being a lesbian, gay, or bisexual person today is no longer really an issue	**Summary of findings**
Age	X(10)=13.997, p=.173	No statistically significant differences.
Gender	X(2)=3.254, p=.197	No statistically significant differences.
Frequency of interaction with LGB	X(2)=3.927, p=.140	No statistically significant differences.
Frequency of interaction with trans	X(2)=.304, p=.859	No statistically significant differences.

GLEN

GLEN is a national policy and strategy focused NGO which aims to deliver ambitious and positive change for lesbian, gay, bisexual and transgender people in Ireland, ensuring full equality, inclusion and protection from all forms of discrimination and harm. We have a range of work programmes including mental health, education, workplace, sexual health, families and older people.

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BeLonG To

BeLonG To is the national youth service for lesbian, gay, bisexual and transgender young people aged between 14 and 23. BeLonG To's vision is for an Ireland where Lesbian Gay bisexual and transgender (LGBT) young people are empowered to embrace their development and growth confidently and to participate as agents of positive social change.

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TENI

Transgender Equality Network Ireland is a non-profit organisation supporting the trans community in Ireland. TENI seeks to improve the situation and advance the rights and equality of trans people and their families. Our Vision is an Ireland where trans people are understood, accepted and respected, and can participate fully in all aspects of Irish society.

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For information on LGBTI services visit **www.lgbt.ie**

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