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Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the 'failed' self

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Abstract

International evidence suggests that young people are less likely to seek help for mental health problems in comparison with adults. This study focused on lesbian, gay, bisexual and trans young people who are a population group with an elevated risk of suicide and self-harm, and little is known about their help-seeking behaviour. Utilising qualitative virtual methods, lesbian, gay, bisexual and trans youth web-based discussions about seeking help for suicidal feelings and self-harming were investigated. Findings from a thematic analysis indicate that these young people wanted assistance but found it difficult to (1) ask for help, (2) articulate emotional distress and (3) 'tell' their selves as 'failed'. This analysis suggests that key to understanding these problems are emotions such as shame which arise from negotiating norms connected to heterosexuality, adolescence and rationality. I argue that these norms act to regulate what emotions it is possible to feel, what emotions it is possible to articulate and what type of young lives that can be told. The future development of health and social care interventions which aim to reduce lesbian, gay, bisexual and trans youth suicide and self-harm need to work with a nuanced understanding of the emotional life of young people if they are to be effective.

Keywords

help-seeking, LGBT, online, suicide, youth

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Introduction

Prevalence rates of adolescent self-harm and suicide attempts vary and are dependent upon the definition utilised, the type of sample assessed and the method of measurement (Stallard et al., 2013). However, it is clear that self-harm and suicide attempts in adolescents are a significant problem, with European community surveys indicating that between 3 and 10 per cent report at least one episode of self-harm in the past year and lifetime rates of between 9 and 14 per cent (Kokkevi et al., 2012; Madge et al., 2011; Moran et al., 2012). Lesbian, gay, bisexual and trans[1] (LGBT) young people have an increased risk of self-harm and suicide. International research from the United States, Australia, New Zealand and Europe estimates this to be between four and eight times higher than their heterosexual peers (Haas et al., 2011). Survey evidence repeatedly suggests that the key factors behind this are homophobic and transphobic abuse, social isolation, early identification as LGBT, conflict with family or peers about sexual or gender identity, inability to disclose sexual or gender identity and common mental health problems (Haas et al., 2011).

Evidence from high-income countries worldwide indicates that young people are reluctant to seek help for mental health problems (Gulliver et al., 2010), and adolescents who self-harm[2] are particularly disinclined to seek help for their emotional distress (Michelmore and Hindley, 2012). In a representative sample, Evans et al. (2005) surveyed over 6000 15- to 16-year-old school pupils in England and found that young people who self-harmed were most likely to feel the need for help but least likely to seek help compared to those with other mental health problems. We know that LGBT youth have difficulties accessing help (Grossman and D'Augelli, 2006; Lucassen et al., 2011), but we know relatively nothing about how they might seek help, who they look to for help and whether this support is successful.

School surveys show that young people who self-harm are less able than their peers to talk to their family or teachers and have fewer categories of people they can talk to (Hawton et al., 2006). They also find it difficult to express their distress and ask for help (Fortune et al., 2008; Hawton et al., 2006). For all young people, the most frequent source of help is friends and then family; far fewer seek help from formal services or health professionals (Evans et al., 2005; Fortune et al., 2008; Michelmore and Hindley, 2012). These studies indicate there are 'attitudinal barriers' to accessing help; young people who self-harm do not want help, do not think their problems serious enough or think you should sort your problems out on your own (Curtis, 2010; Fortune et al., 2008; Michelmore and Hindley, 2012). In general, the factors which influence whether a young person in mental distress chooses to talk are under-researched (Evans et al., 2005; Fortune et al., 2008).

The scant evidence we have about LGBT youth who self-harm suggests that they may be reluctant to use mainstream mental health and school-based services (McDermott et al., 2013a; PACE, 2010; Williams and Chapman, 2011) and rely on LGBT voluntary organisations for support for suicidal distress (Johnson et al., 2007; McDermott et al., 2008; Scourfield et al., 2008). However, research suggests some do seek help online, wanting help with, for example, confusion about sexuality and gender, dealing with homophobia, biphobia and transphobia, how to stop self-harming, and coping with suicidal thoughts and emotional distress (McDermott et al., 2013a; McDermott and Roen, 2012; PACE, 2010).

One explanation for young people's reluctance to seek help for mental health problems has been the stigma associated with a mental health diagnosis (Biddle et al., 2007; Gulliver et al., 2010; Hawton et al., 2006; Moses, 2009). This evidence suggests young people are concerned about being considered 'weird' or 'crazy' or labelled an attention seeker if they approach mental health services; they also describe feeling ashamed or embarrassed (Biddle et al., 2007; Curtis, 2010; Fortune et al., 2008; Scourfield et al., 2011). Most research on young people's mental health service utilisation is based on survey data, which tends to reduce the stigma of mental illness to a variable and does not question *why* mental illness is stigmatised or whether this stigma may be related to other factors such as sexuality or adolescence. The stigma related to mental health, it has been argued, is profoundly shaped by social factors, that is, by both structural relations within society and cultural norms (Scambler, 2011). There is an emerging understanding, furnished through qualitative studies of young people with mental health problems, that they do not seek help because they want to position themselves within normative expectations of young adulthood and refuse to take actions which compromise this normality (Biddle et al., 2007; Fullagar, 2005; McDermott et al., 2008; Prior, 2012). Biddle and colleagues' findings suggest young people do not seek help for mental health problems because they want to avoid social disapproval. They state that stigma was 'a prominent reason underlying normalisation, non-help-seeking and avoidance of real distress' (Biddle et al., 2007: 16). This resonates with studies on youth suicide which highlight the role of shame, stigma and feelings of failure in relation to help-seeking. Fullagar's (2005) research connects shame to the failed normative-self and suggests that suicidal thoughts enable young people to escape those pressures which make them feel unworthy or failed as a young person. Similarly, research on LGBT youth suicide shows they are reluctant to seek help due to shame related to transgressing heterosexual norms and attempt to deal with emotional distress through minimising its importance and trying to cope alone (McDermott et al., 2008).

In this article, I report on a study which aimed to explore LGBT young people's online discussions about help-seeking for emotional distress to provide insight into why there are difficulties asking for help. At the heart of the analysis is an examination of *what* is stigmatised, in other words, what is normal? I argue that in order to understand why young people avoid help-seeking, we must first thoroughly critique the developmental psychology concept of 'adolescence' and how this establishes a particular normative development which governs young citizens as future rational and emotionally restrained adults. I suggest that self-harming LGBT youth have a particularly onerous task of positioning themselves as subjects worthy of helping because they transgress the intersecting social norms of adolescence, rationality *and* heterosexuality. The navigation of these imposed normative conditions of existence may make it almost (im)possible to ask for help, articulate distress or tell the youthful LGBT self as troubled. In the next section, I outline the theoretical framework used for the study, and the subsequent four sections present the study method and findings.

Theoretical framework

Current biomedical and psychiatric models of self-harm and suicide individualise the problem, pathologise emotional distress and exclude the social, economic and cultural

factors which may influence young people's self-harming behaviour and their help-seeking (Alder and Alder, 2011; Chandler et al., 2011; Inckle, 2010). The medicalisation of suicide and its reformulation as a question of pathology (rather than a crime or a sin) underlies contemporary suicide research, policy and intervention, and firmly anchors self-harm within the 'interiority' of an individual subject (Marsh, 2010). As a result, suicide and self-harm are understood as a private and individual distress which is divorced from issues of social justice, exclusion and discrimination, stigma and power (Fullagar, 2005).

While the dominant frame within which suicide is understood focuses on individual intrapsychic risk factors, ignoring the social context, the long historical psychopathologisation of 'deviant' sexualities and genders, where a person is labelled as mentally ill by virtue of their sexual and/or gender non-conformity, serves to remind us of the role mental illness diagnoses have in defining social 'deviance' and social norms (Rogers and Pilgrim, 2010). Despite the removal of homosexuality from psychiatric classification in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, there remains a dangerous association between certain gender and sexual characteristics and pathology (Davy, 2011). LGBT people continue to encounter this pathology model in mental health services (Welch et al., 2000), and LGBT youth continue to be psychopathologised through the association of sexual and gender non-normativity with the *risk* of mental illness (Harwood, 2004).

Alongside the wilful exclusion of social context to explain self-harm, the psychopathologising models used to investigate youth suicide operate within a developmental psychology paradigm where adolescence is taken-for-granted as naturally occurring and biologically determined (Lesko, 2001). Developmental perspectives define adolescence as a transitional period between childhood and adulthood which is marked by linear sequential stages of physiological change, bodily development and identity experimentation (see, for example, Erikson, 1968; Hall, 1904; Kroger, 1996). However, adolescence is far from a wholly 'natural' biological stage in the human life-cycle. Critics have shown that the term 'adolescence' appeared in the late 19th and early 20th century in the West as part of wider concerns regarding children and the future of the state, race and nation (Burman, 2008; Lesko, 2001; Rose, 1999; Walkerdine, 1984). Both Lesko's (2001) US analysis and Rose's (1999) UK analysis highlight the anxieties and concerns in this period over the threat of children and young people to social order and morality, and the need to produce docile workers, healthy soldiers and model citizens. As a result, a plethora of government organisations (e.g. public health, juvenile courts, child guidance clinics), social agencies (e.g. Boy Scouts) and legal powers (e.g. formal secondary education) grew around addressing the troubled and delinquent child and shaping future citizens. Adolescence became, and remains, a technology to produce a certain kind of rational individual (Harris, 2004; Lesko, 2001; Rose, 1999).

Within this adolescent development paradigm, young people's emotions are considered unruly, under-developed, immature, out of control and often 'unreasonable' (Lesko and Talburt, 2011). This characterisation can be traced back to G Stanley Hall's (1904) renowned view that adolescence is inherently a time of 'storm or stress'. Emotional restraint and mastering one's emotions is a key feature of adulthood with which young people must comply if they are to become a 'mature' neo-liberal individual (Rose, 1999).

As Norbet Elias (1994) suggests, the systematic institution of 'self-control' is crucial to civil society – 'the regulation of the whole instinctive and affective life by steady self-control' (p. 365). The need for adolescent emotional 'disorder' to be regulated is reflected in the fact that the current version of the DSM-V (APA, 2013) has almost 100 pages of disorders associated with infancy, childhood and adolescence. Developmental psychological discourses reproduce a division between the rational adult and the emotional adolescent (Burman, 2008; Lesko, 2001; Wyn et al., 2012), which produces a tendency for young people's emotions to be demeaned and temporalised – 'it's a phase', 'they will grow out of it', 'it's their hormones', 'it's a teenage thing'. If young people display emotions, even articulating distress, it functions to confirm their immaturity and their absence of emotional restraint. I frame my analysis of LGBT youth self-harm and help-seeking from the understanding that neo-liberal democracy requires a certain type of adult subject, one who is rational, autonomous and responsible for their own emotions (Walkerdine et al., 2001).

The regulation of the lives of young people does not only focus upon governing the emotions. As Lesko (2001) eloquently observes, adolescent bodies are 'a terrain in which struggles over what would count as an adult, a woman, a man, rationality, proper sexuality, and orderly development' are played out (p. 50). A substantial body of work on youth, gender and sexuality has demonstrated that to become a rational and responsible adult citizen, young people are regulated to 'develop' through heterosexuality and the essentialist gender-binary (see, for example, Epstein and Johnson, 1998; Harris, 2004; Mac an Ghaill, 1994; Nayak and Kehily, 1997; Talburt, 2004); they must become the 'heteronormative good future citizen' (Robinson, 2012: 257). This poses a potential problem for LGBT youth who transgress heterosexual norms of sexuality and gender. Studies have shown how gender and sexual norms are policed through homophobia and transphobia, where differences from heterosexuality and transgressive-gender bodies are punished through ridicule, verbal abuse, physical violence and silence (Epstein and Johnson, 1998; Frosh et al., 2002). It should be no surprise that internationally, homophobia and transphobia are both established in the literature as a major factor in explaining emotional distress and elevated rates of suicide and self-harm in LGBT youth (D'Augelli, 2003; Hillier and Harrison, 2004; McDermott et al., 2008; Rivers and Cowie, 2006).

The interpretative frame for this study works with the idea that, despite improvements in LGBT equality, some LGBT youth experience difficult emotions, such as shame, which arise from transgressing the norms of heterosexuality, adolescence and rationality. The combination of having same-sex feelings and/or the 'wrong' gender orientations, being emotional, unable to cope and wanting to hurt themselves, make asking for help seem impossible. In a sense, emotional distress is, Ahmed (2004) argues, 'the affective cost of not following the scripts of normative existence' (p. 107). From a post-modern, Foucauldian viewpoint, Butler's (2004) idea of intelligibility allows us to appreciate how difficult it is to *be* human when an individual feels outside the norms of recognition in terms of gender and sexuality, is young so has not had 'adult' status conferred and has irrational feelings of hurting oneself. As Foucault (1976) illustrated, these norms do not just exist; they regulate, coerce and enforce narrow ways of sexual and gendered existence and what it means to be a rational adult, and they 'operate as a condition of cultural intelligibility' (Butler, 2004: 52). For this study, self-harm and suicide are re-thought so

that emotional distress is not figured as solely residing in the individual but is instead understood as relational to social norms and implicated in their production and maintenance (Burman, 2008). In the next section, I outline the methodology of the study, and the subsequent sections present findings which suggest that the failure to fit within narrow social norms impacts the help-seeking behaviour of young LGBT people who are emotionally distressed.

Method

This study[3] was an examination of public Internet spaces where young LGBT people were discussing self-harm and suicidal feelings. This article examines the research findings addressing the question, 'What help-seeking strategies do LGBT youth employ regarding their self-harm?'

The research did not interact with participants but collected already existing publically available material on the Internet. Consent was not sought from individuals who had posted this material. Ethical guidance was drawn from the British Psychological Society (2007) and the Association of Internet Researchers (Markham and Buchanan, 2012) and focused upon respecting the Internet contributors' expectations of privacy and considering the extent to which researchers' observations may potentially harm Internet contributors. Web-based discussions were only included in the study if it appeared that contributors did not have an expectation of privacy and where the use of this data was judged to not lead to harm. In order to protect contributors' anonymity in this article, paraphrasing and very short quotations are utilised because often full quotes can be traced back to the original post through web search engines (Wilkinson and Thelwall, 2011). No identifying information is given about the contributors or the specific websites from which data have been drawn. The study was reviewed and approved by the University of York Humanities and Social Science Research Ethics Committee.

Data were collected using a search strategy with specific criteria that included gender, sexuality, age, self-harm, geographical location and time. A range of search terms were used to identify where issues of youth, sexuality, gender identity, suicide and self-harm were discussed online, for example, LGBT youth websites, self-harm support websites, forums and blogs.

These search terms lead to a variety of websites where self-harm was mentioned, but did not necessarily contain discussions of self-harm by LGBT youth. To find such specific websites, two strategies were employed. First, two categories of relevant sites were identified: (1) those tailored for young LGBT people and (2) those focusing on self-harm. Many of the websites identified had their own search engines which were used to locate relevant material. Relevant material was successfully located by searching LGBT youth websites for self-harm discussions. There were not many relevant threads found by searching self-harm sites for discussions related to sexuality and gender identity. The second search strategy involved working at the level of the generic search engine and combining different search terms, that is, ('I self harm' and 'I am lesbian') or ('I cut myself' and 'I am transgender'). Using such advanced searches led to a significant increase in relevant results, as this did not limit the number of accessed websites but widened the searches to the entire World Wide Web.

The final dataset consisted of 49 excerpts from 20 websites. A total of 12 excerpts were from blogs and 37 were from discussion forums. It is estimated that there were 290 contributors in the dataset. The sample was differently distributed than one generated face-to-face through LGBT youth groups and clinical support services because it contained LGBT youth with a variety of experiences of help-seeking and included those who have not sought help. This is important because much self-harming is hidden and does not result in medical attention (Hawton et al., 2006), and similarly suicide ideation does not always lead to clinical intervention in adolescents. In other words, clinical-based samples exclude a significant proportion of adolescents who self-harm and/or have suicidal feelings. The contributors' ages ranged from 13 to 25 years which included adolescents through to young adults, and it is the range used to define young people in UK policy. The analysis of the posts took account of the differences these ages may make to help-seeking.

The data were analysed thematically, inputting the selected downloaded text into the data analysis software Atlas.ti/6. Guided by the research questions and theoretical framework, the data were 'open-coded' descriptively and conceptually through a line-by-line inspection of each primary document (Miles and Huberman, 1994). A coding frame was designed by the three members of the research team to improve inter-code validity, and the coding process was carried out by the same research team members to ensure inter-code reliability. The next stage clustered the codes into potential themes through the constant comparison technique (Strauss and Corbin, 1998). Subsequent analysis used thematic maps and reports to produce a coherent set of themes (Mason, 2002). From the selected data extracts, a descriptive and theoretical argument consistent with the purpose of the study was formulated (Braun and Clark, 2006) (for a full methodological account see McDermott et al., 2013b). The next three sections present the findings of the analysis.

Findings

Asking for help online

> all my family think i am straight. i want to tell them im gay because i am sick of lying about it. some friends know my secret but no one knows i sometimes self harm because i have no one to talk to. please help? (Gay, 16 years old)[4]

The data for this study were drawn from web spaces where contributors were asking each other for help and support about their emotional distress, self-harming, suicidal feelings, being lesbian, gay, bisexual and/or trans and dealing with homophobia, biphobia and transphobia. In the post above, this young gay person exemplified the web of lies, silence and deceit which circulates around *both* self-harm and sexuality. They wrote that they must hide their emotions and orientations from their family and some friends. However, as this study makes clear, young LGBT people were willing to disclose their sexual and gender non-conformity, write about their mental health difficulties and ask for help in cyber space. A 16-year-old lesbian posted, 'I've self harmed for like a year and I can't stop, there's no way I'm telling anyone … please help; self harm help, gay help

advice whatever'. This young person was asking for help online, but they also write 'there's no way I am telling anyone', that is, they were prepared to communicate their sexuality and self-harm online but not directly to helping professionals or other responsible adults. The study only found LGBT youth asking for help in forums specifically designed for LGBT youth not generic self-harm sites. This reflects research evidence that LGBT youth are more likely to use LGBT-orientated support services rather than mainstream mental health services. The broader point here is that the spaces in which LGBT youth feel they can ask for help are restricted, even online.

A significant proportion of LGBT youth encouraged each other to seek help from clinical services, schools, friends and 'trusted' adults. For example, a gay 16-year-old responding to a post describing homophobic bullying in school wrote,

> As for the physical abuse, can't you tell a teacher/family member/counselor? Tell someone, it's important that you do!
>
> Secondly, none of this is your fault. Don't take out the hurt on your body (smoking, drinking, cutting).

Despite the encouragement to seek help, a dominant theme in the data was LGBT youth describing the difficulty in asking for help. A queer trans, 18-year-old posted, 'I want to call a helpline but I just can't bring myself to pick up the phone'. Their online discussions indicated they were concerned about what others may think of them, confidentiality, hurting their families, fear of disclosing their sexuality, gender-variance or self-harm, and fear of rejection, isolation and the future. The most prominent reason articulated for not seeking help was fear regarding their sexuality or gender. For example, a 22-year-old trans man posted,

> I'm at the point where I need to go to a doctor and see about getting something to help with the anxiety. But at the same time, I'm terrified of coming out, terrified of being disowned, ignored, hated. Terrified of trying to find a job in super-conservative city while I transition. And I have no idea what to do and this is all just adding to the stress and emotional burden But I really needed to tell someone.

This young trans man clearly stated, like many other young people writing online, that the uncertainty and fear about the future were worsening his emotional turmoil. The expectations on young people to show an independent, self-determined orientation to future adulthood lays a heavy burden at their feet; they must, as Valerie Walkerdine et al. (2001) suggest, endure the 'emotional costs of success and failure' (p. 214). The online data demonstrated that these young distressed people had to think about a future which entailed navigating the potential hostility or misunderstanding towards their sexuality and gender, and the psychological strain seemed to make it more challenging to seek, and ask for, help. In many cases, they wrote that it was easier to remain silent and hide their pain and distress.

In addition to fears about disclosing their LGB or T identity, the posts suggested that young people were deeply concerned about the stigmatising consequences of being labelled 'mad' if they asked for help for their emotional distress. The following post illustrates the dilemma:

> I have been feeling pretty stressed recently, mainly due to work. So I decided to use the free counselling service they provide. She suggested thinking about medication again, to prevent illness. I know she is right. But I really don't like everything it represents. I do not want to be ill. I do not want to be a patient. I want to be the therapist. Not the crazy one. Funny that I said I wanted on going help. This ambivalence is killing me. I want help but I don't. Want to be gay or straight not bi. (Bisexual, female, 23 years old)

The contributor both understood that they need help and indeed they had sought help, but they were resistant to the consequences of being labelled as mentally ill. Biddle et al.'s (2007) study found young people did not seek help because of possible undesirable outcomes that would follow such as frightening treatments, a change of identity and the stigma of mental illness. The ambivalence written about in this post was related to getting help 'I want help but I don't' and sexual identity 'Want to be gay or straight not bi'. Ambivalence may be understood as young people knowing they need help for their emotional distress but not wanting the perceived consequences of asking for help which labels them as irrational and unable to cope. Ambivalence is a difficult psychological frame of mind ('this ambivalence is killing me'), and it was frequently articulated in the young people's posts. It signifies uncertainty, contradiction, doubt and inconsistency, and these are not the features of self-controlled, sure-footed steps into young adulthood. Ambivalence is in direct contrast to the requirements of the neo-liberal young citizen who must be future-orientated, self-inventing and self-realising (Harris, 2004; Walkerdine et al., 2001). Ambivalence is a youth subject position of failing to be certain about the future, which generates a range of difficult feelings. The struggle to articulate such complex emotions was a major topic within the young people's online discussions.

Articulating emotional distress

Lupton (1998) states emotions are viewed as 'unruly' embodied sensations which are the antithesis of rationality. Part of being the rational and civilised self is to be emotionally in control, and to not talk about emotions, or only in certain socially sanctioned ways, for example, men can be upset when their football team loses, women should be at their happiest on their wedding day (Ahmed, 2004). The difficulty of verbalising emotions was a consistent theme in the online data; one queer, 17-year-old contributor wrote, 'I think I'ma have a go at the support group thing. It sucks talking about it and I hate it'. Another posted, 'Thanks for putting the Samaritans number on this site i think i need to give them a call. I'm scared i don't know what to say exactly' (gay, male, 23 years old). In this analysis, I am suggesting that part of the reason that young people found it difficult to ask for help and communicate their feelings is the way their emotional distress was responded to by adults and wider society. In the online posts, the contributors wrote about their experiences of their distress being demeaned as 'teenage' and due to 'hormones':

> they always say 'its just a teenage thing'
> -self harm/cutting, punching walls
> -suicide attempts
> -isolation/no friends

> -revulsion of who i am/im gay so you know
> do these behaviours sound like a normal 15 year old? (Gay, male, 15 years old)

> Adults would always say 'its just hormones' when I would ever even begin to try to ask for help. Its not exactly normal for any age. (Gay, 17 years old)

In these two posts, the contributors wrote that their emotional distress had been disregarded by adults. There was a diminishing of young people's emotions where their suffering is explained through hormonal imbalances and therefore dismissed as not requiring attention. Open expression of 'teen' angst was characterised as attention-seeking behaviour and over-dramatic (Scourfield et al., 2011). We see that their pain was temporalised as something that they will outgrow, reducing it to a biological (hormones) stage of life (adolescence). It is significant that in both posts they positioned themselves and their distress in relation to being normal; they want to fit within conventional normative categories, but their distress, self-harming behaviour, age and sexuality make this problematic. In response to their emotional pain being trivialised, some contributors in the study advocated that young people should not tell adults about their anguish; one gay, 15-year-old contributor wrote, 'don't tell adults if they keep saying that'.

My analysis of these online posts proposes that social and cultural norms make it possible to articulate some emotions more easily than others. I argue that it is difficult for young people to verbalise emotional distress because they are defined as over-emotional and they understand that 'growing-up' and becoming an adult require emotional control. Ahmed (2004) suggests that 'emotions are bound up with the securing of social hierarchy: emotions become attributes of bodies as a way of transforming what is "lower" or "higher" into bodily traits' (p. 4). Arguably, the diminishing of youthful emotion is part of the disciplining of subjectivity; it is how young people become the rational (neo-liberal) adult through the institution of a self-controlled affective existence. In the extract below, a 20-year-old gay female described the homophobia in her family, showing there are other emotions that cannot be equally spoken:

> My parents and I dont talk about things at all, they still have hope that i would be normal. Dad told me the other day that he wished i was dead, it almost made me hit the bottom but i held up strong.

In the online retelling of this face-to-face incident, the emotion which was expressed is homophobic hatred – the father stating that he wished his daughter was dead because she is gay, but what was not articulated in the face-to-face interaction is the gay daughter's emotional distress. She wrote in her post that she self-harms, has been suicidal and attributes these to her experiences of homophobia in the family. The online data had many accounts where LGBT youth wrote about the problems of speaking about emotions connected to their sexuality and gender in various settings such as school, home and the clinic. One young bisexual 18-year-old wrote, 'I understand your struggle with your sexuality. I am bisexual and had the same issues. I once tried to raise them with my counsellor, but I failed miserably'. The online writings of the young LGBT people indicated there were often complex intersecting limitations of what was possible to 'tell' in a

therapeutic, school or family setting, suggesting that articulating emotional distress may be shaped by wider social norms. I would propose that part of the non-articulation of distress is because LGBT youth feel they have *failed* to fit with the prescribed norms of young heterosexual adulthood.

Telling the 'failed' self

> it's hard to separate feelings of being different with feelings of not being good enough. (Gay, male, 19 years old)

Skeggs (2004) argues that it is through the telling of the self that 'social processes of positioning, of value, of moral attribution, are put into effect as a manifestation and maintenance of difference and distinction' (p. 120). To articulate difference for young LGBT people is to position themselves as morally failed because their sexual and gendered identities and subjectivities do not fall into normative categorisation. The post above illustrates how emotion circulates around difference even while it may not be easy to articulate the nature of that difference. I am suggesting that part of the reason that young people find it challenging to ask for help is that it requires them to 'tell the self' as different, as deviating from norms of adolescence, rationality and heterosexuality. In doing so, they are admitting they have failed to be 'normal', for example, a 19-year-old pansexual trans male wrote, 'My mum burst in on me cutting not long ago and now shes crying … im such a failure'.

Research on youth suicide has demonstrated how emotions such as shame are related to individual failure and suicidal feelings (Fullagar, 2005; McDermott et al., 2008). Scheff (2000) describes shame as a 'large family of emotions that includes many cognates and variants, most notably embarrassment, humiliation and related feelings such as shyness that involve reactions to rejection or feelings of failure or inadequacy' (p. 96). LGBT youth wrote quite starkly online about their feelings of failure and inadequacy. They had failed to be an autonomous, emotionally controlled young adult, failed to be heterosexual or fit the gender-binary, failed to cope with the hostility they encountered and failed to be sane and rational. The degree of self-loathing this perceived failure engendered is unambiguous; posts contained comments such as 'I make myself sick' (lesbian, 20 years old), 'I'm such a fuckup', (agendered, 16 years old), 'fucked up last night. I am ashamed' (pansexual female queer, 18 years old).

Perhaps it is not surprising that given the struggle of telling the self as failed, often in a hostile environment, some of the online advice from young LGBT people was to not tell the LGB or T self, to keep this hidden as a temporary coping strategy until their circumstances changed in the future and they could avoid the hostile environment, for example, leave school, college or home. A gay, female, 20-year-old advised another young lesbian to 'Be a girl, wear the dresses, style your hair. Go to the psychiatrist and smile and lie through your teeth [I did]'. The following post illustrates the complex negotiations required to tell the self through an 'intelligible' sexual and gender identity performance:

> My parents are from a different culture too where homosexuality is taboo. I learn quickly to keep my 'differences' to myself … tell your parents what they want to hear. Say that you've

> found God, and that you don't want to bring shame to the family, if you tell them what they want to hear (that they were right, it is just a phase and that you're not gay), they won't push it any further. (Gay, 18 years old)

It is clear from these data that young people in the sample felt it was easier to tell the self as culturally and socially conventional, that is, heterosexual and rational. The advice from the above two posts was effectively to hide both their sexuality and their emotional distress and pretend to be 'normal'. An open disclosure of these feelings and emotions would mean facing the likely negative judgement of others, with the accompanying possible consequences of ridicule, hostility, rejection and physical violence. Given the potential for such adverse outcomes, the young people advised that it was safer to remain predominantly 'in the closet' about both their sexuality and self-harm. What I am suggesting here, drawing on Butler's (2004) notion of intelligibility, is that some types of lives cannot easily be told. A young LGBT person in emotional distress is unrecognisable within the dominant norms of heterosexual, gender-binary adolescence. The self-harming LGBT young person is '*hard to tell*' to friends, family, teachers or mental health professionals within the assemblages of power which position them as immature, sexually and gender deviant, and irrational.

Conclusion

The UK National Suicide Prevention strategy has only recently identified LGBT people as a high-risk group (DH, 2012). As a consequence of the low priority afforded to this population group, there is scant evidence on help-seeking or interventions and services which target LGBT youth. King et al. (2007) argue that there is an urgent need for mental health services to develop LGBT-sensitive services. This article has attempted to provide an in-depth understanding of the dynamics of help-seeking in LGBT youth. The study provides a unique perspective on LGBT youth help-seeking for self-harm and suicidal feelings because the data are collected online without the intervention of an adult. I would argue that while this provides only a partial understanding, it is one which gives access to viewpoints which may not be easily expressed in a face-to-face settings, such as those used for research and clinical intervention.

The findings presented illustrate that if we are to understand why self-harming LGBT youth find it difficult to ask for help, then we must appreciate the social, cultural and economic context of young lives. It is necessary to recognise that LGBT youth contend with the regulatory apparatus of adolescence which emphasises emotional restraint and diminishes open displays of emotional distress. At the same time, they must cope with dominant heterosexual norms which cast diverse sexualities and genders as deviant and shameful. Finally, by virtue of their self-harming and/or suicidal feelings, they are positioned as pathological by neo-liberal norms of subject-hood which emphasise reason, autonomy and self-control. As this study makes clear, the navigation of this nexus of norms makes it difficult to ask for help, articulate emotional distress and enunciate the self as failing to meet with normative standards of young adulthood, heterosexuality and rationality.

The findings add to the growing literature that recognises young people with mental health problems as active help-seekers, but underlying their strategies to cope with

emotional distress, self-harm and suicidal feelings is the desire to fit within prescribed normative expectations. In the case of LGBT youth, this study reveals that despite experiences of hostility, fear, homophobia, biphobia and transphobia, young people sought help online, albeit from other young LGBT people rather than health and social care professionals or other adults.

There are obvious limits to an online study of this nature. The sample excludes those young LGBT people who cannot access the technology or do not want to express their feelings online. It was not possible to gather the type of demographic data that social science analysis usually requires (e.g. ethnicity, social class, geography) which means it was not feasible to analyse which LGBT youth were emotionally distressed. There has been an improved tolerance of sexual and gender diversity in the West, and it is likely that for some young LGBT people this will have benefited their wellbeing. The findings from the study are not representative of LGBT youth, and care must be taken not to generalise to all LGBT youth. Data drawn from archived Internet-based interactions such as blogs and forums are 'snapshots' of young people's perspectives of their mental health. They do not allow for longitudinal research or comparisons between different groups of young people, nor do they allow for in-depth probing which may provide further details about their feelings of distress. Research of this nature does at the very least show that we must develop a more in-depth and nuanced understanding of why young LGBT people who self-harm find it so difficult to ask for help. It requires a much deeper understanding of how social norms and emotions work in relation to adolescence, sexuality, gender-variance and rational neo-liberal adulthood. Further research is required, using both online and conventional methods, to investigate why young distressed LGBT people do not seek help and, more importantly, find out what type of support and interventions are required to persuade LGBT youth to want to live and believe they can have a future existence without emotional distress.

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Notes

1. 'Trans' refers to a spectrum of gender-diverse transgender/transsexual possibilities.
2. I use the term self-harm to refer to behaviours that are purposefully self-injurious, regardless of whether there is suicidal intent. While some researchers draw a clear line between instances of self-harm based on intentionality, this is only possible where intentions are known.
3. The study was a collaboration with Katrina Roen, University of Oslo.
4. The descriptors of the contributors' sexuality, gender and age are their own online definitions.

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