# Compassion, shame, and sexual violence experienced by lesbian, gay, bisexual, transgender, queer and questioning young people

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**ABSTRACT**

**Background:** Research indicates that LGBTQ+ young people are more likely to experience sexual violence than their heterosexual peers. However, sexual violence experienced by LGBTQ+ young people has not been previously investigated in the UK. Sexual violence is associated with increased shame and psychological distress, whereas compassion may reduce these experiences. Developing understandings of the relationships between shame, compassion, psychological distress and wellbeing could therefore inform clinical practice for this population. Compassionate support from services could also improve LGBTQ+ young people's wellbeing, but LGBTQ+ communities frequently report poor service experiences. Exploring their perspectives of services could facilitate service improvements. Investigating how LGBTQ+ young people make sense of sexual violence may increase understandings of the social conditions which enable sexual violence against them. This avoids situating them as responsible for sexual violence.

**Aims:** To explore the relationships between shame, compassion, psychological distress and wellbeing for LGBTQ+ young people who have experienced sexual violence and the service related factors which impact on them. To explore how LGBTQ+ young people make sense of sexual violence victimisation and experiences with services. To situate the research in a wider context, engaging with sociocultural influences upon LGBTQ+ young people.

**Methods:** A mixed-methods approach was employed to quantitatively examine relationships between shame, compassion, psychological distress and wellbeing using validated measures through an online survey (N=36). Participants' experiences of sexual violence and views of barriers to service use and sexual violence reporting were also investigated through the survey. Seven participants subsequently took part in semi-structured qualitative interviews to discuss sexual violence and the role of services.

**Results:** Self-compassion and shame were significantly associated with psychological wellbeing and distress. Both survey and interview participants highlighted the importance of acceptance and safety in services but reported discriminatory attitudes as a barrier. In the interviews, participants described how stigma and stereotypes enabled the normalisation of sexual violence and victim blaming experiences.

Participants' interview accounts also provided insights about how they live and cope with sexual violence.

**Conclusions:** The findings indicate that shame and compassion constructs may be relevant to LGBTQ+ young people's lives in the context of sexual violence experiences. Compassion from services could facilitate feelings of connection and safety but services also need to address structural barriers. Participants' accounts suggest that the normalisation of sexual violence enables victimisation, and that heteronormativity contributes to the marginalisation and invisibility of their experiences. Implications for interventions to address sexual violence experienced by LGBTQ+ young people are explored across individual, service, and wider sociocultural levels.

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## LIST OF ABBREVIATIONS

Within this thesis, the following abbreviations will be used:

LGBTQ+ = Lesbian, gay, bisexual, transgender, queer, questioning, + indicates acceptance of any other terms used by individuals to describe their gender and/or sexual identity.

WHO = The World Health Organisation

CFT = Compassion Focused Therapy

OAS =The Other As Shamer (OAS)

SCS = Social Comparison Scale (SCS)

SSC = Short Self-Compassion Scale (SSCS)

DASS-21 = The Depression Anxiety Stress Scales 21 (DASS-21)

SWEMWBS = Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS)

SES-LFV & SES-SFV = Sexual Experiences Survey-Long/Short Form Victimisation

PIS = Participant Information Sheet

M = Mean

SD = Standard Deviation

SK = Skewness

Rku = Kurtosis

K-S = Kolmogorov-Smirnov

PAR = Participatory Action Research

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# 1. INTRODUCTION

## 1.1. Overview

The contexts of lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) young people's lives are explored to situate understandings of why these young people may be subject to sexual violence and experiences of psychological distress. These explorations inform the relevance of shame and compassion constructs for this population. The research framework provides an account of why these experiences and constructs are being investigated. Literature reviews discuss LGBTQ+ experiences across three strands: sexual violence and psychological distress; shame and compassion; and interactions with services for sexual violence. These identify gaps in the literature and shape the research questions.

## 1.2. The Research Framework

The exploration of sexual violence experienced by LGBTQ+ young people in relation to the constructs of psychological distress, wellbeing, shame, and compassion, and impacts of services and sociocultural contexts, incorporates large areas of theory and research. This inclusion of diverse elements is necessary to adequately address the multiple levels of context that affect this population and the psychological constructs under investigation. It also avoids individualising sexual violence experiences and associated psychological impacts, which can facilitate narratives of self-blame (Healicon, 2016). The exploration of LGBTQ+ young people's perspectives of services may inform understandings of service access that go beyond the barriers and facilitators model commonly investigated in service accessibility, because it enables LGBTQ+ young people to describe *why* these factors help or hinder service use (McDermott, Hughes, & Rawlings, 2018). To inform the multiple contexts under investigation in this study, this chapter will firstly explore the experiences of LGBTQ+ young people and subsequently address the social contexts that may enable sexual violence against this population.

To explore the potential impacts of sexual violence, the construct of shame will be investigated as it is frequently associated with sexual violence victimisation (DeCou, Cole, Lynch, Wong, & Matthews, 2017; Sarkar & Sarkar, 2005; Vidal & Petrak, 2007; Weiss, 2010; Yoon, Stiller Funk, & Kropf, 2010) and psychological distress (Cunha, Matos, Faria, & Zagalo, 2012). Conversely, compassion may reduce the impacts of sexual violence through decreasing experiences of psychological distress and shame

(Close, 2015), and increased self-compassion has been positively associated with wellbeing for LGBTQ+ adults (Crews & Crawford, 2015). This is indicative of a potential intervention which could improve the psychological wellbeing for LGBTQ+ young people who have experienced sexual violence, and therefore arguably warrants further exploration. An initial exploration of whether relationships exist between the constructs of shame, compassion, psychological distress and wellbeing for this population may ascertain if compassion-based interventions could be useful. However, again it is important to contextualise potential interventions within the services in which they are delivered, and the wider social structures services exist in. This will more meaningfully explore if these interventions can create change for LGBTQ+ young people and identify where wider changes (service, societal level) may be needed. An individually compassionate response to sexual violence may be less impactful if LGBTQ+ young people cannot access services or will return to social environments that shame or blame LGBTQ+ young people who have experienced sexual violence.

## 1.3. Gender and Sexual Minority Young People

### 1.3.1. Terminology

Sexual and gender identities are often amalgamated and definitions lack consensus (Gates, 2011; Herek & Garnets, 2007; Monro & Richardson, 2010; Moradi, Mohr, Worthington, & Fassinger, 2009). To minimise further conflation, it will be held in mind throughout that this is not a homogeneous group, both within and across gender and sexual identities. UK statistics modestly estimate that 4.73% of adults aged 18 – 34 are sexual minorities (Public Health England, 2017). Although, young people are more likely to consider sexuality as 'fluid'; 49% of 18-24 years identified as not exclusively heterosexual (YouGov poll, 2015). However, there are no available statistics for numbers of UK transgender young people (Government Equalities Office, 2018). For practicality and consistency, the acronym 'LGBTQ+' will be used to describe lesbian, gay, bisexual, transgender, hereafter referred to as 'trans' as an umbrella term inclusive of all identities under the transgender umbrella (e.g. non-binary), queer (includes genderqueer), questioning (exploring gender and/or sexual identity) and + to indicate acceptance of any other terms used by young people (Stonewall, 2015). Definitions of 'young people' vary (e.g. YouGov, 2018); in this study, people aged 16 – 25 will be considered young people, consistent with the age range used by many LGBTQ+ youth services (e.g. Allsorts Youth Project, METRO Charity, & Galop).

The terms ‘homophobia’, ‘biphobia’ and ‘transphobia’ are typically used to describe individual and systemic anti-LGBTQ+ prejudice and heterosexism, conflating these constructs. These terms are increasingly recognised as problematic as they stem from words emphasising fear and suggest mental illness (Dermer, Smith, & Barto, 2010; Herek, 2004). Therefore, ‘anti-LGBTQ+ prejudice’ will be used to refer to prejudice against LGBTQ+ people, and ‘heterosexism’ and ‘heteronormativity’ to describe the systemic privileging of heterosexuality embedded in our institutions and UK society (Herek, 2007).

### 1.3.2. Sexual Violence and LGBTQ+ Young People

LGBTQ+ young people have been identified as a population of interest in this study as prior research indicates they experience higher rates of sexual violence than their cisgendered, heterosexual peers (e.g. Hoxmeier, 2016; Rothman, Exner, & Baughman, 2011; Stotzer, 2009). This suggests that social conditions enable perpetrators of sexual violence to more frequently target LGBTQ+ young people, indicative of inequality and structural violence. Structural violence is a process which creates and maintains social inequalities, leading to suffering (Farmer, 1996). Statistics indicate that LGBTQ+ adults also experience higher rates of sexual violence, although research in this area is also limited (e.g. Centre for Disease Control and Prevention, 2010). However, this study focuses specifically on LGBTQ+ young people because currently no research exists in the UK which describes their experiences, whereas there is research with adults (e.g. Hester et al., 2012; Love et al., 2017). Additionally, LGBTQ+ young people who experience sexual violence face additional challenges of negotiating adolescent norms and developing their gender and sexual identities (McDermott et al., 2018). For example, familial responses to young people’s disclosures of their gender and/or sexual identities (‘coming out’) can have a profound impact on LGBTQ+ young people (e.g. D’amico, Julien, Tremblay, & Chartrand, 2015; Ryan, Legate, & Weinstein, 2015; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). These factors may be less relevant in adulthood and indicate increased complexity for LGBTQ+ young people. Moreover, young people aged 16 – 25 report the highest rates of sexual violence (Office for National Statistics, 2017), suggesting young people are more vulnerable to sexual violence victimisation than adults aged over 25. Thus, the rationale for specifically focusing on LGBTQ+ young people is the high proportions of sexual violence experienced by this age group and population, coupled with the challenges in developing their gender and sexual identities. The lack of previous explorations of their experiences may also contribute towards structural violence and inequality.

### 1.3.3. Psychological Distress

Due to the problems associated with the use of psychiatric diagnoses, such as validity, reliability, and stigmatisation (Bentall & Pilgrim, 1999; Johnstone, 2013; Kinderman, Read, Moncrieff, & Bentall, 2013), psychological distress will be used instead of specific diagnoses. Psychological distress is conceptualised as existing along a continuum and is a separate but related construct to psychological wellbeing (Keyes, 2002; Keyes, 2006). Psychological wellbeing is a multi-dimensional construct, incorporating happiness, life satisfaction, and positive psychological functioning (Ryan & Deci, 2001).

There is substantial literature concerning the elevated psychological distress experienced by LGBTQ+ young people (e.g. Collier, van Beusekom, Bos, & Sandfort, 2013; King et al., 2008; Nadal et al., 2011; Thorne et al., 2018). Heteronormative contexts are understood as facilitating psychological distress through microaggressions, direct experiences of anti-LGBTQ+ prejudice, and structural heterosexism (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Mays & Cochran, 2001; Meyer, Schwartz, & Frost, 2008; Warner et al., 2004). In a UK survey of 7,126 LGBTQ+ young people aged 16-25, all respondents had experienced high levels of disadvantage and discrimination compared to their heterosexual, cisgender (gender identity corresponds with biological sex) peers. LGBTQ+ young people felt less accepted; experienced higher levels of sexual, physical and verbal abuse and familial rejection; and reported higher experiences of psychological distress. Of LGBTQ+ young people, trans young people experienced the greatest levels of discrimination and abuse and the lowest life satisfaction (METRO Charity, 2016). These experiences illustrate objectively stressful environments and events (Herek, 2007).

#### *1.3.3.1. Stigmatising minority stress processes*

The Minority Stress Model (Meyer, 1995, 2003, 2007) describes how psychological distress is produced through the discriminatory experiences of minority groups. The model postulates that anti-LGBTQ+ prejudice, stigma and heterosexism create unique stressors, which cause adverse health outcomes. Whilst the model was originally developed to describe the mechanisms underlying health disparities for sexual minorities, it has been extended to include other minority groups, such as gender minorities (e.g. Bockting, 2009). Minority stress processes exist along a distal - proximal continuum. Distal stressors are events and experiences *external* to the person (e.g. discrimination, microaggressions, life events), and proximal stressors are *internalised* negative societal attitudes (e.g. felt stigma, internalised anti-LGBTQ+

prejudice, expectations of rejection and discrimination, concealment of LGBTQ+ identity). The model draws heavily on Goffman's (1963) conceptualisation of stigma as a socialising process, which exists in relationships between people and creates a 'spoiled identity'.

However, comparisons between minority and majority groups may depict the disadvantaged group as 'damaged', subsequently perpetuating social stigma (Braveman, 2006; Frost, 2017). This notion of a minority group as 'damaged' may be facilitated through the conceptualisation of stigma as 'a discrediting attribute'. This characterises people as having a negative difference, enabling marginalisation, as Parker & Aggleton, (2003) describe: "*stigma, understood as a negative attribute, is mapped onto people, who in turn by virtue of their difference, are understood to be negatively valued in society*." (p.14). Thus, stigma can be used to create and reproduce social inequality (Parker & Aggleton, 2003), facilitating certain focuses in research, for example HIV and LGBTQ+ populations (Coulter, Kenst, Bowen, & Scout, 2014). This indicates that viewing LGBTQ+ people as inherently vulnerable or individually responsible can stigmatise and pathologize experiences, therefore exploring wellbeing and impacts of community resources is helpful to challenge these narratives. Additionally, when conceptualisations of distress are situated within systems of power and oppression, this can highlight the social conditions that create stigma and prejudice (Frost, 2017; Meyer, 2015).

### 1.3.4. Service Context

Community resilience is conceptualised as the resources available that develop and sustain individuals' wellbeing (Fergus & Zimmerman, 2005; Hall & Zautra, 2010). Support services therefore form tangible aspects of community resilience and accessing these services could reduce psychological distress (McDonald, 2018; Meyer, 2015). For services to be supportive, LGBTQ+ young people identified needing to feel accepted and able to be themselves (Ott, 2018), and the importance of safety, often created through LGBTQ+ specific services (Davis, Saltzburg, & Locke, 2009). As clinicians, we may be more able to intervene at a service level to create positive experiences for LGBTQ+ young people. However, service improvements and access should not replace challenging wider stigmatising social processes.

Services can also reproduce stigma and discrimination, which prevents LGBTQ+ people from accessing support in the UK (Hudson-Sharp & Metcalf, 2016). Historically, mental health services and the state have pathologized and criminalised sexual and gender minority identities (Kahle, 2018; McDermott, 2015), which continues to impact

service accessibility for LGBTQ+ young people (Davy, 2011; Meyer, 2001; Welch, Collings, & Howden-Chapman, 2000). Research suggests heteronormativity is pervasive across services and institutions for LGBTQ+ young people; such as education, healthcare, the police and social services (e.g. Concannon, 2008; Daley, Solomon, Newman, & Mishna, 2007; Dwyer, 2010; Ellis, 2008; Mule et al., 2009). Moreover, services are commonly identified as inaccessible and staff attitudes as perpetuating negative stereotypes (e.g. Coker, Austin, & Schuster, 2010; Dorsen, 2012; Government Equalities Office, 2018; Greifinger, Batchelor, & Fair, 2013; Hughes et al., 2018). This illustrates the need to challenge wider stigmatising attitudes as these can be enacted in services, violating the human rights of LGBTQ+ young people (Albuquerque et al., 2016).

### 1.4 Sexual Violence

The World Health Organisation (WHO) define sexual violence as:

- *"Any sexual act or attempt to obtain a sexual act*
- *unwanted sexual comments or advances or acts to traffic*

*that are directed against a person's sexuality using coercion by anyone, regardless of their relationship to the victim, in any setting, including at home and at work."* (WHO, 2014, p.84).

Sexual violence is categorised into three types; sexual violence involving intercourse (rape), contact sexual violence (e.g. sexual assault or unwanted touching), and non-contact sexual violence, such as threatened sexual violence and verbal sexual harassment (WHO, 2014). Sexual violence impacts significantly on psychological distress for survivors and is a worldwide public health issue (Krug, Mercy, Dahlberg, & Zwi, 2002). Sexual violence is often not distinct from other forms of violence, demonstrating the complex and multi-faceted nature of 'sexual' violence, which commonly intersects with physical, emotional, verbal violence.

Whilst statistics vary, research suggests LGBTQ+ young people are disproportionally affected by sexual violence in comparison to their cisgendered, heterosexual peers (e.g. Hoxmeier, 2016; Rothman, Exner, & Baughman, 2011; Stotzer, 2009). McCauley, Coulter, Bogen, and Rothman, (2018) propose a minority stress framework can account for increased sexual violence victimisation in LGBTQ+ groups through limited access to resources and heightened conflicts in social environments. These 'social conflicts' may be evident in LGBTQ+ young people's experiences of education as

sexual violence can be perpetrated through anti-LGBTQ+ prejudice, typically illustrated by sexual harassment regarding sexual or gender orientation, which often begins at school (e.g. Formby, 2015; Gruber & Fineran, 2008). Gruber and Fineran (2008) argue that sexual harassment and bullying are distinct phenomena and conflation of these two experiences obscures victimisation that is rooted in wider social constructions of gender and sexuality. The use of anti-LGBTQ+ language in educational settings creates 'gender policing', which reproduces sexual and gender inequalities (Payne & Smith, 2012). This illustrates an additional challenge that LGBTQ+ young people may experience when developing their gender and sexual identities. The social conflicts created may also represent intersections between hate crimes and sexual violence; in the UK approximately 1 in 10 hate crimes against LGBTQ+ people were forms of sexual violence (Antjoule, 2016). Furthermore, LGBTQ+ women and trans people can be subject to aggressions from perpetrators attempting to restore 'correct' gender roles (Fileborn, 2014; Tomsen & Mason, 2001), suggestive of intersections between sexism and anti-LGBTQ+ prejudice. This indicates how intersecting minority identities can create layers of minority stress, as individuals face multiple social discriminations and traumas (McCauley et al., 2018). This is further compounded for individuals who hold multiple minority identities, such as Black bisexual women (Sigurvinsdottir & Ullman, 2016). Thus, it is important to understand sexual violence and psychological distress through an intersectional lens (McCauley et al., 2018).

### 1.4.1. Heteronormativity

Heteronormativity is broadly conceptualised as a social process which defines normative sexual practices and "*a normal way of life*" (Jackson, 2006, p.107). Heteronormativity enables men's power over women in patriarchal systems through traditional gender relationships, which deem alternative behaviours or beliefs as unnatural (Anderson & Doherty, 2007). It creates a cultural scaffold for rape that denies survivors' accounts and normalises sexual violence (Anderson & Doherty, 2007; Gavey, 2013; Hlavka, 2014; Hlavka, 2016). This is reflected in young women's descriptions of sexual harassment as 'normal' and men as 'natural' sexual aggressors (Hlavka, 2014), suggesting a normalisation of sexual violence.

Heteronormative culture can be viewed through the lens of structural violence as a dynamic process which facilitates the oppression of LGBTQ+ people through three dimensions; symbolic domination, institutional violence, and everyday violence (Bourgeois & Scheper-Hughes, 2004; Flynn et al., 2018). Symbolic domination is a system which maintains hierarches through its representations and (re) productions of

beliefs, for example the promotion of heteronormativity in UK primary schools (DePalma & Atkinson, 2010). Institutional violence is understood as violence perpetrated by the state and associated institutions, such as the police or health services (as highlighted in section 1.2.4.), and everyday violence is defined as normalised daily individual experiences of violent practices in interactions (Scheper-Hughes, 2006). This everyday violence encompasses the intersections between sexual violence and hate crimes experienced by LGBTQ+ young people, as well as the normalisation of sexual violence in young people's interactions described by Hlavka (2014).

Hegemony is defined as "*the social, cultural, political, structural, and institutional power and dominance of one or more groups, identities, behaviours, and/or practices over others*" (Allen & Mendez, 2018, p.74). Thus, the hegemonic power of heteronormativity stigmatises and marginalises groups outside of this norm, such as the LGBTQ+ community (Allen & Mendez, 2018; Connell & Messerschmidt, 2005). Menning and Holtzman (2014) argue that through sexual violence, LGBTQ+ women are subjugated by men and LGBTQ+ men are punished for betraying scripts of masculinity. This may begin in schools through performances of masculine dominance and privilege, often demonstrated in boy-girl relationships and boy-boy hierarchies (Gruber & Fineran, 2008). Moreover, the hegemonic power of heteronormativity will further intersect with factors such as race, class and ability, to give certain groups increased dominance (Allen & Mendez, 2018).

#### *1.4.1.1. Rape myths*

Rape myths; "*prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists*" (Burt, 1980, p.27) deny and justify sexual violence (Burt, 1980; Grubb & Turner, 2012; Lonsway & Fitzgerald, 1995). They are premised in heteronormativity and misogyny and contribute towards the normalisation of sexual violence (Davies, Gilston, & Rogers, 2012; Hlavka, 2014; Lonsway & Fitzgerald, 1995). Rape myths can shame and invalidate people who have experienced sexual violence (Edwards, Turchik, Dardis, Reynolds, & Gidycz, 2011; Turchik & Edwards, 2012; van der Bruggen & Grubb, 2014). These invalidations are strengthened if individuals transgress normative gender/sexuality roles and are therefore considered 'fair game' (Anderson & Doherty, 2007; Burt & Estep, 1981; Grubb & Turner, 2012). This creates epistemic injustice (Fricker, 2007) because experiences of sexual violence are dismissed based on the survivor's identity. This injustice is described by a lesbian woman in her interaction with the UK legal systems "[they] *do not take rape against lesbians*

*seriously*" (Hester et al., 2012, pp.36). This is suggestive of rape myths within the legal system obstructing justice. Rape myth acceptance is also positively associated with anti-LGBTQ+ prejudice, sexism, racism, classism and ageism (Aosved & Long, 2006; Davies, Gilston, & Rogers, 2012; Suarez & Gadalla, 2010), which could further contribute to epistemic injustice for people who have experienced sexual violence.

#### *1.4.1.2. The gender paradigm*

Turchik, Hebenstreit, and Judson (2016) propose that feminist understandings of sexual violence may have inadvertently contributed towards rape myths and epistemic justice through a gendered focus on male perpetrators. They suggest this gender paradigm (men as perpetrators, women as victims) in sexual violence may promote heterosexism by obscuring experiences of LGBTQ+ people, particularly violence perpetrated by women and towards men (Cannon & Buttell, 2015). Consequently, survivors experience increased barriers and stigma (Stemple, Flores, & Meyer, 2017) and LGBTQ+ communities report that sexual violence is not being addressed (Potter, Fountain, & Stapleton, 2012; Todahl, Linville, Bustin, Wheeler, & Gau, 2009). However, Ingraham, (2006), proposes gender is a feature of heteronormativity, and thus the operation of gender is only made possible through heteronormativity and heterosexism. Therefore, the ideology of heteronormativity could still explain the minimisation of LGBTQ+ sexual violence experiences through its' marginalising processes.

## 1.5. Shame

The term 'shame' stems from Hindi and Indo-European languages, meaning to cover or hide (Akhtar, 2016). Shame has been theorised extensively across a wide range of disciplines, including psychology, literature, anthropology, and sociology, creating different shame conceptualisations (e.g. Gilbert, 1998; Kaufman, 1989; Lewis, 2003; Nathanson, 1992). However, there is broad consensus that shame is a significant phenomenon in contemporary capitalist societies (Giddens, 1991; Lasch, 1991), that shame experiences are unique from other emotional constructs, and shame has potentially detrimental effects (Andrews, Qian, & Valentine, 2002; Gilbert, 1998; Kaufman, 1989; Lewis, 2003; Retzinger, 1998; Tangney & Dearing, 2002; Tangney & Fischer, 1995).

Shame can have significant interactions with sexual violence; 75 – 95% of sexual violence experienced by young people is unreported due to feelings of shame, self-blame, embarrassment, and fears that accounts will not be believed (Mayor of London Office for Policing and Crime & NHS England, 2016; National Union of Students, 2010).

Higher shame experiences following sexual violence are associated with greater psychological distress (DeCou et al., 2017; Sarkar & Sarkar, 2005; Vidal & Petrak, 2007; Weiss, 2010; Yoon et al., 2010). Shame constructions are also inherently associated with counter-discourses of gay pride; presenting a binary between proud, 'out' positions, and closeted, ashamed positions in LGBTQ+ communities (Probyn, 2005; Sedgwick & Frank, 2003). Giordano, (2018) argues questions regarding gender are questions about who we are as people, therefore shame about gender relates to shame about yourself as a person.

### 1.5.1. The Biopsychosocial Model of Shame

Gilbert (1998, 2000, 2006) developed the Biopsychosocial Model of Shame based on social understandings of shame. Shame is formulated as an interpersonal experience; appropriate to this study's investigation of sexual violence, a form of interpersonal violence, and interpersonal experiences with services. The model posits humans evolved motivational systems, which facilitate attachment to carers (Bowlby, 1969/1982; Cassidy & Shaver, 1999) and groups (Baumeister & Leary, 1995) because human relationships are essential for survival and wellbeing (Bowlby, 1969/1982; Buss, 2003; Gilbert, 1989).Therefore, the ability to co-construct a positive self-representation in the mind of the other is crucial. Being loved and accepted creates feelings of connectedness, which impacts upon brain development and affect regulation, and deactivates threat systems (Caccioppo, Berston, Sheridan, & McClintock, 2000; Gilbert, 1998, 2003). Whereas, experiences of rejection, abuse, and criticism activate threat systems, dysregulate affect and have a detrimental effect on positive co-constructions of the self in the minds of others. Thus, the experience of shame operates as a warning signal, informing individuals that others' co-construction of them may be negative. This results in self-blaming, monitoring, and submissive responses (Matos, Pinto-Gouveia & Costa, 2011) to protect the self from possible exclusion and attacks (Gilbert, 1998, 2003;  Gilbert & Irons, 2009).This is aligned with Social Rank Theory (Gilbert, 1998; Gilbert, 2000) which postulates submissive behaviours are positively associated with perceptions of inferior social rank/status and highly related to shame experiences.

### 1.5.2. External and Internal Shame

External shame is the central experience in the Biopsychosocial Model of Shame. It is how we experience ourselves through the minds of others and is activated when these experiences are negative, critical or exclusionary (Gilbert, 1998, 2000, 2006). These negative interactions lead to negative experiences of the self, conceptualised as

internal shame. These processes can be especially relevant to adolescents and young people due to their emerging sense of self (Cunha et al., 2012; Gilbert & Irons, 2009). Importantly, for LGBTQ+ young people, social processes such as stigma and discrimination facilitate external shame experiences in the model.

Internalised anti-LGBTQ+ prejudice (often termed 'internalised homophobia') is associated with increased shame and is conceptually similar to internalised shame. Anti-LGBTQ+ prejudice represents a proximal stressor which is internalised through distal stressors (e.g. heterosexist attitudes), rather than the more global negative evaluations associated with internal shame (Brown & Trevethan, 2010; Mereish & Poteat, 2015). Wells and Hansen (2003) argue internalised anti-LGBTQ+ prejudice creates a shame based identity, and is associated with increased psychological distress (Wells, 2004). However, the construct of internalised anti-LGBTQ+ prejudice neglects wider socio-political contexts, pathologizing LGBTQ+ young people, restricting macro interventions, and maintaining a heterosexist status quo (Russell & Bohan, 2006).

#### 1.5.3. The Biopsychosocial Model of Shame in Context

The focus on inner experiences risks minimising social contexts (Smail, 2005). It obscures questions about how unsafe, threatening, or abusive contexts are created, and the influence of cultural ideologies upon individuals' perceptions of their social rank. It is important to ask why society positions LGBTQ+ young people as inferior (McDermott et al., 2008), normalises sexual violence, particularly for young people (Hlavka, 2014), and shames survivors of sexual violence through victim blaming narratives (Weiss, 2010). These factors may mean LGBTQ+ young people who have experienced sexual violence view themselves as being negatively evaluated by society, consistent with distal stressors in the Minority Stress Model (Meyer, 1995, 2007; Meyer, 2003). Thus, to effectively situate shame in sexual violence research, the sociocultural context must be explored.

### 1.6. Compassion

Neff (2003), conceptualized self-compassion as: being kind and understanding towards the self when faced with pain or failure, perceiving one's experiences as part of the human condition, and being mindful; holding painful thoughts and feelings in awareness, not over-identifying with them. Self-compassion concerns communication and caring, and improves psychological wellbeing through connection with others and a sense of security (Gilbert & Irons, 2005). Gilbert (2009) developed Compassion

Focused Therapy (CFT) as a transdiagnostic intervention for people who experience high levels of shame and self-criticism. CFT is rooted in Buddhist philosophies which propose that happiness is connected to compassion for the self and others. This is integrated with neuroscience and evolutionary theory to conceptualise three emotion regulation systems:

1. Threat and protection systems: detect and respond to dangers in our environment (including social interactions and memories), triggering emotions such as anxiety, fear or disgust, motivating us to respond to protect ourselves.
2. Drive, resource-seeking and excitement systems: give individuals positive feelings by directing them to resources and rewards. Linked to arousal and achievement.
3. Contentment, soothing and safeness systems: operational if we have sufficient resources and do not need to respond to threats. This system mediates feelings of wellbeing, peacefulness and contentment.

CFT aims to develop the contentment system, which regulates the threat and drive systems. Gilbert (2009) hypothesises that this system is poorly accessed and/or developed if people experience high levels of shame. Interpersonal cues of social safety, acceptance, and being cared for, challenge shame and support individuals to develop a compassionate relationship with themselves, as opposed to a self-critical relationship which may have developed through adverse experiences.

### 1.6.1. Compassion in Action

Research indicates robust negative associations between compassion and measures of psychological distress (Kirby, Tellegen, & Steindl, 2017; Leaviss & Uttley, 2015). In LGBTQ+ populations, self-compassion has been found to be positively associated with wellbeing and happiness (Beard, Eames, & Withers, 2017; Crews & Crawford, 2015). The development of self-compassion has been associated with affirmative environments (Greene & Britton, 2016), indicative of importance of social contexts in facilitating self-compassion for LGBTQ+ people and the relevance of this construct across multiple levels.

The cultivation of self-compassion through CFT resulted in clinically significant reductions in external and internal shame and psychological distress (captured through measures of depression and post-traumatic stress) for a young woman survivor of sexual assault (Bowyer, Wallis, & Lee, 2014). Self-compassion also moderated shame and psychological distress for women who had been sexually assaulted (Close, 2015).

When there are barriers to experiencing compassion, such as internalised shame, compassion from counsellors was able to challenge invalidating messages women survivors of sexual abuse had received (McLean, Bambling, & Steindl, 2018). These findings suggest that self-compassion can improve psychological wellbeing for LGBTQ+ populations and affect the psychological distress associated with sexual violence, potentially through reducing shame. Moreover, compassion from others may create experiences of being valued. This suggests compassion can function interpersonally, which disrupts experiences of external shame, as individuals feel accepted by others, and challenges internal shame through these compassionate experiences. Interpersonal conceptualisations are helpful to avoid constructing self-compassion cultivation as an individual responsibility. A purely individual focus could shame LGBTQ+ individuals by positioning them as 'not self-compassionate enough'. Whereas, in CFT the therapist demonstrates the attributes and skills of compassion ('compassionate mind training') (Gilbert, 2009), again highlighting the importance of the interpersonal relationship in this approach.

Young people report positive experiences when services respond compassionately to sexual violence (Campbell, Greeson, & Fehler-Cabral, 2013; Fehler-Cabral, Campbell, & Patterson, 2011; Greeson, Campbell, & Fehler-Cabral, 2014). This suggests that compassionate services can impact upon young people's experiences. However, the interactions of shame and compassion in response to services is unexplored. Services could act as a compassionate other, moderating and, potentially alleviating, feelings of shame and psychological distress for LGBTQ+ young people. Thus, compassionate approaches could be extended from interpersonal interventions to inform service cultures. The emphasis on compassionate care in health systems (Crawford, Gilbert, Gilbert, Gale, & Harvey, 2013; de Zulueta, 2013) indicates the significance of the construct of compassion to services. However, it may be that wider pressures (e.g. limited resources) and their associated ideologies, such as the emphasis on productivity and individual responsibility in neoliberalism, limits the capacity of services to respond compassionately (Crawford et al., 2013, de Zulueta, 2013). It is also important to understand how other societal factors pertinent to LGBTQ+ young people, for instance heteronormativity, may impact upon compassion in services. If the safe, non-judgmental and accepting approach CFT advocates for was applied on a societal level, this could act to counter discriminatory heteronormative processes.

### 1.6.2. Limitations of CFT

It is unclear if CFT offers a more effective alternative than other, well-established therapies, due to variability in research methods (Leaviss & Uttley, 2015). CFT assumes compassion is positively associated with psychological wellbeing (Neff, Kirkpatrick, & Rude, 2007), however, this was not measured directly in the studies reviewed (Beaumont & Martin, 2015; Leaviss & Uttley, 2015). Clinically, implementing CFT techniques can be challenging for participants (e.g. Gilbert & Irons, 2004; Mayhew & Gilbert, 2008). Potentially, because the concept of compassion can be challenging to understand and because people had not received compassion from others (Pauley & McPherson, 2010).

CFT derives from Buddhist ideas which could conflict with other religious and spiritual beliefs. However, CFT has secularised these ideas which may make them more palatable. Although by doing this, there are concerns that concepts such as mindfulness have been diluted and divorced from their origins (Sun, 2014) and commodified by neoliberal agendas (Walsh, 2016).

Conversely, Crawford et al. (2013) contend that the emphasis CFT places on engaging and understanding others and the self, requires staff to relate to service users compassionately. However, the current target and outcomes driven environments in health care, arguably associated with neoliberal ideologies of productivity, are creating a social context for services which may inhibit compassionate care (Crawford et al., 2013). Therefore, perhaps that rather than compassion or CFT approaches being limited, it is the social conditions of services which are limiting. Moreover, if services do not exist within compassionate conditions, then the interpersonal capacity for compassion and CFT is reduced. This again highlights the significance of compassion across interpersonal, service and socio-cultural levels. Thus, explorations across multiple levels of the system are important to sufficiently understand how compassion and CFT can be impacted by, and impacts on, wider systemic factors.

## 1.7. Literature Reviews

An initial systematic database search incorporating all aspects of this study did not yield any results. Thus, three search strands were identified to sufficiently inform the project; LGBTQ+ young people's experiences of sexual violence and associated psychological distress; UK based LGBTQ+ people and shame or compassion; and LGBTQ+ people's service experiences for sexual violence in the UK.

### 1.7.1. Literature Review One: LGBTQ+ Young People's Experiences of Sexual Violence

The first narrative review was developed using Booth, Sutton, & Papaioannou's (2016) framework to define its' scope:

1. Who = LGBTQ+ young people
2. What = sexual violence and distress
3. How (will the study impact on the who) = situate and rationalise the current research component investigating LGBTQ+ young people's experiences of sexual violence, psychological distress.

A systematic database search was conducted using PsycINFO, Academic Search Complete, and CINAHL to identify literature consistent with these objectives. Following identification of publications, reference lists were reviewed to identify further literature. Appendix A details the search strategy, including inclusion and exclusion criteria. Themes across publications were explored to synthesize diverse studies and identify gaps in research.

Publications identified:

1. Bendixen, Daveronis, and Kennair (2018): Norwegian Quantitative study.
   Two studies investigating impacts of non-physical sexual harassment on high school students' psychological wellbeing. Sexual minority participants reported higher rates of sexual harassment and lower wellbeing than heterosexual participants.
   Study 1; N = 1,384; 15.8% sexual minority participants. Study 2; N = 1,485; 20.9% sexual minority participants. Mean age = 17.

2. Gruber and Fineran (2008): American Quantitative study.
   Comparison between rates of bullying and sexual harassment for sexual minority and heterosexual high school students. Sexual minority students experienced higher levels of bullying and sexual harassment and more psychological distress as a result.
   N = 522, aged 12 - 17; 9% sexual minority participants.

3. Mitchell, Ybarra, & Korchmaros (2014): American Quantitative study.
   Rates of sexual harassment and their psychological impact between different gender and sexual identity groups. Highest rates reported by gender and sexual minorities.
   N = 5,907, internet users aged 13-18: 1,777 sexual minority, 398 gender minority participants.

4. Murchison, Boyd, & Pachankis (2017): American Quantitative study.
   The relationship between minority stress processes (internalised anti-LGBTQ+ prejudice) and sexual violence. Authors suggests internalised homophobia predicts sexual violence.
   N = 763 undergraduates, all sexual minorities. Mean age 20.69.

5. Priebe & Svedin (2012). Swedish Quantitative study.
   A comparison of sexual minority and heterosexual participants' experiences of online sexual harassment, sexual violence, and psychological distress. Sexual minority participants reported higher incidences of sexual violence (on and offline) and psychological distress.
   N = 3,43, aged 16 – 22; 224 sexual minority participants.

6. Smith, Cunningham, & Freyd (2016). American Quantitative study.
   Differences in experiences of sexual violence, institutional betrayal (failures by institutions to protect or respond to individuals) and psychological distress between heterosexual and sexual minority students. Sexual minority students reported significantly higher incidences of sexual violence, institutional betrayal and psychological distress.
   N = 299 undergraduates aged 19 - 25; 29 sexual minority participants.

7. Wyss (2007). American qualitative study.
   Explored previous high school experiences of gender non-conforming adults. All participants described traumatic experiences of sexual and physical violence, which created psychological distress.
   N = 6, 5 = sexual minority participants.

*1.7.1.1. Anti-LGBTQ+ prejudice*

Murchison et al. (2017) identified a positive relationship between sexual violence experienced by sexual minority participants and anti-LGBTQ+ stigma (measured using the internalised homonegativity subscale of the Lesbian, Gay, Bisexual Identity Scale).

Murchison et al. (2017) contends minority stress leads individuals to become more submissive when threated with sexual violence, thus increasing sexual violence. However, this conceptualisation of internalised anti-LGBTQ prejudice neglects the socio-political context in the Minority Stress Model (Meyer, 2003, 2015). Instead, it is framed as a linear process, creating an individualised pathology, and potentially a 'discrediting attribute' (Parker & Aggelton, 2004). This discourse is strengthened through the implementation of a predictive model for sexual violence victimisation, which uses variables concerned with inner experiences. Similarly, Mitchel et al, (2013) also suggest that self-esteem negatively predicts sexual harassment. These framings may contribute to risks of sexual violence, and possible blame, being situated within individuals. Additionally, describing responses to sexual violence along a submissive-assertive continuum (Murchison et al. 2017) could engender feelings of self-blame and shame, also commonly associated with sexual violence (e.g. DeCou et al., 2017; Sarkar & Sarkar, 2005; Vidal & Petrak, 2007; Weiss, 2010; Yoon et al., 2010). Thus, the unintended consequences of research which discusses survivors as submissive may frame them as responsible for the management of sexual assault attempts, obscuring perpetrators.

Gruber and Fineran (2008), Smith et al., (2016) and Wyss (2004) agree increased sexual violence for LGBTQ+ young people is related to anti-LGBTQ+ prejudice. However, in their investigations, increased victimisation is understood in sociocultural contexts of institutional heterosexism and a lack of support from others (family, teachers, universities). Gruber and Fineran, (2008) propose transgressions of cultural constructions of gender and sexuality leads others to sexually harass individuals. Concordantly, participants' in Wyss's (2004) study described being attacked because they were gender non-conforming. This suggests that stigmatising processes create environments which facilitate violent sexual attacks and harassment by peers through anti-LGBTQ prejudice. Consistent with this, Mitchell et al., (2013) also found that sexual harassment experiences meant environments felt hostile to participants. Stigmatising processes are demonstrated through participants' experiences of institutional heterosexism following sexual violence, which Smith et al., (2016) proposes leads their identity to become a source of shame. This may suggest the process of external shame becoming internalised (Gilbert, 1998, 2000, 2006).

However, the proportion of sexual minority participants in Smith et al.'s (2016) study was low (N=29) and all drawn from the same university, limiting the generalisability of findings and assertions. Similarly, Gruber and Fineran's (2008) paticipants were all

drawn from the same area and neither study included gender minorities. However, these studies do suggest anti-LGBTQ+ prejudice and heterosexism may facilitate sexual violence and prevent effective support for LGBTQ+ young people. Heterosexism is indicative of structural inequalities and suggests needs for changes in services, as well as wider societal shifts. Whilst Wyss (2007) described heteronormativity as underlying victimisation, this focused on peer interactions, rather than the school environment. Similarly, Gruber and Fineran (2008) explored interpersonal peer relationships. Subsequently, interventions may remain at the interpersonal or individual level. An individualised focus is reflected in Mitchell et al., (2013)'s recommendation: self-esteem building to reduce the probability of LGBTQ+ young people being sexually harassed.

*1.7.1.2. Psychological impacts of sexual violence*

Psychological distress remained significantly higher than for heterosexual participants, even controlling for the effects of sexual violence (Mitchell et al., 2014**;** Gruber & Fineran, 2008; Priebe & Svedin, 2012; Smith et al., 2016), and sexual violence was associated with increased distress across the research. However, all the studies measured sexual violence and psychological distress differently, thus comparisons are tentative. Gruber and Fineran (2008) found peer sexual harassment had more adverse impacts than bullying, which could be because it is rooted in cultural gender and sexuality stereotypes. This may be supported by Mitchell et al.'s (2014) finding that heterosexual boys reported the least distress from sexual harassment, compared to young people of any other gender and/or sexuality. Potentially, this reflects their more privileged status and heteronormative patriarchal structures.

LGBTQ+ young people may experience more intense victimisation and elevated levels of fear in their lives due to anti-LGBTQ+ stigma, which could explain increased psychological distress (Mitchell et al., 2014). This is also reflected in Wyss's (2004) findings which describe students as consistently afraid and targeted regularly with sexual violence. Importantly, Smith et al., (2017) found that institutional betrayal uniquely predicted depression, suggesting the importance of institutions and services in contributing to psychological distress experienced by LGBTQ+ young people.

The research suggests sexual violence may negatively impact on self-esteem (Wyss, 2004; Gruber and Fineran, 2008; Bendixen et al., 2017; Priebe & Svedin, 2012; Mitchell et al., 2014) and LGBTQ+ young people were more likely to have lower self-esteem than heterosexual peers, independently of sexual violence experiences (Priebe & Svedin, 2012, Smith et al., 2016). Smith et al., (2016) propose lower collective self-

esteem indicates internalised discrimination. This implies conditions, such as supportive environments, increase self-esteem. However, the construct of self-esteem individualises and minimises context by focusing on an attribute that people possess. Shame constructions may be more appropriate than self-esteem because they involve social interactions.

#### *1.7.1.3. Parallels with shame and compassion*

Experiencing environments as hostile (Bendixen et al, 2018; Gruber & Fineran, 2008; Wyss, 2004), particularly following sexual violence (Mitchell et al., 2014), may increase stimulation of the threat detection system (Gilbert 2009), reflected in descriptions of being constantly fearful at school (Wyss, 2004). This suggests very active threat and protection systems, and limited activation of the soothing system, restricting compassion. Mitchell et al. (2014) suggest LGBTQ+ young people may be more likely to internalise harassment, relating it to their gender/sexual identity, increasing distress. These sexual violence experiences, compounded by institutionalised heterosexism and anti-LGBTQ+ prejudice, may suggest negative representations of the self in the minds of others, creating shame.

#### *1.7.1.4. Summary and limitations*

The research indicates sexual violence is pervasive part of LGBTQ+ young people's lives and impacts on psychological distress, wellbeing and safety. This review suggests LGBTQ+ young people are currently being failed by their institutions and more widely through socio-political structures. However, none of the research is UK-based which makes it difficult to generalise to young people nationally. The samples were predominately in education, which may not be representative of all young people. There is an absence of trans young people in the research, when included, they experience the highest rates of sexual violence. The research is cross-sectional, making it difficult to identify causality and the findings disseminated focus on individual interventions. Further qualitative research would be useful to understand impacts and causality from young people's perspectives. Young people may also suggest how institutional change should be enacted. There are parallels to shame and compassion, but no direct explorations of these constructs, although previous research highlights their importance in sexual violence research (e.g. Sarkar & Sarkar, 2005; Vidal & Petrak, 2007; Weiss, 2010; Yoon et al., 2010; DeCou et al., 2017; Close, 2015; Campbell, et al., 2013; Fehler-Cabral et al., 2011; Greeson et al., 2014).

### 1.7.2. Literature Review Two: UK LGBTQ+ People and Shame or Compassion

The second narrative review explores how the constructs of shame and compassion have been investigated with LGBTQ+ people in the UK (Appendix B for search strategy, exclusion and inclusion criteria). Only two studies were identified; McDermott, Roen, and Scourfield (2008) on shame, and Beard, Eames, and Withers (2017) on compassion.

#### *1.7.2.1. Shame*

McDermott et al. (2008) explored how 27 LGBTQ+ young people negotiated being positioned by a heteronormative society as 'deviant' by using strategies of 'shame avoidance'. McDermott et al. (2008) emphasised the heteronormative context in their investigation of social and cultural influences on young people's sexual identities and self-destructive behaviours (e.g. suicide attempts, self-harm). This challenged individualistic 'risky behaviour' discourses. These obscure how power relations shape LGBTQ+ young people's positions and pathologise LGBTQ+ mental health as inherently fragile. Shame was identified as the 'unspoken emotion' through Foucauldian discourse analysis and McDermott et al. (2008) argues that:

"*Homophobia works to punish at a deep individual level to create psychological distress; it shames the self and requires a young person to deal with being positioned, because of their sexual desire, as abnormal*" (p.821)

Gay pride discourses enabled young people to refuse the shaming of homophobia and construct 'proud' identities. However, this binary between the successful proud self who can cope and the failed ashamed self who cannot cope, limits nuanced understandings wherein young people can occupy both positions. McDermott et al. (2008) found heteronormative contexts made proud positions difficult to maintain.

Shame avoidance strategies, such as minimising anti-LGBTQ+ prejudice, were individually focused; therefore, psychological distress and a shamed self were created when individual resources were limited. Minimisation meant young people did not expect or seek support from formal or informal structures (e.g. family, educational institutions). McDermott et al. (2008) recommend further research exploring LGBTQ+ young people's distress negotiating heteronormative settings.

#### *1.7.2.2. Compassion*

In a quantitative investigation of self-identifying gay men (N = 139), Beard et al. (2017) explored the relationships between self-compassion, wellbeing, pride (authentic and

hubristic), self-esteem and two minority-specific processes; outness and internalized heterosexism. Outness is the degree to which an individual is open about their sexual identity. Authentic pride is conceptualised as unstable and controllable attributions (e.g. I won because I trained), whereas hubristic pride results from stable and uncontrollable attributions (e.g. I won because I'm always great). Wellbeing was defined using the BBC Wellbeing scale, which measures psychological wellbeing, physical health, and relationships (Kinderman, Schwannauer, Pontin, & Tai, 2011).

They identified a significant relationship between self-compassion and wellbeing. Authentic pride, self-esteem, self-compassion, and outness were significantly positively associated with wellbeing. Beard et al. (2017) suggest self-kindness creates a buffer against minority stress effects and/or someone who is kind to themselves may appraise stress differently. Whereas, if people view their experience as isolating, they may appraise events more negatively. Beard et al. (2017) propose that self-compassion, rather than proud identities, may explain gay men's resilience to shame experiences when faced with anti-LGBTQ+ prejudice, heterosexism and stigma, shifting from a deficit focused model of LGBTQ+ mental health.

*1.7.2.3. Summary and limitations*

The studies suggest the sociocultural context of LGBTQ+ people's lives are important for shame experiences, and shame can be negotiated (not always successfully) through proud identity constructions and managed through self-compassion.

The studies' generalisability is limited by their samples; McDermott et al.'s (2008) participants were all white LGBTQ+ individuals from South Wales and the North East and Beard et al.'s (2017) sample predominately white gay men. Therefore, their experiences may not be representative all of LGBTQ+ people, particularly ethnic minority people. Shame avoidance was interpreted from the data by McDermott et al. (2008); participants may understand their experiences differently. However, it provided insights into young people's identity constructions. Potentially, sexual violence experiences may compound the challenges LGBTQ+ people already face in managing shame, anti-LGBTQ+ prejudice and heterosexism.

Beard et al. (2017) recommend extending investigating self-compassion with LGBTQ+ adolescent populations as they have the increased complications of developing a minority identity. Both studies explore relational experiences and highlight the importance of shame and compassion for psychological distress and wellbeing. Beard et al. (2017) argues self-compassion can facilitate wider social change by reducing

sexual prejudice through "*the resolution of sexual stigma in gay men*" (p.18), indicating potential wider impacts of this work.

1.7.3. Literature Review Three: LGBTQ+ Experiences of Services for Sexual Violence

A systematic database search identified relevant academic publications. This was supplemented by a grey literature search as service related reports are not consistently published in academic journals. The literature reviewed is outlined below (Appendix C for search strategy, inclusion and exclusion criteria). This review will explore how different levels of context shape service use and experiences in the UK (Moylan & Javorka, 2018).

1. Love et al., (2017). Academic journal:
   Thematic analysis of 35 online surveys and 8 semi structured interviews. Explored barriers to service access for survivors of sexual violence and recommendations for improvements using an intersectional approach.
   - 15 LGBTQ+ survivors of sexual violence completed surveys, 80% White British.
   - 20 professionals from LGBTQ+, Black & Ethnic Minority (BME) & other general organisations completed surveys.
   - 1 interview - Asian heterosexual woman survivor.
   - 1 interview – Black lesbian woman survivor.
   - 6 interviews with professionals (2 LGBTQ+ organisations, 4 BME organisations).
   - All aged 18+. All based in Brighton and Hove.

2. Harvey, Mitchell, Keeble, McNaughton Nicholls, & Nilufer (2014). Report for Welsh Government:
   Rapid Evidence Assessment, qualitative interviews, online submissions to investigate the barriers in accessing domestic abuse, stalking, harassment and sexual violence services.
   - 18 interviews with practitioners working in a range of services in Wales.
   - 35 online submissions from LGBTQ+ people aged 16+ living in Wales.

3. Hester et al. (2012). Report for the Home Office:
   Thematic analysis of interviews, online surveys, and a focus group. Explored the service and support needs of male, lesbian, gay, bi-sexual and transgender and BME victims of domestic and sexual violence. LGBTQ+ participants detailed below:
   - 9 lesbian/gay/queer women and 6 bisexual women discussed. experiences of sexual violence through interviews and an online survey.
   - 15 trans individuals discussed domestic and sexual violence in a focus group. All aged 18+. Based in South West, North West, and London.

4. Rymer and Cartei, (2015). Academic journal.
   Thematic analysis of an online survey and interviews exploring the needs and experiences of trans people accessing services for sexual violence.
   - 42 trans survivors of sexual violence completed the survey.
   - 3 interviews with trans survivors.
   - 3 interviews with professionals working with trans survivors.
   - All aged 18+. Based in Brighton & Hove.

*1.7.3.1. Sociocultural level*

The research reviewed is suggestive of structural inequalities; heteronormative structures were identified by LGBTQ+ people and service providers as creating fears of services and poor experiences, for example, gender binary service provisions (Harvey et al., 2014; Hester et al., 2012; Love et al., 2017; Rymer & Cartei, 2015). Victim blaming narratives and rape myths also restricted help-seeking and increased sexual violence stigma for LGBTQ+ people (Harvey et al., 2014; Hester et al., 2012; Rymer & Cartei, 2015). Trans survivors were particularly concerned sexual violence would be attributed to their gender identity (Love et al., 2017). Intersections with institutionalised racism, sexism and class further increased barriers and poor experiences for ethnic minority, working class and/or women LGBTQ+ people (Harvey et al., 2014; Love et al., 2017). This highlights how socio-cultural factors can create intersectional discriminations, impacting upon service accessibility.

These sociocultural factors led LGBTQ+ people to normalise and minimise experiences of sexual violence, limiting help-seeking, which is further compounded when sexual violence services minimise LGBTQ+ experiences of abuse (Harvey et al., 2014). Additionally, avoiding services may be protective, given experiences of discrimination described in services. These experiences of being excluded are illustrated in

participants' descriptions of a lack of understanding of their identities, for example, mis-gendering trans survivors (Rymer & Cartei, 2015).

#### *1.7.3.2. Service level*

Inadequate training and understanding was highlighted as a consistent issue when working with LGBTQ+ people (Harvey et al., 2014; Hester et al., 2012; Love et al., 2017; Rymer & Cartei, 2015), potentially contributing to the invisibility of their needs within services. A lack of knowledge regarding abuse in LGBTQ+ relationships restricted help-seeking (Harvey et al., 2014), which may indicate a failure by institutions to provide adequate healthy relationships information. Participants described positive experiences when services explored LGBTQ+ issues and sexual violence together (in a non-blaming manner), highlighting the importance of understanding sexual violence impacts on their identity (Hester et al., 2012).

A lack of clarity whether services were LGBTQ+ friendly also prevented their use (Harvey et al., 2014; Hester et al., 2012; Love et al., 2017; Rymer & Cartei, 2015), potentially as it strengthens fears of discrimination. Subsequently, the research reviewed recommended services should be overtly inclusive, for example through gender inclusive language, LGBTQ+ staff and outreach in LGBTQ+ communities (Harvey et al., 2014; Love et al., 2017; Rymer & Cartei, 2015). Although staff in services were aware of structural barriers, their recommendations for improvements described interpersonal interventions, whereas survivors articulated recommendations for wider change (e.g. campaigning) (Love et al., 2017). This demonstrates the importance of hearing survivors' voices.

#### *1.7.3.3. Interpersonal level*

Trans people discussed fears of being shamed through gender binary service provision (Hester et al., 2012; Rymer & Cartei, 2015). Additionally, shame was created through rape myths that participants' gender identity was responsible for sexual violence (Rymer & Cartei, 2015). This indicates the impact of societal attitudes on psychological distress. Lack of confidence and shame in gender/sexual identity could represent a lack of affirming interpersonal relationships, limiting service use (Harvey et al., 2014). Controlling tactics by perpetrators also prevented service use and LGBTQ+ people were concerned accessing services could lead to other types of violence (e.g. hate crimes) or being outed (Harvey et al., 2014; Love et al., 2017, Rymer & Cartei, 2015). This could mean LGBTQ+ people are less likely to seek help from services and may rely more on informal supports (e.g. friends).

*1.7.3.4. Summary and limitations*

The research reviewed indicates LGBTQ+ people's experiences and utilisation of services is informed by heteronormativity. This shapes service structures and may account for a lack of knowledge and understanding concerning LGBTQ+ experiences. These factors contribute towards shame experiences, which can be perpetuated through interpersonal relationships. The differing levels of context affecting service use suggest the need to explore how interventions could affect change at multiple levels to create equitable access. However, service use for sexual violence is only investigated with adults, who may not encounter the additional challenges of negotiating adolescent norms and developing a sexual/gender identity (McDermott et al., 2018). A psychologically informed approach could enable a greater exploration of the impacts of differing levels of contexts for young people. Additionally, the studies included small sample sizes and two studies were based in one city only, limiting generalisability of findings. The qualitative approaches are useful to explore why barriers exist, but may lack the power of quantitative methods to affect change, as these supersede qualitative approaches in the evidence hierarchy (Denzin, 2010).

If services were explicitly LGBTQ+ inclusive, this could create experiences of security and safety, activating the contentment system in CFT (Gilbert, 2009). If service issues were addressed, services could act as sites of compassion, as indicated in previous research of heterosexual young people's experiences of service use for sexual violence (Campbell et al, 2013; Fehler-Cabral et al., 2011; Greeson et al., 2014). This could enable LGBTQ+ young people to access support that changes shame experiences. This may also reduce inequalities in health care for LGBTQ+ young people, an NHS priority (Independent Mental Health Taskforce, 2016), and consistent with the NHS commitment to improve access to services for LGBTQ+ people who have experienced sexual violence (NHS England, 2018).

## 1.8. Research Gap

The psychological impact of sexual violence on LGBTQ+ young people has not been previously investigated in the UK. Research from other countries indicates it has significant implications for psychological distress and wellbeing. The construct of shame is indicated as important in the lives of LGBTQ+ young people, although there is no research that explores shame in the context of their experiences of sexual violence. Research suggests self-compassion could affect shame for people whom have experienced sexual violence, although again these relationships have not been

investigated in a UK based LGBTQ+ youth population. These factors indicate exploration at the individual level is important. However, there may be increased complexity created through heteronormativity and anti-LGBTQ+ prejudice, which facilitates shaming contexts, suggesting research needs to be situated in the wider context. Moreover, services have a critical role in engendering shame and compassion, thus interventions at this level may impact on psychological distress and wellbeing. An exploration of LGBTQ+ young people's perspectives and experiences concerning services could begin to challenge their invisibility and potentially subvert heteronormative structures.

### 1.9. Research Aims

Anchoring explorations at different levels of context can enable an understanding of how these levels interact to shape the experiences of LGBTQ+ young people. This can inform the structuring of potential interventions. Therefore, this study aims to explore:

- Individual level; experiences of psychological distress and wellbeing and their relationships with self-compassion and shame for LGBTQ+ young people who have experienced sexual violence.
- Service level; young people's experiences in services and their ideas for service change.
- Wider level; the research will be situated in a context which recognises the sociocultural ideologies affecting LGBTQ+ young people.

The study will use a mixed method approach to extend the current research base on sexual violence experienced by LGBTQ+ young people and understand their perspectives of sexual violence. The service level explorations will prevent responsibility for change being situated within young people. It is hoped this will inform clinical practice and service development which challenge inequality. By attending to the sociocultural environment, the findings may be able to contribute towards addressing discrimination experienced by LGBTQ+ young people.

### 1.10. Research Questions

Research questions one, two, and three will be investigated through an online survey and analysed quantitatively. Research questions four and five will be explored through interviews using a qualitative methodology.

1. Are internal shame, external shame, and self-compassion significantly associated with psychological distress?

2. Are internal shame, external shame, and self-compassion significantly associated with psychological wellbeing?

3. What factors do LGBTQ+ young people identify to explain:
   A) Service use
   B) Sexual violence reporting

4. How do LGBTQ+ young people make sense of sexual violence?

5. How do LGBTQ+ young people describe experiences of services?

# 2. METHOD

## 2.1. Overview

This chapter situates the research in its epistemological stance and discusses the ethical considerations underpinning the study. The research design is described, and a detailed outline of the methodology provided. Finally, the analytic strategies and researcher reflexivity are explored.

## 2.2. Epistemological Position

This research is constructed from a pragmatist epistemological stance. Whilst differing ideas exist within the pragmatist movement, it is broadly conceptualised as *"what is true of beliefs, right of actions and worthwhile in appraisal is what works out most effectively in practice"* (Rescher, 2005 p.83). Therefore, the practical functions and consequences of knowledge, theories, and concepts are of principal importance (Jones-Chesters, 2007). This frames the present study as it aims to practically improve clinical practice and experiences of services.

Pragmatism contends there are no objective truths and for classical pragmatists, such as Dewey and Pierce, meanings are generated through experiences with another. Therefore, establishing what works most effectively in practice depends upon the consequences and meanings of actions or events in social situations (Denzin, 2012). This is congruent with the Biopsychosocial Model of Shame under investigation, where shame experiences are rooted in social interactions and experiences (Gilbert, 1998; Gilbert, 2006). In this study, constructs such as shame, compassion, and psychological distress, are not assumed to exist independently. Instead, the study is concerned with how useful these constructs are in understanding responses to sexual violence. This aligns with pragmatism as it conceptualises theories as helpful frameworks for predicting or describing observed data, not structures that exist in the world (Cacioppo, Semin, & Berntson, 2004). These emphases on pluralistic knowledge as contextual, emotional and social (Dewey, 2008), as well as functional, enables both critique and action in psychological research (Cornish & Gillespie, 2009). This is through a rejection of the realist correspondence theory of truth, which maintains there is an objective reality, and pragmatism's functional aspects avoids the inaction associated with relativism (Cornish & Gillespie, 2009). This critical action orientation is consistent with a social justice agenda, as both pragmatism and social justice aim to affect meaningful

change within social contexts (Morgan, 2014). Feminist pragmatist positions also align with social justice through analyses of prejudices to address the subjugation of minorities (Seigfried, 2002), consistent with this study's wider aims.

The generation of meanings as shaped by our beliefs and actions is central to pragmatism (Morgan, 2014). This indicates the role of the researcher's experiences in shaping how knowledge may be constructed as useful. Whereas, if pragmatism is reduced to practicality, it limits understandings which inform why researchers pursue certain aims and their chosen methodology (Morgan, 2014). Dewey's process based approach to research inquiry provides a framework to explore how researchers' positionality affects their work (Cornish & Gillespie, 2009). Initially, situations are recognised as problematic, which may be through the researcher's own experiences; this study was originally inspired by previous clinical work with LGBTQ+ young people and CFT, creating an awareness of the high proportion of sexual violence victimisation and frequent poor experiences of services. A mixed methods approach was chosen following consideration of what actions are most likely to have an impact (Morgan, 2014). The quantitative analysis enables exploration of the relationships between shame, compassion, wellbeing and psychological distress, and has greater political power in the evidence hierarchy (Denzin, 2010). Through the qualitative approach, LGBTQ+ young people can define issues that matter to them (Morgan, 2014), which can inform service development and clinical practice. This aligns with the transformative potential of critical pragmatism (Vannini, 2008) and Denzin's (2012) assertion that mixed methods should be used to further social justice, as the consequences of pragmatic inquiry are always political (Denzin, 2012; West, 1995). Therefore, a pragmatic mixed methods paradigm may make injustices experienced by LGBTQ+ young people more visible, creating the possibility of change and transformation (Denzin, 2012).

## 2.3. Ethical Considerations

### 2.3.1. Ethical Approval

Ethical approval for this study was granted by University of East London Ethics Committee subject to minor amendments (Appendix D). As participants were not recruited directly through NHS services, no other ethical approval was needed.

### 2.3.2. Informed Consent and Confidentiality

All participants were presented with a Participant Information Sheet (PIS) when logging onto the survey. If participants offered to be interviewed, they were emailed a PIS (Appendices E & F). These information sheets outlined the nature of the study, what to expect, right to withdraw and how data would be used and stored. Participants were able to contact the researcher with any questions prior to consenting to the study. In the interviews, participants returned a signed consent form provided by the researcher via email. Verbal consent was additionally taken at the beginning and end of the audio recorded interview. No personally identifiable information was stored (e.g., email address) and interview participants selected pseudonyms for their data. Names of services and other identifying information (e.g., names of people or places) were changed to ensure anonymity. All data was stored on password protected files.

### 2.3.3. Possible Distress

The potential distressing nature of conducting research on sexual violence experiences was given careful consideration in the study design. Quantitative measures of distress suggested young people (aged 15-25) experienced minimal discomfort when participating in sexual violence research (Kuyper, de Wit, Adam, & Woertman, 2012), including young people who had been sexually abused or were sexually inexperienced (Priebe, Bäckström, & Ainsaar, 2010). Engaging in research also supported participants to seek help if needed (Kuyper et al., 2012; McClinton Appollis, Lund, de Vries, & Mathews, 2015; Priebe et al., 2010; Wager, 2012).

Consistent with ethical guidelines for internet mediated research (British Psychological Society, 2017), consent and withdrawal procedures were clearly stated on PIS and debrief sheet. Details of support services were provided on the PIS for participants to download, ensuring all participants viewed these even if they withdrew prior to completion. To make information more accessible, support services were grouped by LGBTQ+ specific services, sexual violence services and services for young people.

The implementation of a questionnaire to measure sexual violence experiences was carefully considered. Each item on the Sexual Experience Survey for both the short form and long form victimisation versions (Koss et al., 2006a; Koss et al., 2006b; Koss et al., 2007) was reviewed. Subsequently, the tactics of sexual violence perpetration for each item was removed because it could require participants to recall sexual violence experiences in more depth. This information was not central to the research questions and could have increased the possibility of distress.

The PIS and promotional materials stated the study would ask about sexual violence experiences, allowing participants to make an informed choice regarding participation. The online format was selected because it enables young people to be more honest and open, as they are protected by anonymity when discussing stigmatised or sensitive issues (McDermott & Roen, 2012).

Within the survey, sexual violence questionnaires were placed towards the end of the battery, and after the Short Warwick-Edinburgh Mental Wellbeing Scale. This positioning meant participants may be more accustomed to questionnaire completion, and able to reflect on their current psychological wellbeing before proceeding. The webpage prior to the sexual violence questionnaires reminded participants of what to expect and the nature of the survey.

In the interviews, the PIS and debrief sheet also provided support services information. Participants were reminded they could decline to answer any questions, to only disclose information they were comfortable sharing, and they could withdraw their data any time until March 2019. This contributed towards a process consent approach, and verbal consent continually sought during interviews (Polit & Beck, 2006). Additionally, participants decided whether to discuss personal experiences or speak more generally about sexual violence (although, all chose to discuss their experiences). The interviews were conducted in a warm and validating manner, consistent with recommendations for interviewing survivors of sexual violence (Campbell, Adams, Wasco, Ahrens, & Sefl, 2010), and attention paid to how participants presented during interviews.

#### 2.3.4. Debrief

Consistent with the British Psychological Society's (2014) ethical guidelines, debrief sheets, were provided online following survey completion and emailed to participants after interviews (Appendices G & H). Time was allotted at the end of interviews for verbal debriefs, where participants could reflect upon interview experiences and raise any concerns or questions. Additionally, they were reminded of the right to withdraw.

### 2.4. Design

A cross sectional mixed methods design employing quantitative and qualitative methodology was implemented, consistent with the epistemological stance (Johnson & Onwuegbuzie, 2004) and research rationale. Participants completed a range of online questionnaires at a single time point and subsequently could complete semi-structured interviews. The relationships of interest are between shame, self-compassion,

psychological distress and wellbeing. The use of quantitative, validated self-report measures extends the current shame and compassion research base (e.g. Gilbert, 2009). The qualitative data can contextualise young people's experiences of shame, compassion and sexual violence in their personal and social environments (Wilkinson, Joffe, & Yardley, 2004). The qualitative exploration of young peoples' ideas for service improvements may also inform relevant service development.

## 2.5. Materials

All the measures were reviewed by the researcher and supervisor, and attention paid to their psychometric properties, length, content and face validity. Shame, compassion, distress and psychological wellbeing measures were selected due to their implementation in previous research. Appendices I and J for materials outlined below.

### 2.5.1 Shame Measures

#### *2.5.1.1. The Other As Shamer (OAS)*

The OAS is an 18-item scale designed to measure external shame (Allan, Gilbert, & Goss, 1994). Items include self-evaluations ('*I feel other people look down on me'*) and beliefs about how others see the self, such as ('*other people see me as somehow defective as a person'*), which are rated on a 5-point Likert scale from 0 (never) to 4 (almost always). Scores range from 0 – 74, with higher scores indicating greater external shame. In this study a total score was computed, consistent with prior research with adolescents and students (Cunha et al., 2012; Pinto-Gouveia & Matos, 2011). The scale demonstrated high internal consistency in its' original study (Cronbach's α = .93). Cunha et al., (2012) and Pinto-Gouveia & Matos, (2011) also found high internal consistency (Cronbach's α =.95 and .91 respectively). This measure was selected over the short-form version as it is freely available.

#### *2.5.1.2. Social Comparison Scale (SCS)*

The SCS consists of 11 bipolar constructs rated of a scale of 1 – 10. Participants respond based on how they compare themselves to others (e.g. '*in relationship to others I feel different – same'*). In the study this scale was used to measure internal shame. A total score is computed and ranges from 11 – 110, higher scores indicate lower internal shame. The SCS has high internal consistency in clinical (Cronbach's α of .88, .90 & .96) and student populations (Cronbach's α of .91, 90, & .89) (Allan & Gilbert, 1995; Gilbert, Irons, Olsen, Gilbert, & McEwan, 2006; Gilbert & Miles, 2000). The SCS was preferable to other measures of internal shame, such as, the Experience of Shame Scale (Andrews et al., 2002), which may conflate internal and external

shame experiences (Matos & Pinto-Gouveia, 2010). The Internalised Shame Scale (Cook, 1994, 2001) was considered but is not freely available.

2.5.2. Short Self-Compassion Scale (SSCS)

The SSCS is 12 item scale, selected as a measure of self-compassion because it has good internal consistency (Cronbach's α = .86) and a near perfect correlation with the long form Self-Compassion Scale (r ≥ .96; Raes, Pommier, Neff, & Van Gucht, 2011). All items are prefaced with '*how I typically act towards myself in difficult times'*, such as '*I try to see my failings as part of the human condition',* which are ranked from 1 (almost never) to 5 (almost always). Higher scores indicate higher self-compassion and scores range from 1 - 5. It has been widely implemented in research with young people (e.g. Lockard, Hayes, Neff, & Locke, 2014; Muris et al., 2017; Muris, Meesters, Pierik, & Kock, 2016; Neff & McGehee, 2010), as well as in Beard et al., (2017)'s UK based study of compassion with gay men, enabling comparisons with the literature.

2.5.3. The Depression Anxiety Stress Scales 21 (DASS-21)

The DASS-21 was developed from the DASS (Lovibond & Lovibond, 1995) as a measure of psychological distress. It has three subscales that measure distress based on the constructs of stress, anxiety and depression. Participants rate the extent to which the 21 items applied to them over the past week, using a 4-point Likert scale (0 – 3), for example *'I felt that life was meaningless'.* A total score and scores for each subscale is computed, which is multiplied by 2, enabling comparisons with the DASS. Higher scores indicate greater distress. The total score, and stress, anxiety and depression subscales have all demonstrated high internal consistency (Cronbach's α = .93, .95, .92 & .97 respectively), and the scale has shown acceptable to excellent concurrent validity (Antony, Bieling, Cox, Enns, & Swinson, 1998; Henry & Crawford, 2005). This scale was selected because it represents a dimensional measure of distress and was developed empirically through iterative procedures. This is in contrast to other measures of distress where items were selected, in part, to reflect diagnostic manuals (e.g. Beck Depression Inventory, Beck, Steer, & Carbin, 1988). Additionally, the short form version reduces burden on participants.

The DASS-21 has been widely implemented in research with clinical and non-clinical and adult and adolescent samples (e.g. Antony, Bieling, Cox, Enns, & Swinson, 1998; Henry & Crawford, 2005; Norton, 2007; Osman et al., 2012; Szabó, 2010; Willemsen, Markey, Declercq, & Vanheule, 2011). It has also been used in sexual violence (e.g. Artime, McCallum, & Peterson, 2014; Au, Dickstein, Comer, Salters-Pedneault, & Litz, 2013; Steenkamp, Dickstein, Salters-Pedneault, Hofmann, & Litz, 2012) and LGBTQ+

research (e.g. Walch, Ngamake, Bovornusvakool, & Walker, 2016; Walton, Lykins, & Bhullar, 2016; Yadavaia & Hayes, 2012).

2.5.4. Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS)

The SWEMWBS is a 7-item scale which measures psychological wellbeing by asking participants to rate how much they felt different statements on 1 – 5 Likert scale over the past two weeks, for example *'I've been feeling useful'* (Stewart-Brown et al., 2009). Total scores are transformed using a conversation table (see Stewart-Brown et al., 2009). Higher scores indicate higher psychological wellbeing. For men and women in England aged 16 – 24 the normed scores are 23.57 and 23.17 respectively (Ng Fat, Scholes, Boniface, Mindell, & Stewart-Brown, 2017). The SWEMWBS demonstrates high internal consistency (Cronbach's α = .84) (Ng Fat et al., 2017) and a near perfect correlation with the longer 14-item Warwick Edinburgh Mental Well-Being Scale (Pearson's correlations of .95 and above) (Stewart-Brown et al., 2009; Ng Fat et al., 2017). The short form version was selected to reduce burden on participants. Additionally, it has been validated across diverse groups and with individuals aged 13 and upwards (Clarke et al., 2011; Hunter, Houghton, & Wood, 2015; Stewart-Brown et al., 2011), and implemented in compassion research, including research involving traumatic experiences, such as sexual violence (Elaine Beaumont, Durkin, Hollins Martin, & Carson, 2016; Seligowski, Miron, & Orcutt, 2015).

2.5.5. Sexual Violence Victimisation

The sexual violence measures were developed to capture diverse experiences of sexual violence (appendix J outlines construction). They were based primarily upon the Long and Short Form Victimisation versions of the Sexual Experiences Survey (SES-LFV & SES-SFV) which have been widely used, and often amended, in research (Koss et al., 2007). Revisions of SVS-LFV/SFV include gender neutral language, important in this study as participants may identify as non-binary. The SVS uses non-judgemental language and behavioural descriptions of sexually violent acts. This avoids legal terms and aids identification of sexual violence. Two measures were constructed:

- 16-item non-contact sexual violence measure, based on the SVS long form victimisation (SES-LFV) and Project De-Shame, which investigated online sexual harassment (Project De-Shame, 2017).
- 10-item contact sexual violence measure (sexual assault and rape and attempted sexual assault and rape), based on the SES-SFV. The last 2 items on this measure described rape and were only displayed to participants who

meet the legal definition of female gender (i.e. have a vagina), because in English Law only women can be raped (McKeever, 2018). This is consistent with the SES-LVF/SFV.

In line with the SES-LVF/SFV format, on both measures, participants report the frequency of experiences over last the 12 months and since the age of 14 on a 4-point scale (0, 1, 2, or 3+ times). Responses greater than zero are used to produce percentages of the types of sexual violence victimisation of participants (e.g. percentage of participants who were sexually assaulted, percentage who experienced sexualised bullying).

For the non-contact sexual violence measure, participants reported the methods used to harass them (e.g. in person, by phone), generating a categorical score. For the contact sexual violence measure, participants reported the tactics used to assault or to attempt to assault them (e.g. use of force) on a 5-point scale (0, 1, 2, 3, 4+ times). Responses greater than zero are used to generate a percentage for each tactic. Cronbach's alpha is inappropriate for measures of behavioural experiences and therefore not calculated for the SVS-LFV/SVF (Anderson, Tarasoff, VanKim, & Flanders, 2019; Koss et al., 2007).

### 2.5.6. Service Experience Measure

The measure was constructed to ascertain participants experiences in services, particularly relating to compassion and gender/sexual identity, (appendix J outlines construction and scoring). The measure asks participants who had used services to rate seven statements describing their experience of a service on a 1 (not at all) to 5 (completely) Likert scale .This format is useful to capture ordinal data describing experiences (Fowler, 2014). The seven statements described experiences of being believed and respected, and of compassion from staff (e.g. '*The staff in the service believed me'*). Higher scores indicate more positive experiences of services.

### 2.5.7. Qualitative Survey Questions

These were designed to capture participants reasons for not reporting victimisation, and LGBTQ+ young peoples' views regarding service utilisation. These questions formed the basis of the survey content analysis (appendix K).

2.5.8. Demographic Information

A demographic questionnaire recorded age, occupation, ethnicity, gender and sexual identity. The gender and sexual identity items were based on Stonewall recommendations (Stonewall, 2016).

2.5.9. Interview Schedule

A semi-structured interview schedule was used to guide the individual interviews (Appendix L). The interview schedule broadly explored the impact of sexual violence experiences and potential experiences of shame and compassion, as well as ideas about services. Probes and follow up questions were used where appropriate, and participants were invited to add anything they felt was important at the end of the interview.

Interviews were selected as they provide a confidential space which may support discussions of sexual violence. It meant the views of each participants were included and their perspective explored on their own terms (Frith & Gleeson, 2012). As the interviews were over Skype, timings were flexible to participants' schedules.

## 2.6. Participants

2.6.1. Recruitment

Online research designs with LGBTQ+ young people have been effective to recruit participants who do not usually take part in research (McDermott & Roen, 2012). Participants were recruited through convenience sampling using advertisements on Twitter and Facebook social media platforms. This included promotions by large organisations with significant social media profiles, such as the National Union of Students, METRO Charity, Terrence Higgins Trust and Galop. LGBTQ+ organisations, sexual violence support organisations and youth and educational organisations were also contacted by email and asked to promote the research. The research project was included in several newsletters for youth workers. Appendix L for recruitment strategy and promotional materials.

2.6.2. Inclusion Criteria

The inclusion criteria for the survey were young people aged 16 – 25 who identified as LGBTQ+ and had experienced sexual violence. All interview participants completed survey and thus reflect the same inclusion criteria.

2.6.3. Exclusion Criteria

Participants unable to read or write in English were excluded from the study as this was essential for informed consent to be appropriately given, particularly important for the online component. Additionally, most measures were only validated English. However, this limits the generalisability of findings to non-English speakers.

## 2.7. Procedure

2.7.1. Pilot Phase

The pilot phase was used to review content and length of questionnaires. It was conducted with a convenience sample of three young people aged 21 – 24, identifying as heterosexual or questioning, two men (age 28 and 30) who identified as gay, one woman who identified as queer aged 27 and a bisexual woman aged 30. To ensure maximum involvement in the research phase of the study by the population of interest, participants in the pilot phase were deliberately drawn from outside of the population (one young person later identified as questioning). Following the pilot, the fears of compassion questionnaire (Gilbert, McEwan, Matos, & Rivis, 2011) was removed as participants felt it was lengthy and amendments made to the sexual violence measures (appendix J). The interview schedule was discussed with pilot phase participants and felt to be clear and non-leading.

2.7.2. Online Survey

Participants accessed the study via an electronic link and were presented with a study information sheet and details of support services. Participants were unable to progress to the questionnaires until they indicated informed consent (appendix G). The main questionnaire battery took between 15 – 30 minutes to complete. Participants could discontinue at any time. Participants were able to take breaks during the survey and return to it for a period of one week. Partially completed questionnaires indicated study withdrawal. Upon completion of the questionnaire battery, participants were asked if they would like to be interviewed and provided with another link to provide contact details. Subsequently, all participants were presented with the debrief sheet (appendix H). This provided greater detail concerning the nature of the study, support services, and contact details of the researcher. There was also an opportunity to enter a prize draw to win one of four £15 Amazon vouchers. Contact details for the interviews and the Amazon draw were stored separately to ensure anonymity. At the end of data collection, all data was transferred to SPSS (v. 25) and NVivo (10) for analyses.

2.7.3. Individual Interviews

Participants who offered to be interviewed were contacted by the researcher to arrange a suitable time for a Skype interview. Participants were emailed the PIS and consent form (appendices E & G) which were all returned and stored in a password protected file. Participants also gave verbal consent and confirmed they had read the PIS at the start of the interview. Interviews lasted between 45 minutes to 1 hour 20 minutes. At the end of the interview, consent to use material generated was revisited with participants. Lastly, participants were emailed the debrief sheet (appendix H). All participants who were interviewed were offered an Amazon voucher worth £5. All interviews were audio recorded using a dictaphone, transcribed under pseudonyms.

Throughout the interviews, the inherent power imbalances between researcher and participants were reflected upon by the researcher. This is particularly acute for younger participants as adolescents are often evaluated by adults, and may be accustomed to the idea that there are 'correct' answers to questions (Schelbe et al., 2015). Participants were encouraged to ask questions and reassured there is no 'right' answer. Discussions concerning sexual violence can be extremely sensitive, therefore a straightforward approach was taken to avoid embarrassment (Bellamy, Gott, & Hinchliff, 2011). Responses to disclosures of sexual violence by participants were compassionate and gave participants control over whether to continue interviews (Campbell et al., 2010). The interview space was deliberately constructed as informal and open to create a relaxed and empathic context (Hedges, 2005).

## 2.8. Analytic Approach

2.8.1. Quantitative Strategy

Numerical survey data was analysed using SPSS (v. 25). Descriptive statistics were computed for each measure and percentages calculated for categorical variables. Correlational analyses were conducted to explore relationships between constructs to answer research questions one and two. Statistical analysis was limited by the small sample size. G*Power sample size calculations indicated 88 participants were required to detect moderate relationships at a power of .90 (Erdfelder, Faul, & Buchner, 1996). However, difficulties in recruitment led to a low number of participants (N=36), which G*Power sample size calculations indicated resulted in a power of .43 to detect moderate relationship, suggesting the likelihood of Type Two II errors. However, to detect a strong relationship, G*Power sample size calculations indicated a sample size of 36 at a power of .88, an acceptable level in statistical analysis (Field, 2013).

A content analysis was selected as an quantitative method to analyse qualitative data in the survey to categorise meanings from semantic information (Hsieh & Shannon, 2005). Data from each participant was reviewed and coded, and categories developed from coding using NVivo (10) software.

### 2.8.2. Qualitative Strategy

Thematic analysis was selected as the most appropriate analytic approach to identify and analyse patterns of meanings and develop themes (Braun & Clarke, 2006) from the experiences of interview participants.

Inductive and deductive analytic strategies were employed; codes, themes and interpretations were generated through semantic content, and these were also informed by existing research and theory. To ensure consistency and transparency in the decision-making process, the six phases were implemented (Braun & Clarke 2006):

1. Familiarisation with the Data

The immersion process began through the conducting and transcribing of interviews. Following an initial reading of the entire dataset, transcripts were read and re-read to capture meanings and patterns.

2. Generating Initial Codes

The dataset was coded systematically using NVivo (10) software. Data was coded inclusively, retaining relevant contextual content, and coded for as many themes as possible. This meant data extracts were coded under several themes as appropriate (Appendix S for initial codes).

3. Searching for Themes

Initial codes were organised in overarching themes using visual mind-maps, tables and notes to facilitate exploration of code combinations. A flexible approach was used to identify themes across the dataset.

4. Reviewing Themes

Coded extracts under each theme and subtheme were reviewed for consistency and refinement. The entire data set was re-read to ensure validity of themes and code any data that was missed.

5. Defining and Naming Themes

Through an iterative analysis process of each theme, hierarchies of subthemes were created and organised into a coherent narrative of the data, consistent with the overarching story of the data.

6. Producing the Report

Through the writing of the final report, the narrative of the data was told with extracts to capture the essence of each theme.

### 2.8.3. Reflexivity: Researcher's Position

It is critical researchers engage with how their experiences, values, beliefs and interests have shaped the research. This acknowledges researchers' contributions to how meanings are constructed, and how the research has influenced them (Willig, 2001). To maintain this personal reflexivity, I reflected throughout the research process on my responses to issues of sexual violence, shame, compassion and service experiences. Below is a summary of my identities and experiences which appear most relevant and I continued to hold in mind throughout:

- Early 30's heterosexual white British middle-class cisgender woman, who grew up in a liberal environment, in a city well known for its LGBTQ+ communities and feel allied to these communities.
- Feminist socialist political views and, through my role as a trainee psychologist at the University of East London, I have been influenced by critical psychology ideas, emphasising social context in distress.
- Previous youth worker positions and in sexual health services informed my belief services can be improved and rape myths and shame are pervasive, particularly for LGBTQ+ young people.
- Experiences of sexual violence as a young person, and awareness of the frequency of these experiences shaped my beliefs in heteronormativity as a cultural scaffold for the normalisation of sexual violence.

# 3. RESULTS

## 3.1. Overview

This chapter explores the findings of the study. The survey sample and sexual violence experiences are described initially before the research questions are addressed. Correlational analyses investigate research questions one and two. A content analysis of qualitative survey data explores research question three. Research questions four and five are explored through thematic analysis of interview data.

## 3.2. Quantitative Survey Analysis

### 3.2.1. Sample Characteristics

#### *3.2.1.1. Survey respondents*

Ninety-six individuals accessed the online survey, although 22 (22.92%) did not proceed past the PIS, therefore, the total number of study survey respondents was 74. The data for all participants was examined, which identified 38 respondents whom did not fully complete the survey. There was no missing data for any respondents. The decision was taken to use a listwise deletion, or complete case, analysis approach, therefore restricting analysis to complete responses only. This was important ethically as non-completion was an indicator of study withdrawal. Thus, N=36 for all quantitative analyses.

#### *3.2.1.2. Participant characteristics*

Table 1 outlines the participant characteristics for the 36 individuals who completed the survey. This indicates that most participants were aged 19 – 22 (52.78%), had a White ethnic background (80.56%), and tended to be university students (42.59%). Almost half of participants identified as bisexual (41.67%), and one quarter identified as trans (25.00%). The proportion of participants' gender identities was equal for men and women (33.33%) and only slightly lower for non-binary participants (27.78%).

Table 1: Survey sample characteristics

| Characteristics | N | % |
|---|---|---|
| ***Age*** | | |
| 16 - 18 | 9 | 25.00 |
| 19 – 22 | 19 | 52.78 |
| 23 – 25 | 8 | 22.22 |
| ***Ethnicity*** | | |
| Asian/British Asian | 1 | 2.78 |
| Any other mixed/multiple ethnic background | 5 | 13.89 |
| Black/Black British | 0 | 0.00 |
| White – English, Northern Irish, Scottish, Welsh | 19 | 52.78 |
| Any other White Background | 10 | 27.78 |
| Prefer not to say | 1 | 2.78 |
| ***Occupation**** | | |
| School student | 2 | 3.70 |
| College student | 2 | 3.70 |
| University student | 23 | 42.59 |
| Working full time | 4 | 7.41 |
| Working part time | 11 | 20.37 |
| Job hunting | 7 | 12.96 |
| Not working due to disability or mental health issues | 2 | 3.70 |
| Volunteering | 3 | 5.56 |
| ***Sexual Identity*** | | |
| Lesbian/gay woman | 6 | 16.67 |
| Gay man | 6 | 16.67 |
| Bisexual | 15 | 41.67 |
| Queer | 4 | 11.11 |
| Pansexual | 4 | 11.11 |
| Asexual | 1 | 2.78 |
| ***Gender Identity*** | | |
| Woman | 12 | 33.33 |
| Man | 12 | 33.33 |
| Non-binary | 11 | 27.78 |
| Questioning | 1 | 2.78 |
| ***Transgender Identity*** | | |
| Yes | 9 | 25.00 |
| No | 22 | 61.11 |
| Questioning | 2 | 5.56 |
| Gender fluid/queer | 2 | 5.56 |
| Prefer not to say | 1 | 2.78 |

**participants could select multiple occupations*

*3.2.1.3. 'Non-Completers'*

Of the participants who did not complete the survey, demographic information was available for 31 individuals (appendix M for breakdown of 'non-completers' demographics). The demographic data of 'non-completers' was inspected to reduce the

possibility of biased conclusions being drawn from the completed sample (Graham, 2009). The participants in the completed group included a slightly younger age group in comparison to the non-completers group (25% aged 16-18 compared to 12.9%). Participants in both groups were predominately from White backgrounds, although the non-completers group included two participants from Black/Black British backgrounds which was absent in the completed sample. Conversely, the completed sample included more participants from mixed ethnic backgrounds (13.89%). Bisexual people were more likely to complete the survey compared to participants with other sexual identities. Whereas, proportions of gay, lesbian and bisexual participants in the non-completers were more evenly spread (7%, 8%, and 6% respectively). Both samples included 9 participants identifying as transgender. Additionally, the survey stage at which participants discontinued was investigated, this indicated 'non-completers' tended to withdraw towards the start of the study (appendix N).

### 3.2.2. Data Distribution

#### *3.2.2.1. Reliability of measures*

Cronbach's alpha (α) was implemented to assess the internal reliability of the measures for the current sample, outlined in table 3. High internal consistency (>.80) was found for all the measures (Field, 2013). This suggests the measures were internally reliable in this sample.

Table 2: Internal consistency of measures

| **Measure** | **Cronbach's α** |
|---|---|
| Other as Shamer | .92 |
| Social Comparison Scale | .94 |
| Short Self Compassion Scale | .84 |
| DASS-21 Total | .94 |
| DASS-21 Stress | .85 |
| DASS-21 Anxiety | .90 |
| DASS-21 Depression | .86 |
| WE Mental Wellbeing Scale | .86 |

#### *3.2.2.2. Parametric assumptions*

Exploratory data analysis was conducted to assess the normality of distribution of the variables. A visual inspection of P-P Plots, histograms, and Q-Q plots was undertaken (Appendix P) and statistics for Skewness, Kurtosis, and Kolmogorov-Smirnov generated. Table 5 outlines the values for the Means (M), Standard Deviations (SDs), Skewness (SK), Kurtosis (Rku) and Kolmogorov-Smirnov (K-S) with a Lilliefors (1967) significance level, for the Other as Shamer scale (OAS), the Social Comparison Scale

(SCS), the Depression, Anxiety and Stress Scale-21 (DASS-21 Total), as well as its' three subscales of stress, depression and anxiety, the Short Self Compassion Scale (SSCS), and the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS).

Table 3: Descriptive statistics and distribution parameters

| Variable | M | SD | SK | Rku | K-S |
|---|---|---|---|---|---|
| OAS | 35.94 | 12.87 | -.55 | .54 | .14 |
| SCS | 46.25 | 17.52 | .74 | .35 | .20* |
| SSCS | 2.45 | 0.65 | .16 | -.61 | .20 |
| SWEMWBS | 18.53 | 3.99 | .41 | .71 | .02 |
| DASS-21 Total | 61.94 | 30.80 | -.20 | -.78 | .20* |
| DASS-21 Stress | 21.67 | 10.65 | -.25 | -.48 | .20* |
| DASS-21 Anxiety | 17.61 | 12.07 | .29 | -.76 | .20* |
| DASS-21 Depression | 22.67 | 11.64 | -.19 | -1.29 | .04 |

**Lower bound of true significance*

These evaluations indicated normal distributions of all variables (K-S significance level >.05), except the DASS-21 Depression subscale and the SWEMWBS. Tabachnick and Fidell, (2013) recommend assessing for possible univariate outliners (extreme scores) when examining skewness. To detect univariate outlines, scores on DASS-21 Depression subscale and SWEMWBS were converted to Z-scores, and scores greater than 3.29 ($p<.001$) considered outliners (Tabachnick & Fidell, 2013). This process resulted in no significant outliners being identified (appendix Q). Consistent with this, the histograms (appendix P) for the DASS-21 Depression subscale and the SWEMWBS also suggest the degree of skewness is influenced by the range of scores, not extreme scores.

Transforming skewed variables can prevent inflation of the standard error of the mean (Wilcox, 2013), however, transformation techniques can make analytical interpretations more challenging (Feng et al., 2014). It was decided not to use non-parametric tests as these can be less sensitive in comparison to parametric tests, and most variables were normally distributed (Field, 2013).

Instead, bootstrapping techniques were used (based on 1000 bootstrap samples and 95% confidence intervals) for all analyses in the study. Bootstrapping techniques calculate standard errors and confidence intervals, allowing for interpretations of the sampling distribution to manage the impact of skewed variables (Field, 2013; Mooney & Duval, 1993).

### 3.2.3. Sexual Violence Experiences

The types of sexual violence experienced by participants in the last 12 months and since the age of 14 were examined. Figure 1 outlines the proportion of participants who experienced each type of sexual violence. Sexual assault and attempted sexual assault (this includes rape and attempted rape) describe 'contact' sexual violence, whereas the remaining types refer to 'non-contact' sexual violence. Unwanted sexualisation was the most common sexual violence experience, since age 14 and in the last 12 months (100% of participants). Sexualised bullying was also frequently experienced by participants, which includes bullying regarding gender and sexuality. A high proportion of participants had experienced sexual assault since age 14 (86.11%) and half in the last year. Similarly, a large proportion experienced attempted sexual assault since the age of 14 (77.78%). Whilst experiences of exploitation, coercion and threats, and of non-consensual sharing and taking of images and videos, were lower in the last year (16.67% and 25.00% respectively), since the age of 14 just after half (55.56%) had experienced these forms of sexual violence.

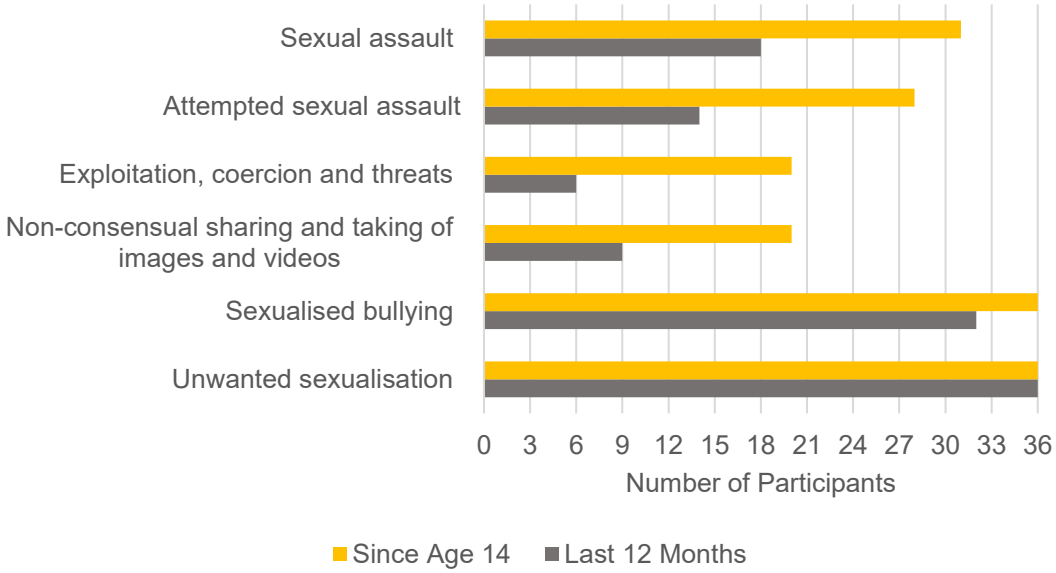


Figure 1: Types of sexual violence experienced

Examination of the perpetrators of contact and non-contact sexual violence is outlined in figures 2 and 3. Participants could select multiple options for their relationships with perpetrators (figure 2). Participants reported the highest number of assaults or attempts to assault them by acquaintances (30.56%), followed by partners (22.22%) and strangers (16.67%). Whereas, non-contact sexual violence was most frequently perpetrated by strangers (31.87%), followed by friends (25.27%) and acquaintances (21.98%).

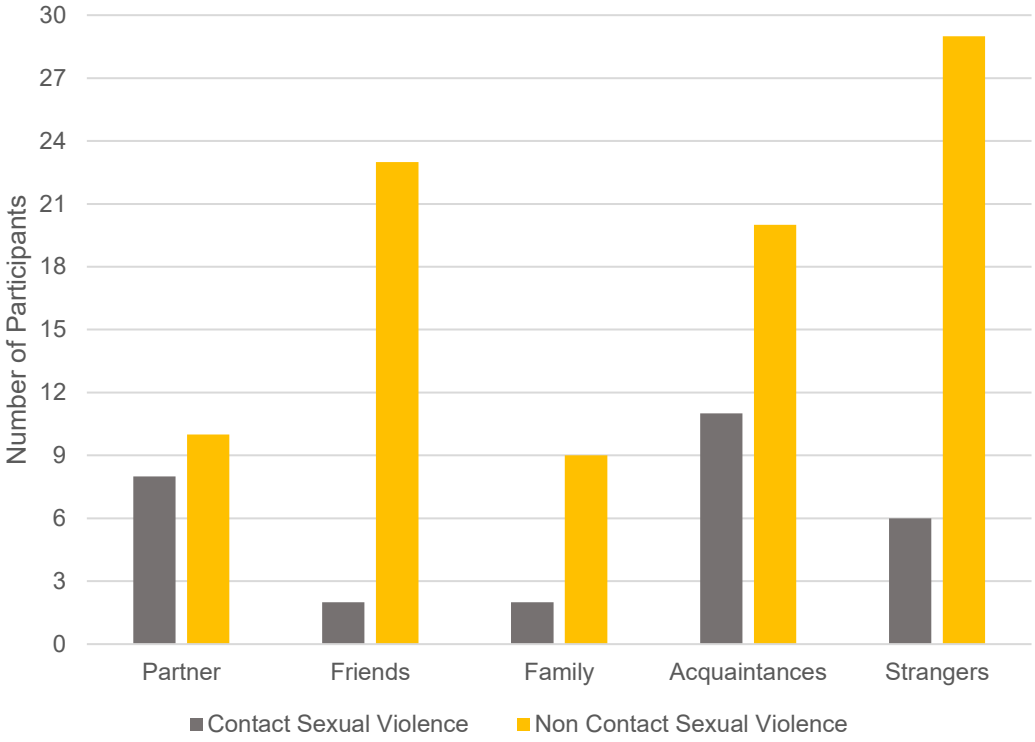


Figure 2: The relationship with perpetrators of sexual violence

Overall, men were most likely to be perpetrators of sexual violence (figure 3). Slightly over half of participants were sexually assaulted, or sexual assault was attempted, by men (52.78%). Women also were perpetrators, particularly of non-contact sexual violence (61.11% men and women perpetrators), although this was never exclusively perpetrated by women.

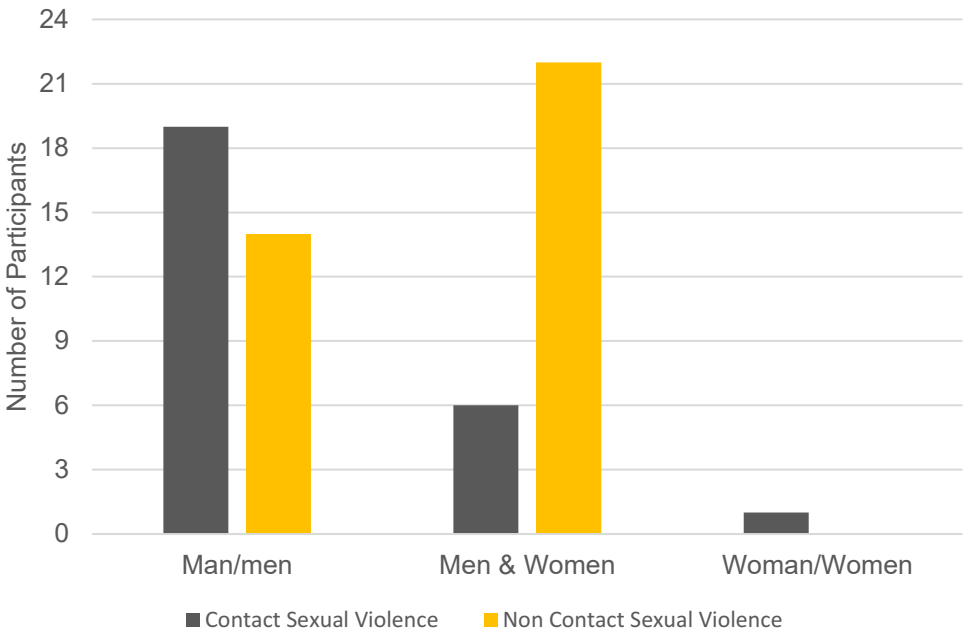


Figure 3: The gender of perpetrators

The tactics used by perpetrators to sexually assault, or attempt to sexually assault, participants are outlined in Table 6. For experiences of sexual assault and attempted sexual assault, the tactics perpetrators used were commonly coercion based; '*Told lies, or threatened you, or continually pressured you, or made you false promises'* = 18.38%, and '*Got angry with you (but didn't use physical force), or criticised your sexuality or attractiveness, or showed their displeasure when you said no* = 19.39. Although, on a single item, the highest proportion of perpetrators took advantage of participants while they were incapacitated (22.45%), and 14.49% of perpetrators used physical force. This meets the legal definition for rape and sexual assault (Sexual Offences Act 2003).

Table 4: Contact sexual violence: perpetrator tactics

| **Perpetrator Tactics*** | **N** | **%** |
|---|---|---|
| Told lies, or threatened you, or continually pressured you, or made you false promises | 18 | 18.38 |
| Used physical force, such as pinning you down, having a weapon, or using their weight to hold you down | 14 | 14.29 |
| Took advantage of you when you were asleep, or drunk or high | 22 | 22.45 |
| Got angry with you (but didn't use physical force), or criticised your sexuality or attractiveness, or showed their displeasure when you said no | 19 | 19.39 |
| Used their authority over you, e.g. a boss or a teacher | 6 | 6.12 |
| Threatened to physically harm you or someone close to you | 8 | 8.16 |
| Other tactics not listed here | 11 | 11.22 |
| *Total* | 98 | 100% |

**Participants could select multiple options*

Further examination of how non-contact sexual violence was perpetrated is outlined in Figure 4. Most non-contact sexual violence happened in person (30.17%) and through private messages (22.41%).

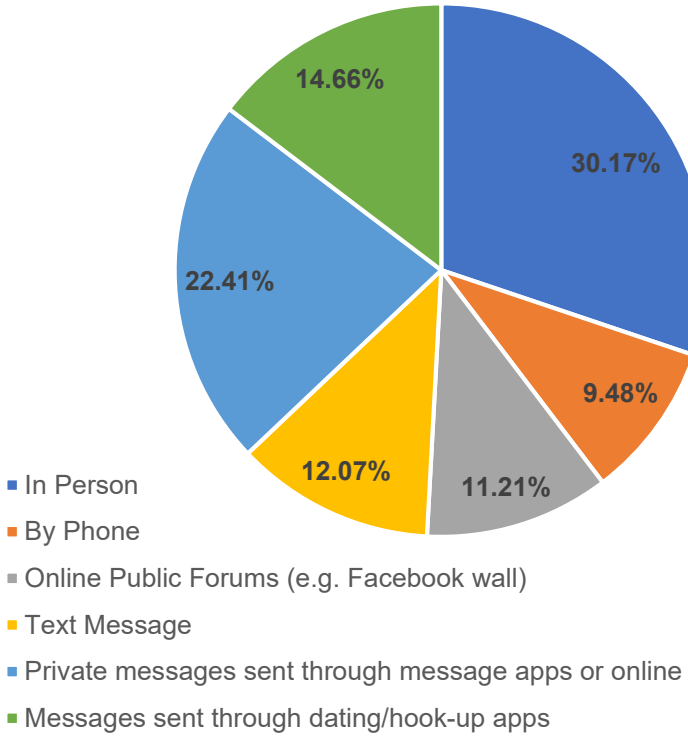


Figure 4: Modes of non-contact sexual violence

Figure 5 outlines the extent to which participants reported sexual violence to services '(*When a person/people have been sexually violent towards you, have you been able to report it to a service(s)?*'), most participants (69.44%) did not report sexual violence experiences.

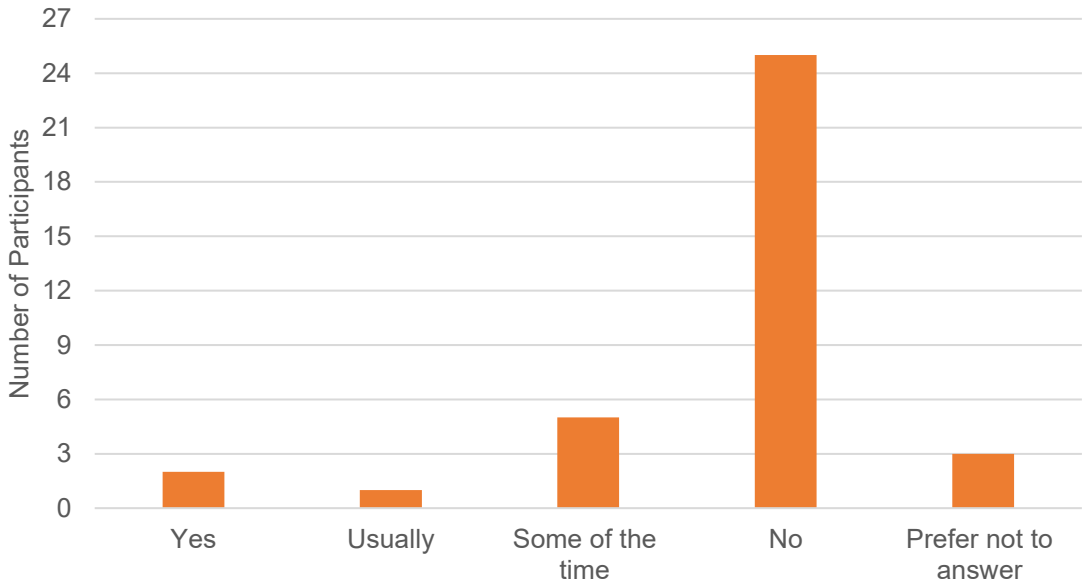


Figure 5: Sexual violence reporting to services

Nine participants completed the service questionnaire (table 7). Participants scores tended to be quite polarised (high or low), indicating a range of positive (therapist, sexual health clinic, and rape crisis charity) and more negative experiences (university). Appendix O for raw scores.

Table 5: Service experiences

| Type of service | Score |
|---|---|
| Therapist | 35 |
| Sexual Health Clinic | 35 |
| Rape Crisis Charity | 32 |
| Police* | 29.75 |
| Social Services | 25 |
| University | 17 |

**mean of 4 participants' responses*

3.2.4. Bivariate Correlational Analysis

To inform research questions 1 and 2, Pearson's correlation coefficients were conducted to explore the strength, direction and significance of relationships between variables. Table 8 displays the correlations between variables. Bonferroni corrections were implemented to reduce the likelihood of Type I errors as numerous correlations were investigated (Field, 2013). Therefore, p values of .05 were divided by the number of tests (35 correlation coefficients), resulting in correlation coefficients as significant if $p < .001$.

Relationship strength was determined using Cohen (1998)'s parameters; weak (r = +/- .10- to +/- 2.9), moderate (r =+/- .3 to +/- 4.9) and strong (r = +/- .50 to +/- 1.0) correlations (Field, 2013).

Table 6: Pearson correlation coefficients

| Variable | SCS | SWEMWBS | OAS | DASS 21 Total | DASS 21 Stress | DASS 21 Anx | DASS 21 Dep | SSC |
|---|---|---|---|---|---|---|---|---|
| SCS | 1.00 | | | | | | | |
| SWEMWBS | .87** | 1.00 | | | | | | |
| OAS | -.72** | -.72** | 1.00 | | | | | |
| DASS-21 Total | -.43** | -.59** | .60** | 1.00 | | | | |
| DASS-21 Stress | -.34* | -.56** | .57** | .93** | 1.00 | | | |
| DASS-21 Anxiety | -0.23 | -.34* | .47** | .89** | .76** | 1.00 | | |
| DASS-21 Depression | -.59** | -.69** | .59** | .88** | .74** | .62** | 1.00 | |
| SSC | .59** | .65** | -.62** | -.46** | -.48** | -.28 | -.48** | 1.00 |

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

*3.2.4.1. Research Question 1: Are internal shame, external shame and self-compassion significantly associated with psychological distress?*

Bivariate correlations indicated a significant relationship between psychological distress and shame and self-compassion variables:

- Internal shame (SCS)
  A moderate negative relationship was found between the SCS and the DASS-21 Total (r = -.43). A strong negative relationship was detected between the SCS and depression (r = -.59). No relationship was detected between SCS and anxiety (r = -.28). The relationship between SCS and stress (r = -.34) was also non-significant (p > .001). This indicates that internal shame (lower scores on the SCS) is associated with some increased psychological distress, particularly depression. Although in this sample, increased anxiety and stress was not associated with internal shame.

- External shame (OAS)
  Moderately strong positive relationships were identified between the OAS and the DASS-21 total, stress, depression and anxiety subscales (r = .60, r = .57, r = .59, r = .47 respectively). This suggests a significant relationship between external shame and psychological distress.

- Self-compassion (SSCS)
  Moderate negative relationships were detected between the SSCS and stress (r = -.46), depression (r = -.48) and total (r = -.46) DASS-21 scores. A weak, non-significant relationship was indicated between the SSCS and anxiety DASS-21 scores (r = -.28). This suggests self-compassion is associated with lower psychological distress, particularly stress and depression, but not associated with anxiety.

*3.2.4.2. Research Question 2: Are internal shame, external shame and self-compassion significantly associated with psychological wellbeing?*

Bivariate correlations suggested a significant relationship between psychological wellbeing and shame and self-compassion variables:

- Internal shame (SCS)
  A strong positive relationship was detected between the SCS and SWEMWBS (r = .87), suggesting higher internal shame is associated with lower psychological wellbeing.

- External shame (OAS)
  A strong negative relationship was found between the OAS and SWEMWBS (r = -.72), indicating higher external internal shame is associated with lower psychological wellbeing.

- Self-compassion (SSCS)
  A strong positive relationship was identified between the SSCS and SWEMWBS (r = .65), suggesting increased self-compassion is associated with increased psychological wellbeing.

3.2.5. Survey Content Analysis

The content analysis quantitatively analysed participants' responses to qualitative survey questions. An initial set of ideas were identified and subsequently ideas with shared meanings were distilled into fewer, content related, categories (Elo & Kyngäs, 2008) (appendix R). This was guided by a deductive and inductive framework to address research question three;

What factors do LGBTQ+ young people identify to explain:

A) Service use

B) Sexual violence reporting

Table 7 details the categories and the number of times participants described ideas within this category. McDermott et al. (2018) argue that barriers/facilitators models of help-seeking limit deeper understandings of why these factors help or hinder young people. Therefore, these categories were mapped out across three levels of context to describe factors affecting service use and reporting, as a structure which goes beyond barriers/facilitators. Some categories were interpreted as interactions between factors

(e.g. discrimination can be produced through heteronormativity) and categorised accordingly.

Table 7: Content analysis categories

| Category | Frequency |
|---|---|
| Acceptance | 24 |
| Normalisation of sexual violence | 20 |
| Safe spaces | 18 |
| Discrimination | 17 |
| Anti-LGBTQ+ prejudice | 14 |
| Accessibility of services | 14 |
| Relationship with perpetrator | 11 |
| Explicitly LGBTQ+ | 11 |
| Heteronormativity | 9 |
| Shame | 9 |
| Emotional impact | 9 |
| Not being believed | 7 |
| Understanding sexual violence | 6 |
| Confidentiality | 5 |
| Being young | 4 |
| Family relationships | 3 |
| Fear of blame | 3 |

*3.2.5.1. Interpersonal factors*

- The emotional impact (suggested 9 times by participants) of sexual violence as preventing help seeking and reporting may be a concern, as, in theory, these should be avenues to support and justice.
- Age ('being young', 4 times) as a barrier to support and reporting highlights that younger people may lack support to help them make sense of experiences.
- Relationships with perpetrators as a category (11 times) is indicative of the interpersonal nature of sexual violence and the subsequent complexities these relationships create when accessing services or reporting.

*3.2.5.2. Service factors*

- Services as safe (18 times) and accepting (24 times) are key factors to utilisation.
- Confidentiality (5 times) may reflect a key factor within safety.
- If services are explicitly LGBTQ+ friendly (11 times), then safety and acceptance can be inferred more easily.

*3.2.5.3. Sociocultural factors*

- The normalisation of sexual violence (20 times) may mean LGBTQ+ young people, people around them and services do not see these experiences as serious.
- Stigmatising societal attitudes may inform factors such as discrimination (17 times), anti-LGBTQ+ prejudice (14 times) and heteronormativity (9 times), which will interact with how accessible (14 times) services are or are perceived to be.

*3.2.5.4. Interacting factors*

- Not being believed (7 times), shame (9 times) and fear of blame (3 times) may be associated with rape myths, suggesting the importance of understanding how wider cultural ideas may impact on service use and reporting.
- A lack of understanding about what sexual violence may be (6 times) could be produced through the normalising of sexual violence, consequently LGBTQ+ young people may not seek help.

## 3.3. Thematic Analysis of Interviews

The data from the interviews was analysed using thematic analysis, following Clarke & Braun's (2013) guidelines. The analysis employed both a deductive and inductive approach to derive themes. The deductive approach was informed partly by the categories in the content analysis. A semantic approach was implemented to identify themes; initial descriptions of patterns in semantic content developed to interpretations, and within this, the meaning and significance of patterns was explored (Patton, 1990).

### 3.3.1. Interview Sample Demographics

Table 8 presents participants' demographic information. This information describes how participants self-defined their demographic details. Of the seven participants, one person identified as a lesbian woman (Anna), three identified as gay/homosexual men (Ed, Nero and Shimeon Lang), one as a bisexual man (Patam), and two participants

identified as bisexual, and non-binary (Quinn), or female aligned and currently questioning gender identity (Onyx). Most participants were from White ethnic backgrounds, although Onyx and Shimeon Lang were from ethnic minority groups. Participants were either studying (university or college) and/or working. Nero was the youngest participant. All the participants discussed their experiences of sexual violence. All participants had used services (e.g. sexual health, youth centres). However, none had accessed services specifically for experiences of sexual violence, although Nero had been in social care and legal systems following experiences of childhood sexual abuse.

Table 8: Interview sample demographics

| Name* | Age | Sexuality | Gender | Gender Pronouns | Ethnicity | Occupation |
|---|---|---|---|---|---|---|
| Anna | 23 - 25 | Gay lesbian | Woman | She/her | White other | Student & working part time |
| Ed | 23 - 25 | Gay | Cisgender Man | He/him | White other | Student |
| Nero | 16 - 18 | Gay | Male at the moment | He/him | White British | Student & working part time |
| Onyx | 19 - 22 | Bisexual | Female aligned, questioning gender | She/her | Mixed Jamaican & White heritage. Identifies as Black British | Recent graduate & working |
| Patam | 23 - 25 | Bisexual | Male | He/him | White other | Working |
| Quinn | 19 - 22 | Bisexual | Non-binary. | They/them | White British | Student |
| Shimeon Lang | 19 - 22 | Homosexual | Cisgender Man | He/him | Asian | Student |

* All names are pseudonyms

### 3.3.2. Thematic Map

An initial large thematic map was developed from the intermediate codes (see appendices T - V). From this, multiple maps were developed to collapse and refine themes through an inductive and deductive process, based upon developing internal homogeneity and external heterogeneity of the themes (Patton, 1990). Figure 6 depicts the final thematic map.

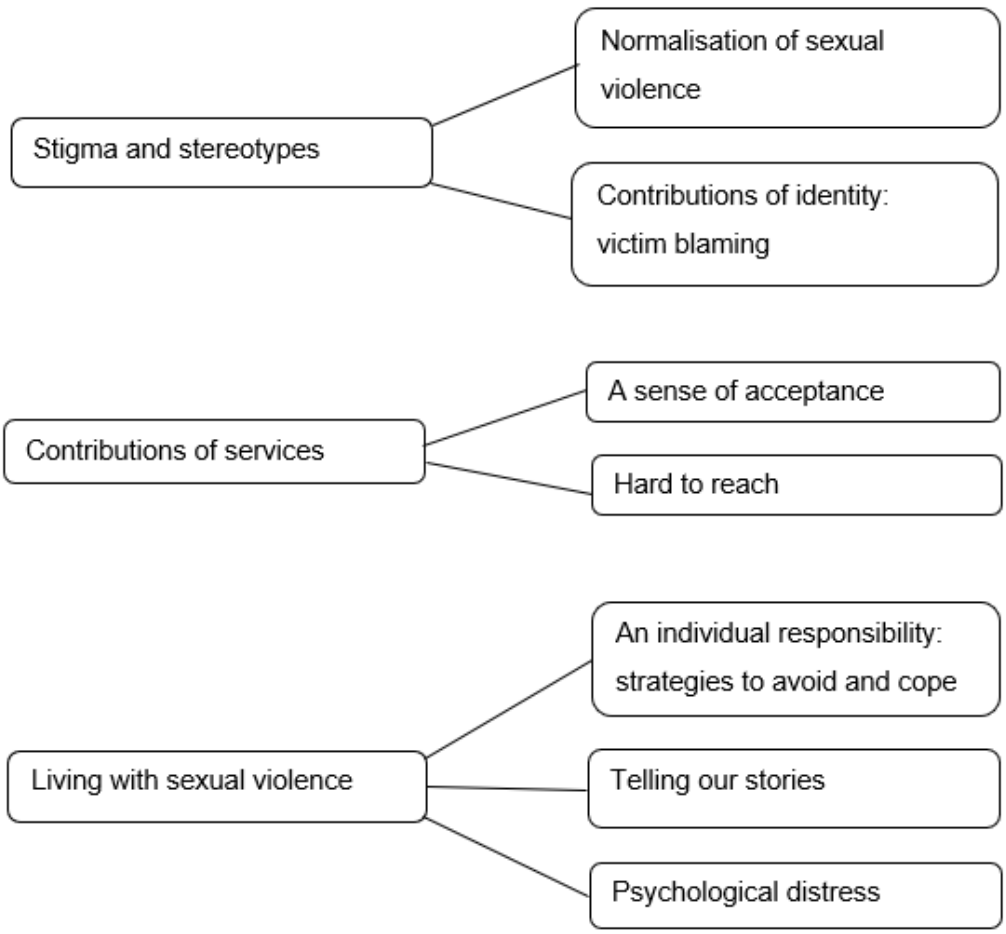


Figure 6: Final thematic map

### 3.3.3. Theme 1: Stigma and Stereotypes

This theme captures the overarching heteronormative context for participants. This context creates conditions which implicitly criticise and undermine participant's sexual and gender identities through their environment; "*it was very heteronormative, it was very, umm they have this sort of ideal views of what you should be",* (Anna). Quinn describes how "*it's really difficult to challenge stereotypes because it's so ingrained in our society, erm but I think it is, it is a much larger change that is needed*". These accounts suggest participants may experience discriminatory societal attitudes as

fixed, supported by Shimeon Lang who felt overt challenges to heterosexist structures would be rejected; "*whenever there's like a big movement towards a certain big change, there's normally more resistance to that*". This may indicate participants have had to accept the pervasiveness of heteronormative ideologies.

*3.3.3.1. Subtheme: Normalisation of sexual violence*

The normalisation of sexual violence may occur through covert patriarchal messages which can denote women and gender and/or sexual minority people as sexualised objects. Onyx describes being socialised to believe harassment was an indicator of attractiveness:

> *"I saw it as something to be desired, erm, because it's like attention that someone is giving you and like it's seen like a compliment or something, but it's really not at all*"

This suggests how patriarchal structures can transform harassment experiences to become desirable. This objectification and subsequent subordination may contribute towards beliefs that dominant individuals' have a 'right to sex', and rights to sexually objectify others. Ed describes this 'right to sex' as an "*individual pursuit, it is only something that you want, you as in I, then it firstly becomes internalizing some kind of right that you have*". Ed later describes this process as enabling the perpetrator of sexual violence against him; "*he chose me, and he got it, even though I didn't want it*". This is illustrated by other participants' descriptions of sexual violence, which suggests perpetrators believe they have rights over the bodies of others. Participant's accounts indicate this is further facilitated by certain environments, such as nightclubs:

> *"they're [men] usually the ones who prowl around groups of people and will try and like try and force their way into dancing circles and dance with you or grab you*,"
>
> Quinn

This additionally intersects with Quinn's bisexual identity where they are subject to sexual violence by men and women, indicating anti-bisexual prejudice from within, and external to, the LGBTQ+ community, as well as a sense of ownership over their body:

*“especially men but not always, erm seem to feel like they more right over your body especially if you’re, I don’t know if especially, but if you’re bisexual they think that you’re not completely gay, so therefore they might have the chance with you, erm and erm yeah I mean I think women do it as well.”*

Quinn

This objectification can further promote stigma and heteronormativity through ideas that bisexual or lesbian women or non-binary people are objects of heterosexual men’s sexual pleasure, illustrating intersections between sexual harassment and anti-LGBTQ+ prejudice. Anna describes being stared at by a group on men whilst holding hands with a woman:

“*but when like the staring continues and it’s like sort of, I don’t know maybe they’re waiting to see something”*

Anna

These processes of objectification may contribute towards environments and interpersonal interactions being unsafe or hostile. But, because objectification is normalised, these experiences may be accepted and unchallenged in the wider sociocultural context, which could mean perpetrators view their behaviour as unproblematic. Potentially, if young people are othered through their gender and/or sexual identity, this could further contribute towards the acceptability of their objectification.

Normalisation may also occur because of the frequency of sexual violence experiences and participants described how this has led to them accepting sexual violence, although aware that it is wrong. This means that sexual violence experiences can become considered as routine and expected, further normalising these experiences and potentially diminishing their importance. This may be rooted in stigmatising assumptions that identifying as LGBTQ+ increases sexual violence victimisation:

*“we’re LGBTQ, there seems to be this strange notion that it’s, like, it’s likely to happen to happen to us anyway, that’s there’s, you know, if it happened to someone and you weren’t expecting it to then it would be serious, but it’s like, it’s kind of part and parcel, you know, of the community, and I think it gets taken slightly less seriously.”*

Shimeon Lang

These processes normalise sexual violence as part of sex, making it harder for participants to identify their experiences as sexual violence, "*why didn't I at the time recognise that something was wrong*?" (Shimeon Lang), shared with Onyx who described this process as obscuring the distinctions between sex, violence and harassment; "*it's just so normalised that we don't see that the lines are so blurred, and you don't see a difference between it*". This is indicative of failings in educational systems to adequately define sexual violence, which may be reflective of sex and sexual violence as taboo subjects. Additionally, cultural narratives may contribute towards the blurring of boundaries, for example the sexualisation of women, and increasingly of men, in advertising.

*3.3.3.2. Subtheme: Contributions of identity – victim blaming*

The normalising of sexual violence experienced by participants may also be facilitated through the sexualisation of their identity by others. Ed describes a friend talking about his experiences as "*the trope is he goes and has all this deviant sex that we can't have because like we're the normals*". This separation between heterosexual or cisgender and LGBTQ communities through stereotypes of LGBTQ+ people as promiscuous can allow sexual violence victimisation to be downplayed, described by Shimeon Lang as a process which means being "*part of the LGBTQ plus community kind of feels like sometimes slightly trivialises what people sort of experience*". This sentiment was shared particularly by gay men, bisexual and non-binary participants. Stereotypes may function to create beliefs that participants are more vulnerable to sexual violence due to their identity. This means if participants are assaulted or harassed, it can create experiences of shame as there is a sense their gender or sexual identity, a core part of the self, is responsible for victimisation:

> "*I guess that leads to, kind of you feeling ashamed about your identity, rather than your behaviour because it feels like your identity is something that's making you more erm, like putting you more in harm's way*"
>
> Quinn

Participants suggested this created a unique victim blaming experience connected to their identity:

> *"a big stereotype within, like of society and LGBT people, is that we are promiscuous and like we want to sleep around and therefore erm things that happen to us are kind of our fault"*
>
> Quinn

These victim blaming experiences also suggest ideas of whom is 'victim worthy' and can create invalidating, dismissive and shaming experiences for participants, where they feel sexual violence is deserved. This also enables structural inequalities to persist as the blame/responsibility is individualised, rather than asking why environments are unsafe. This is furthered strengthened by questioning in services which imply blame, for example regarding alcohol use, which may be associated with stereotypes of young people and/or students:

> *"like the first question is always like, 'how drunk were you?' Erm, which is always a big thing"*
>
> Patam

It may also function to minimise experiences and criticise behaviour and identities, described by Anna as "*a way of policing you*", because if you act outside of societal norms, or are 'irresponsible', then society will not only blame you for sexual violence victimisation, but also make participants feel they deserve sexual violence. Particularly if these norms are based in more conservative ideas as Anna describes:

> "*we're gonna make you feel erm in a way that you deserve, because you deserve it, because there's a sort of, sort of like, victim blaming, and this sort of shaming and they are tricking you into thinking, you know, it's all your fault erm you did this,*"

Alternatively, sexual violence can be taken less seriously as a lesbian woman who has been assaulted by another women, due to beliefs that sexual assault is more damaging if you are physically overpowered and assaulted by a man. This implies a hierarchy of sexual violence of experiences that can be determined by your gender or sexual identity:

> *"they don't expect that you've been assaulted by a woman, erm and even in that case, you know, it's not as valid, or it might not be perceived as valid as when someone that's physically stronger than, err, or more threatening, or whatever"*
>
> Anna

Subsequently, this minimises sexual violence for individuals assaulted by women. Anna's reflections suggest that her experiences as a lesbian woman can be overlooked, particularly in services as she describes how "*gay women are invisible".* This may be associated with heteronormative rape myths (men as perpetrators) but

also is suggestive of how lesbian women are viewed in society. It suggests their unique experiences may be ignored, potentially dismissing their needs.

### 3.3.4. Theme 2: Contributions of Services

This theme explores the impacts of service design and operation on participants. It has been broadly divided into services as creating more hopeful, accepting environments and service contexts which are inaccessible and stigmatising. However, services, and the wider sociocultural structures in which they reside, are unlikely to be as polarised and may embody elements of both. There may be some overlap between subthemes as participant ideas for creating safe services were often premised on more fearful, negative experiences.

#### *3.3.4.1. Subtheme: A sense of acceptance*

Visibly LGBTQ+ friendly services could create feelings of safety as participants felt more confident they would be accepted. Service promotion informed participants they had been considered, which may connect to feeling valued:

> "*Advertising that they do have services for LGBT plus people in the first place is really important because that's how you know, like you've actually thought about those people*"
>
> Onyx

This is also indicative of how much participants expect, and experience services as unwelcoming. Services as potential sources of anti-LGBTQ+ stigma can also be interpreted through the service information and participants discussed looking for signs that services are safe and inclusive:

> "*you have this website that you're looking at for example and it says we help, we support victims because of sexual assault or whatever, erm its very general so it's not really…, you don't know, even when you disclose your sexuality you don't know what's going to happen*"
>
> Anna

Anna conceptualises disclosing her sexuality as taking a risk, which may be associated with the belief that using services can expose you to discriminatory experiences, shared by Patam, who challenges services to be explicitly LGBTQ+ friendly:

> *"services need to say like we don't judge you and it has to come from the service"*

These experiences highlight how much participants are analysing services prior to using them, which suggests services are not clearly articulating their acceptance of LGBTQ+ identities. Consistent with this, as Anna suggested, participants may be waiting for signals that it is safe to disclose their identity in services, reflective of heterosexism in service structures. Similarly, participants described paying attention to when they felt they could trust staff, implying the complex assessments participants may be making to try and ensure their safety:

> *"I knew where was, sort of, like safe for me to go, so that's sort of like yeah, like sort of like implementing services where people know what, erm what person they're gonna talk to and that it's a safe environment"*
>
> Anna

To create an atmosphere of acceptance, Nero suggests services need a non-judgemental approach; *"I have a very strong opinion that someone should go into a sort of service and be sort of clean slate, no judgements*" and participants described developing consistent, genuine relationships with staff as "*people who can actually relate to you*" (Anna) as important. This may suggest that more openness from staff could support LGBTQ+ young people to trust them. Ideas of connection and security are associated with compassion, and reminiscent of secure base ideas. Services acting as a secure base is highlighted by Nero who described his youth service as "*you sort are part of the family*", which he felt was created by the service being a "*very homely environment*" and one which "*made me feel accepted, no matter what*". This may be especially important if participants do not feel accepted by others in their lives, and relationships with staff could help manage these experiences.

Participants' accounts of connection and safety in services are associated with relationships and acceptance, but these are elements which participants could not take for granted in service provision, which may suggest failings in service design and operation.

*3.3.4.2. Subtheme: Hard to reach*

Consistent with the importance of relationships with staff in services, participants discussed the impact of relationships that positioned staff as more superior. These were described as facilitating "*very one sided*" (Nero) interactions, which Onyx articulates as a "*question/answer, question/answer clinical type thing".* Participants felt this created cold interactions as experiences were constructed as "*an inventory of erm technologies and techniques*" (Ed). This is shared by Nero, who suggested relationships with services can feel transactional; "*they just want you to be there,*

*access the service and then come away a better person*". This raises questions about how some clinical boundaries may create barriers between LGBTQ+ young people and staff/services. It suggests participants are accessing services to meet service agendas, not their own. This may reflect restrictive service structures and the possible expert positioning of staff/services.

This expert positioning could create feelings of inferiority. This may be reinforced through the tone of questioning in services that can imply fault, as Nero describes in during police interviews:

> "*They made me feel ashamed that it happened from my view and although they constantly said it wasn't my fault, it constantly felt like it was… they just made me feel really, I don't know the word, undermined maybe*"

This highlighted the impact of implicit blaming attitudes in services, which participants suggested was particularly present in the police; "*if you've been raped, you might be worried about the interaction with the police"* (Patam). Services as invalidating or dismissive of experiences was shared by Quinn who felt services used their gender and sexual identity to explain problems:

> "*People can hyper focus on that aspect on your identity when talking about erm issues that you want to talk about and I think that can definitely make you feel as if your identity is the cause for your problems*"

These experiences may lead to participants feel judged. It could imply that services are making stigmatising assumptions about them and their experiences, again reinforcing notions of shame and blame through victim blaming discourses. Experiences of stigma and heterosexism may be illustrated through an emphasis on participants to explain their identity in mainstream services. Onyx describes the impact of accounting for identity as "*it's kind of like double the trauma kind of in a way, cos you're already dealing with something and then you having to like, erm, put in emotional, physical, mental energy to actually explain stuff*". The need to explain your identity may create a feeling that LGBTQ+ young people are required to justify themselves, which may strengthen experiences of invalidation by services. This "*trauma*" means it may be protective to avoid using services.

Service access can be framed as an individual choice. This may dismiss the experiences of participants who 'chose' not to use services and the protective role this

can serve, and ignore structural barriers to service access. Ed reflects how he can access services as a person of privilege and how that subsequently positions others as inferior or irresponsible. Thus, obscuring wider structural inequalities in access for people with different identities:

> *"here I am, like a white privileged person, able to access services, able to use them, able to understand them"*

The complexity of service use is highlighted by Shimeon Lang, who situated the use of services within his cultural background, and what it means if a person is not out to their family; "*I think especially because the Asian community, we're quite, you know, family focused, a large part of our support comes from the family, so not having that, we wouldn't really even think about accessing other services if your step one already, you know, kind of failed*". This indicates the importance of understanding the wider sociocultural context of participants lives; as well as the invaliding and discriminatory experiences participants can encounter in services, when conceptualising service accessibility. Thus, services become hard to reach.

### 3.3.5. Theme 3: Living with Sexual Violence

This theme captured how participants live and cope with sexual violence in their lives. It explores the focus on individualised strategies and what it meant to share their experiences with others, as well as insights into the psychological and emotional costs of living with sexual violence for participants.

#### *3.3.5.1. Subtheme: An individual responsibility: strategies to avoid and cope*

Participants identified individual strategies to reduce the risk of sexual violence. For Onyx, Anna, and Quinn it was important to remain vigilant and with trusted friends, particularly in nightclubs, to protect themselves and others:

> *"I don't go to clubs with anyone that I don't really well, although I might go to pre-drinks or something like that with them, but I won't go out, erm I think, it means I do spend a lot of time looking at where my friends are*"
>
> Quinn

This can mean they are restricted in accessing spaces and may create feelings of exclusion. This exclusion from spaces can be further complicated for participants who hold multiple minority identities, which may put them in increased danger from hate crimes and prejudice as Onyx describes "*especially where I live which is, err erm white*

*erm mainly area and I know that people don't like immigrants, even though I'm not an immigrant, people may see me as one*". The social demographics of an area can also inform experiences of feeling threatened; Anna describes moving from London to a smaller town and feeling unsafe because of implicit unwelcoming attitudes to minority identities; "*when you go to town things change a bit, it's like smaller, erm it's not really diverse*". This increases strategies of vigilance and avoidance of certain areas. The frequency of sexual violence described by Onyx, Anna and Quinn meant these strategies are part of their everyday lives; "*having to think about that and having to protect myself in that way is really not how I should have to live every single day, but it is*" (Onyx), which may be bound up in their gender and other minority identities. Onyx described performing power and strength in order to protect herself, but that this is not without its limits and she still experiences fear; "*I can be quite domineering, so people don't feel like they can over power me in some situations erm and, but like also its very scary to live as the person that I am*". Whereas, Anna describes dealing with the vulnerability discussing sexual violence produces by de-personalising experiences, potentially so these cannot be used against her, another way of increasing power in interactions: "*I feel very wary just generally talking about experiences and when I do its very general*". The need to develop strategies indicates the very real threat of sexual violence, which intersects with racism. It suggests the pervasiveness of sexual violence has meant participants have had to alter their behaviour to try and increase their safety, again putting the onus on them to defend against sexual violence.

To cope with sexual violence victimisation, participants described minimising experiences through attempting to forget about them, potentially to protect themselves from the emotional costs of living with sexual violence; "*I just like pushed it back and I think I never really considered, like I was sort of deciding for myself that I would always forget about that*" (Anna). Ed told himself a different story from one of sexual violence, "*so the story then is it was bad sex as opposed to like something now I would consider, like you know, non-consensual sex*", and Patam made a joke of his experiences through telling others *"like I can talk about it, like it's funny, its joke."* During the interview, Quinn used humour to talk sarcastically about sexual violence they and a friend had experienced; "*basically like sexually assaulted by someone in a club who then went on to sexually assault my friend, which was good, good fun but [laughs]".* This could suggest participants feel they have to minimise their experiences when discussing them with others. This could be associated with ideas of coping as an individual responsibility, which could reflect a lack of resources available and/or

neoliberal discourses. Nero describes his process of managing his experiences of sexual abuse as one he went through on his own:

> "*I sort of sat myself down really and thought about everything's what's going on and thought well this is not going to affect this, it shouldn't affect this, or it shouldn't affect erm friends, it should just affect that one small part and it should always be contained to that*"

These strategies may indicate that services and legal structures are failing in their efforts to support and protect young people, as they are required to creatively cope alone with sexual violence. The minimisation may be reflective of the wider normalisation of sexual and efforts to avoid being a blamed victim.

*3.3.5.2. Subtheme: Telling our stories*

Sharing experiences of sexual violence may represent a more collective coping strategy as participants describe valuing the support of friends following sexual violence, particularly as they may have shared experiences:

> "*I got a lot of support from my best friend cos she had some similar situations, so it was nice to, sort of like, be understood in that in way, she was relating back to these things*"
>
> Anna

> "*I honestly, I couldn't imagine trying to make sense of experiences without a really good friend network*"
>
> Quinn

These relationships were very important to participants, particularly if other relationships in their lives, for example with their family, were more complex. Shimeon Lang describes his friends as acting as a family; "*they've kind of become my family, so they've kind of filled in for that niche*". Friends can also be a source of safety through their responses to sexual violence, in the immediate aftermath of being sexually assaulted, Onyx describes her friends as "*multiple people who were there for me, to help me*". Friends enacting helping roles may reflect the inaccessibility of services wherein friendships then play the role of services. This can then create "*pressure on friendship*" because "*you're acting as kind of erm as a service would for your friends, but you don't really know how to do it properly or how to separate it" (Quinn).* This suggests the emotional impact of supporting friends.

However, disclosures can also lead to experiences of secondary trauma where participants described sharing experiences of sexual violence as distressing as it may mean re-living sexual violence:

> *"it's hard to go through it and tell people what's happened and re-live a traumatic experience because for 8 years I've tried putting it to the back of my head"*
>
> Nero

This highlights the need for others to appreciate the emotional impact of disclosing experiences of sexual violence. When participants had shared experiences with others, but these stories were told in ways which were shaming, this violation could feel like an enactment of the sexual violence:

> *"her bringing it up in itself felt like a repetition of the non-consensual act"*
>
> Ed

This indicates the risks in disclosure and may have prevented participants from sharing experiences, particularly if disclosures have not resulted in any support from services:

> *"if it doesn't work when you first try then usually people don't try again"*
>
> Patam

However, Onyx describes how it is becoming easier to speak about sexual violence; "*it's getting better, its encouraged to speak out, you're encouraged to like, the me-too hashtag and stuff like is happening*". Onyx relates this to a creation of a more compassionate society through connecting with others, and beginning to make visible and challenge external structures, that can shame people who have experienced sexual violence:

> "*I think that at the core of it, there's compassion but outside influences are the things that bring shame"*

This suggests sharing stories of sexual violence can be a powerful tool to challenge blaming and shaming discourses in sexual violence. However, sharing stories of sexual violence is associated with significant emotional costs and risks, which may need greater understanding. Friendships as informal supports implies the strength of relationships participants have developed with others, although it highlights the lack of formal support, which pressurises these relationships.

*3.3.5.3. Subtheme: Psychological distress*

Participants described a myriad of impacts of sexual violence upon their psychological wellbeing. Participants suggested notions of self-blame and regret were significant contributors to psychological distress:

> "*I still look back on it and all the shoulda/woulda/couldas, what could I have done? What should have I done? You know, and I always knock myself*"
>
> Nero

> "*it's so ingrained in me that sort of mentality of, oh I should have done something*"
>
> Anna

This may be associated with assumptions we can prevent sexual violence through our actions, related to societal attitudes of individual responsibility, as factors which increase psychological distress.

Participants described sexual violence experiences, particularly in nightclubs, as fearful and distressing, indicative of the creation of hostile environments and experiences of being violated;

> *"definitely pretty frightening, erm and like erm like I guess, it does, it does feel like quite upsetting"*
>
> Quinn

> *"I just felt horrible and gross and yeah it was really sad"*
>
> Onyx

This suggests the emotional cost of sexual violence and, given the frequency of sexual violence, may mean participants are regularly experiencing psychological distress which is not recognised because sexual violence is normalised. Ed also describes feeling very afraid due to possible risk of sexually transmitted diseases but needing to minimise it, potentially to cope; "*to downplay how scared I was, I was terrified, erm I laughed about it, I was like, oh isn't that funny, like it was so risky*". Minimisation may mean impacts of sexual violence become more present later. This connects to Anna's experience of entering a new relationship and feeling afraid at the possibility of sex but unable initially to understand why:

*"I was sort of like scared, but I couldn't really understand why, and I think because I pushed that so far back in the back of my mind that I only realised after, like a few days later*"

The interpersonal nature of sexual violence may partly explain the disruption of trust and subsequent fear. Nero described the impacts of sexual abuse as "*it's trust issues erm depression, anxiety and being insecure were the main ones for me*" and how sexual abuse how affected all parts of his life:

"*sort of like a spider graph, you know, you've got that one situation in the middle and it all swans off because then you got your school life, you've got home life, erm and then you got the actual situations, the events*"

These wide-reaching impacts suggest how significant psychological distress associated with sexual violence can be and therefore the need to think more widely about the impacts:

*"you got emotions and how your emotions will impact nearly everything, it will change your life and it can't be focused all down to one thing like the event"*

Nero

This is supported by Onyx who described the life changing impacts of sexual violence through its emotional costs and revelation of human interactions as dangerous, which change our ways of being in the world:

"*it really changes you in your core being, erm and I think that's really important cos you're gonna have to live with that the rest of your life*".

# 4. DISCUSSION

## 4.1. Overview

This chapter explores the characteristics of the study sample, with reference to the current research base. The quantitative and qualitative data are discussed in response to the research questions. These findings are drawn together to describe their implications at different levels of context. The limitations of the study are highlighted and proposals for future research presented. The process of conducting the study is reflexively engaged with, before final conclusions are made.

## 4.2. Summary of Quantitative Findings

### 4.2.1. Survey Sample

An assessment of demographic differences between participants who completed and did not complete the survey indicated a disparity between their sexual identities. The 'completers' sample included a higher proportion of bisexual and non-binary participants compared to 'non-completers'. Bisexual and non-binary groups can be invisible in UK culture and subsequently in research (Bostwick & Hequembourg, 2013; Clark, Veale, Townsend, Frohard-Dourlent, & Saewyc, 2018; Richards et al., 2016). Thus, they may be less 'research saturated' than other minority groups (Clark, 2008), which could partly explain higher completion.

Both the completers and non-completers samples included relativity high proportions of participants identifying as trans, another group typically overlooked in research (Ortiz-Martínez & Ríos-González, 2017; White Hughto, Reisner, & Pachankis, 2015). Higher proportions of trans, non-binary and bisexual participants could also be reflective of higher rates of sexual violence experiences in these groups (Ford & Soto-Marquez, 2016; Mitchell, Ybarra, & Korchmaros, 2014; Rymer & Cartei, 2015).

The study sample comprised of predominately White university students aged 19 – 22. This suggests that extrapolating the results to other populations of LGBTQ+ young people should be done cautiously.

### 4.2.2. Contextualising the Findings

To contextualise the findings, the mean scores for each variable will be compared to previous research. Although, conclusions are tentative given the limitations of the mean as a measure of central tendency (e.g. sensitive to variability), therefore, standard

deviations will be reported. Additionally, experiences of sexual violence in the sample will be explored with consideration to past research, again interpretations are tentative, especially due to the small survey sample.

#### *4.2.2.1. External shame*

The mean score on the OAS (M = 35.94, SD = 12.87) was higher than previous research with undergraduates (M = 18.93, SD = 11.77,Gilbert & Miles, 2000; M = 19.76, SD = 9.32, Pinto-Gouveia & Matos, 2011). Whilst, there is increased variability in the current study, high experiences of external shame are still indicated. This could be suggestive of negative or shaming attitudes from others towards participants, and/or that participants felt others perceived them as inferior. Although, reviews of the literature suggest this has not been investigated with LGBTQ+ populations before, making it difficult to substantiate claims.

#### *4.2.2.2. Internal shame*

The mean score on the SCS (M = 46.25, SD = 17.52) was lower than studies with student samples (M = 62.99, SD = 15.06, Gilbert, Cheung, Grandfield, Campey, & Irons, 2003; M = 60.77, SD = 13.46, Gilbert & Miles, 2000). This suggests the study sample experienced higher levels of internal shame, comparing themselves less favourably to others, than in other research. Although, the standard deviation indicates there is greater variability within scores in the current sample. Additionally, the comparison studies are over ten years old and internal shame increases could be impacted by cultural changes, for example, the rise of social media is associated with increased negative social comparisons (Lup, Trub, & Rosenthal, 2015).

#### *4.2.2.3. Self-compassion*

The mean score on the SSCS (M = 2.45, SD = 0.65) was lower than the average self-compassion score, which Neff (2016) suggests is 3. Compared to studies with adolescents and young people (age 14 – 17, M = 2.97, SD = 0.62; age 19 – 24, M = 2.99, SD = 0.61, Neff & McGehee, 2010) a study with gay men (M = 3.04, SD = 0.75, Beard et al., 2017), scores were also lower in this sample, and variability in scores roughly equal. This indicates lower experiences of self-compassion for this sample than in other research.

#### *4.2.2.4. Psychological distress*

The mean scores on each subscale of the DASS-21 (stress; M = 21.67, SD = 10.65; anxiety; M = 17.61, SD = 12.07: depression; M = 22.67, SD = 11.64) were considerably higher than in previous research with students (stress; M = 12.30, SD = 8.12; anxiety; M = 7.29, SD = 6.69: depression; M = 7.65, SD = 7.75,Pinto-Gouveia & Matos, 2011).

The mean total DASS-21 score (M = 61.94, SD = 30.80) was also higher than in previous studies with men who had experienced sexual violence ( M = 27.72, SD = 24.72; Artime, McCallum, & Peterson, 2014) and with gay men (M = 28.96, SD = 14.16, Matos, Carvalho, Cunha, Galhardo, & Sepodes, 2017). In comparison to national normed scores, the mean scores in this sample are in the 90 – 96$^{th}$ percentiles (Henry & Crawford, 2005), suggestive of high levels of psychological distress within the sample. However, the high variability within scores indicates high variability in experiences of psychological distress. The findings are consistent with research which suggests LGBTQ+ young people may experience elevated levels of psychological distress (e.g. Connolly, Zervos, Barone, Johnson, & Joseph, 2016; Semlyen, King, Varney, & Hagger-Johnson, 2016).

*4.2.2.5. Psychological wellbeing*

The mean score on the SWEMWBS (18.53, SD = 3.99) was lower than the normed national average for men and women aged 16 – 24 (M = 23.57, SD = 3.61 and M = 23.17, SD = 3.86 respectively, Ng Fat et al., 2017). It was also lower compared to a sample of students who had experienced at least one traumatic event (M = 24.86, SD = 5.24, Seligowski, Miron, & Orcutt, 2015), although their scores were more variable. This suggests the study sample has lower levels of psychological wellbeing than in previous research.

*4.2.2.6. Sexual violence experiences*

As sexual violence experiences were an inclusion criterion, the high proportion of these experiences is expected. However, the prevalence of sexual assault is noteworthy, especially given the low reporting to services. Reporting of sexual offences nationally is low (Office for National Statistics, 2018), which may be associated with low rates of prosecutions, dissuading individuals from reporting (METRO Charity, 2016, Office for National Statistics, 2018). This suggests failures in systems to achieve justice for people who experience sexual violence.

The types of sexual violence reported by participants indicate a wide range of experiences. In a European study of online sexual harassment, experiences of sexualised bullying (26% of participants) and unwanted sexualisation (24%) tended to be greater than exploitation, coercion, and threats (12%), and non-consensual sharing and taking of images and videos (6%) (Project De-Shame, 2017). This is approximately reflected in the survey findings, and differences may be because the survey included in person harassment.

The ways in which non-contact sexual violence is perpetrated can create hostile environments (Mitchell et al., 2014). The use of online messaging to sexually harass participants is concerning as the internet can be helpful place for LGBTQ+ to explore their identities (Priebe & Svedin, 2012). In this sample, almost 14% of participants reported dating apps as sites of sexual violence. However, there is a dearth of research concerning sexual violence in these forums (Henry & Powell, 2018). Mitchell et al. (2014) and Priebe and Svedin (2012) stress the need for professionals to have a greater understanding of the different methods (e.g. online, messaging) used to sexually harass LGBTQ+ young people.

Understanding strategies used to perpetrate sexual violence against LGBTQ+ young people may inform prevention approaches for perpetrators. The study findings suggest perpetrators predominately sexually assaulted participants through coercion (37.77%), taking advantage of them when incapacitated (22.45%) and physical force (14.29%). Reports of coercion are similar to experiences of LGBTQ+ students in Murchison et al.'s (2017) study (incapacitation = 52.23%, coercion = 40.90%, force = 25.00%). These tactics emphasise unsafe contexts for LGBTQ+ young people. This could decrease wellbeing through activation of threat systems whilst in these environments (McLean et al., 2018).

Relationships with perpetrators may provide further insights into the contexts of participants' lives. In this study, 31.87% reported non-contact sexual violence by strangers, which may be indicative of hostile environments. Consistent with this study, Murchison et al. (2017) found that perpetrators of sexual assault were most frequently acquaintances, then partners. This indicates greater support is needed for LGBTQ+ young people regarding intimate partner violence (Brown & Herman, 2015).

Findings suggest men were more likely to be perpetrators of sexual assault, consistent with prior research (Gruber & Fineran, 2008; Murchison et al., 2017; Priebe & Svedin, 2012). However, women perpetrators, particularly of non-contact sexual violence were reported. Heteronormative ideologies of masculinity (e.g. rape as a sign of weakness) and femininity (e.g. rapes by women are less harmful) may mean sexual violence by women and towards men are stigmatised and less discussed, reducing awareness (Rollè, Giardina, Caldarera, Gerino, & Brustia, 2018). This highlights the need for further research and understanding in this area, especially as these gendered stereotypes can increase rape myth discourses (Bates, Klement, Kaye, & Pennington, 2019).

Whilst these findings only describe a small cohort of LGBTQ+ young people's experiences of sexual violence, they indicate dangerous contexts for the lives of participants. These contexts may inform the lower levels of wellbeing and self-compassion and higher experiences of shame and distress, relative to other populations, reported by participants.

### 4.2.3. Research Question 1: Are internal shame, external shame, and self-compassion significantly associated with psychological distress?

To replicate and develop the current literature concerning shame, psychological distress and self-compassion, this study examined the associations between psychological distress and the variables of shame and self-compassion. This aimed to explore the relevance of these concepts and their relationships in the context of sexual violence experienced by LGBTQ+ young people. The results indicate shame and self-compassion are significantly associated with psychological distress. Whilst findings imply these constructs are relevant to participants, they will be explored pragmatically for their usefulness, not assumed to exist within participants. This avoids pathologizing participants and contributing to binary shame/pride discourses which can shame LGBTQ+ young people (McDermott, Roen, & Scourfield, 2008).

- Internal shame:

A strong negative relationship was found between depression and low internal shame (r = -.59, lower scores indicate higher internal shame). A moderate relationship was detected between internal shame and overall psychological distress (r = -. 43, DASS-21 total score). However, no relationship was identified between anxiety and internal shame (r = -.23) or stress (r= -.34). This suggests increased internal shame was associated with increased psychological distress, particularly depression (although not with anxiety or stress), for participants.

The stronger association between internal shame and depression could be because both constructs measure experiences of negative feelings towards the self (e.g. feelings of worthlessness). In studies with gay men (Matos et al., 2017) and adolescents (Cunha et al., 2012) internal shame was also strongly associated with psychological distress. However, these studies both used a different measure of internal shame (the Internalised Shame Scale), restricting comparisons. The finding that anxiety and stress were not associated with internal shame is not replicated in the literature (e.g. Cunha et al., 2012). This could indicate a Type II error and a relationship may be identified with a larger sample (Field, 2013), especially due to the low power in the study to detect a moderate effect.

- External shame:

Moderately strong positive associations were identified between external shame and psychological distress (r = .57, .59, .47. for stress, depression and anxiety subscales respectively). Of these associations, the overall measure of psychological distress (r = .60, DASS-21 total score) was most strongly associated with external shame. This supports Gilbert's (1998) contention that existing negatively in the minds of others is associated with higher psychological distress. It also supports prior research by Cunha et al. (2012). Overall, stronger relationships were detected between psychological distress and external shame than internal shame. This is interesting in the context of the participants' lives as heterosexism and sexual violence victimisation can be associated with shaming experiences by others (Koss, 2000; Robertson, 2014). This is consistent with the conceptualisation of external shame as created through stigmatisation (Gilbert & Irons, 2009).

- Self-compassion:

Moderate negative relationships were found between self-compassion and the stress and depression subscales, and the overall measure of psychological distress (DASS-21 total score) (r = .-48, .-48, -.46, respectively). These findings support research which indicates negative relationships between self-compassion and psychological distress (Cunha et al., 2012; Matos et al., 2017). Matos et al. (2017) found that self-compassion mediated relationships between internal shame and psychological distress for gay men. This indicates self-compassion cultivation could improve psychological distress for individuals experiencing internal shame.

However, no significant relationship was detected between self-compassion and anxiety, which is unsupported in the literature. A large sample size may give sufficient power to detect a relationship if it exists (Field, 2013).

#### 4.2.4. Research Question 2: Are internal shame, external shame, and self-compassion significantly associated with psychological wellbeing?

The study suggests significant relationships between these constructs and consequently their potential relevance to participants. The findings can replicate and extend the current literature on psychological wellbeing and support a departure from deficit-based models of LGBTQ+ mental health (Beard et al., 2017). Again, these constructs are not assumed to exist and will be examined for their usefulness for exploring, and possibly improving, LGBTQ+ wellbeing.

- Internal shame:

A strong positive relationship was identified between low internal shame and psychological wellbeing (r = .87) This suggests that increased experiences of internal shame are associated with decreased mental wellbeing. The relationship between internal shame and psychological wellbeing was stronger than between internal shame and psychological distress (r = .43). This may suggest that for this cohort comparing yourself positively to others was more likely to be associated with wellbeing than distress. There is a lack of prior research concerning internal shame and psychological wellbeing, this finding indicates it could warrant further investigation.

- External shame:

A strong negative relationship was identified between external shame and psychological wellbeing (r =-.72), indicating increased external shame was associated with decreased psychological wellbeing. The strength of the relationship between internal and external shame (r = -.72) suggests they are distinct but related concepts, supporting Gilbert's Biopsychosocial Model of Shame (1998, 2000). The relationship between external shame was slightly weaker with psychological wellbeing in comparison to internal shame. Conversely, external shame had a stronger relationship with psychological distress. This suggests that these two shame processes may interact with psychological distress and wellbeing differently. Additionally, it suggests that psychological distress and wellbeing are separate but related concepts (Keyes, 2002; Keyes, 2006), supported by the relationship between these variables (r = -.59, DASS-21 Total).

- Self-compassion:

A strong positive relationship was detected between self-compassion and wellbeing (r = .65), suggesting that increased self-compassion is associated with increased psychological wellbeing. This supports previous findings which indicate self-compassion is associated with wellbeing in studies with gay men, sexual minorities and gender nonconforming adults (Beard et al., 2017; Greene & Britton, 2015; Keng & Kenny Liew, 2016). This highlights the possibility of compassion acting as a moderator in experiences of psychological wellbeing and distress. It could be especially relevant when investigating experiences of internal shame as research suggests self-compassion is negatively associated with social comparison (Neff & Vonk, 2009). Additionally, in this study, self-compassion was strongly negatively associated with internal (r = .59) and external shame (r = -.62). Thus, increasing self-compassion could reduce psychological distress and shame experiences for LGBTQ+ young people who have experienced sexual violence. However, it is important to explore how services

and wider structures may create compassion to avoiding situating responsibility in young people. This is especially relevant given external shame is facilitated through experiences such as stigma and marginalisation (Gilbert & Irons, 2009). Thus, to problematise LGBTQ+ young people for their stigmatisation could contribute to shaming.

4.2.5. Research Question 3: What factors do LGBTQ+ young people identify to explain: A) Service use B) Sexual violence reporting?

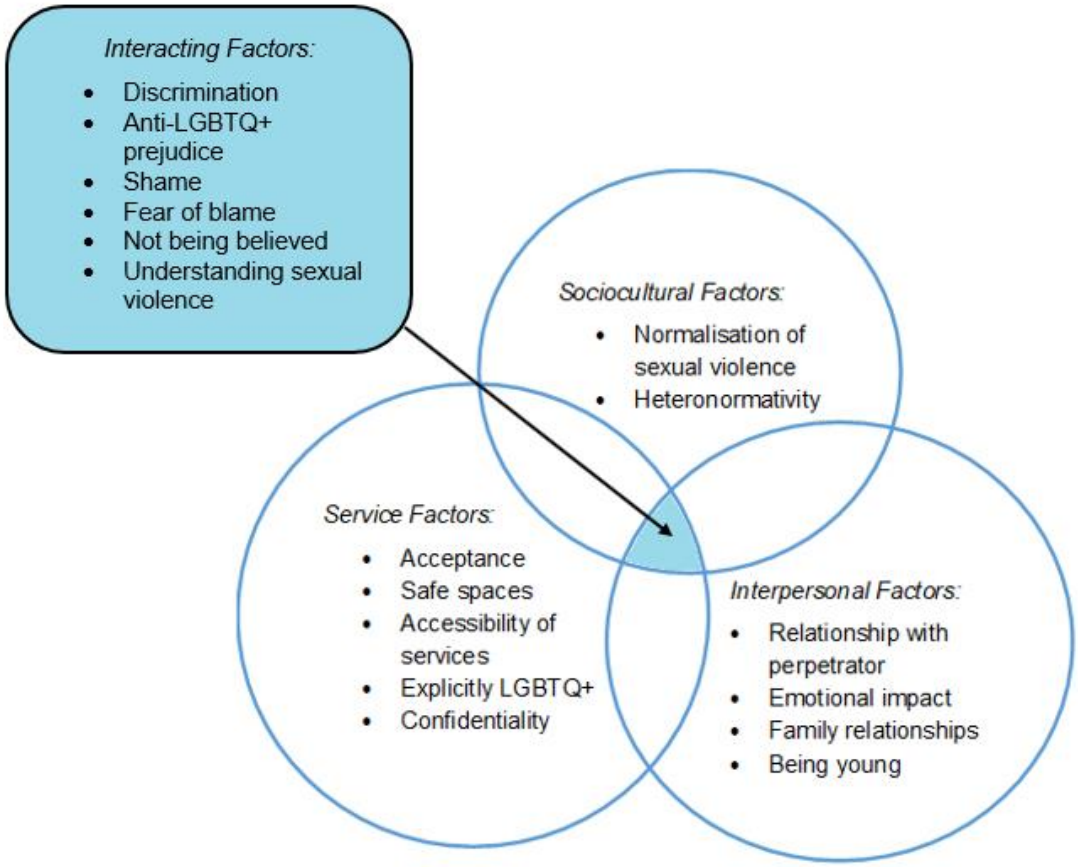


Figure 7: Factors affecting service use and reporting

The views of participants were categorised into factors which affect support seeking and sexual violence reporting (figure 7). Findings suggest sociocultural factors produce experiences which interact with, and directly impact upon, service related factors and interpersonal factors.

Experiences of discrimination and shame may be rooted in heteronormativity, and the normalising of sexual violence may prevent service use and sexual violence reporting. Experiences of shame may be connected to heteronormatively because the construction of gender roles can interact with shame (e.g. cultural narratives of women

as to blame, men as weak), impacting on reporting (Weiss, 2010). These experiences could be reproduced through interactions with services, or other interpersonal relationships (e.g. family), particularly if individuals lack supportive relationships (Harvey et al., 2014). This could potentially increase experiences of self-blame, which may restrict future help seeking or reporting (Sable, Danis, Mauzy, & Gallagher, 2006).

Understanding how relationships with perpetrators can affect service use and reporting may be important when considering LGBTQ+ young people's safety. The quantitative data indicates perpetrators include friends, acquaintances and partners, subsequently participants may have more regular with individuals who are sexually violent towards them. These potentially abusive relationships can be associated with narratives of self-blame, as suggested by LGBTQ+ people in abusive relationships with partners (Murray, Mobley, Buford, & Seaman-DeJohn, 2008). Thus, services may need to actively challenge these narratives and provide greater support.

Perpetrators of sexual violence, particularly more normalised forms of sexual violence, could be less aware their actions constitute sexual violence. UK research suggests the boundaries of consent and coercion can be difficult to comprehend, and whilst young people understand what it means to give consent, the processes of getting consent are much less understood (Coy, Kelly, & Kanyeredzi, 2013). Younger age groups (ages 13 - 14) were less likely to recognise non-consensual sex than older groups, which may be associated with age ('being young') as a barrier to accessing support, suggesting failings in education systems (Coy et al., 2013). Similarly, the lack of understanding of what sexual violence is highlights gaps in education (Sherriff et al., 2011). This lack of knowledge may be further strengthened through teachings of heteronormative relationships in sex education in schools (Smith, 2015). Moreover, this focus on gender roles may contribute to normalising sexual violence. This suggests the importance of affirmative consent and increased education, as well as investigating cultural attitudes which may condone sexual violence.

Service level factors were the most frequently categorised, suggesting the importance of service design and delivery in enabling service utilisation. This is consistent with a review of barriers to sexual health services for young people, which cites service quality and fears about how young people will be received (or accepted) as paramount to service access (Bender & Fulbright, 2013). Compassion, a sense of security and connectedness (Gilbert & Irons, 2005), could provide a helpful frame for creating acceptance in service design.

The need for safe spaces may suggest an awareness that services exist in heteronormative contexts, consistent with UK research describing impacts of structural discrimination (e.g. Harvey, et al., 2014; Hester et al., 2012; LeFrançois, 2013; McDermott, 2015; McDermottet al., 2018; Sherriff et al., 2011). Discrimination from services is, understandably, a critical barrier in service access (e.g. Rymer & Cartei, 2015). Being explicitly LGBTQ+ friendly and accepting could enable the creation of safe spaces. However, to do this meaningfully services and staff also need to be aware of how heterosexism and rape myths may be impacting on their practice and delivery (Rymer & Cartei, 2015). These ideas of safety and acceptance in services are not new (e.g. Harvey, et al., 2014; Hester et al., 2012; LeFrançois, 2013; McDermott, 2015; McDermottet al., 2018; Rymer & Cartei, 2015; Sherriff et al., 2011), but they were consistently highlighted by participants, suggesting improvements in service delivery are still needed. It may be helpful to situate these service factors within the wider context to understand why these issues still exist and what sociocultural factors may be perpetuating them.

## 4.3. Summary of Qualitative Findings

### 4.3.1. Interview Sample

The seven young people interviewed had a diverse range of experiences and backgrounds. The process of giving voice to participants' perspectives through quotations was carefully considered. This was driven by practicality (some participants tended to discuss ideas more broadly, hence quotes were longer) and thought regarding whose voices may be more silenced, for example, the lack of non-binary experiences in research (Frohard-Dourlent et al., 2017).

### 4.3.2. Research Question 5: How do LGBTQ+ young people make sense of sexual violence?

Through describing experiences of sexual violence and its impact, participants offered insights into how they understand sexual violence, which subsequently informed their responses to it. These explorations are predominately drawn from themes one and three of the thematic analysis.

#### *4.3.2.1. Conceptualisations of the reasons for sexual violence*

Participants reflected on how routine sexual violence can be in their lives, which contributes to, and can be a function of, the normalisation of sexual violence. This is reminiscent of LGBTQ+ people's accounts of hate crime as 'part and parcel' of the

LGBTQ+ experience in the UK, suggesting the normalisation of violence more generally (Hardy & Chakraborti, 2015). The routine nature of sexual violence may mean it goes unchallenged in systems. This supported by LGBTQ+ young people's discriminatory experiences in education, which commonly include experiences of sexual violence and harassment (Formby, 2015). Normalisation may also be strengthened through environments where sexual violence is culturally sanctioned, such as nightclubs (Fileborn, 2012).

Hlavka (2014) contends normalisation occurs through socialisation into patriarchal cultures that encourage male dominance, possibly reflected in participants' descriptions of objectification by men. This objectification was described by the women and non-binary participants as erotising them, representing insidious trauma and microaggressions (Miles-McLean et al., 2015). This could undermine their sexual and gender identities through positioning them as objects of male pleasure. Descriptions of a sense of ownership over participants' bodies, both from inside and outside of LGBTQ+ communities, suggests conceptualisations of sexual violence based solely on men as perpetrators/women as victims are limiting. Potentially, the cultural scaffolding of rape (Gavey, 2013), which enables objectification, may inform understandings of sexual violence beyond the gender paradigm. For example, discourses of male sexuality as ever-present and the sexualisation of gay men may scaffold their sexual violence victimisation (Virginia Braun, Schmidt, Gavey, & Fenaughty, 2009). Similarly, participants' descriptions of women as perpetrators may suggest the normalising and scaffolding of sexual violence.

Women perpetrators of sexual violence against other women and non-binary people are far less explored in research. This may be reflective of an invisibility of lesbian and bisexual women and non-binary people in conversations about sexual violence (Bates et al., 2019). Anna felt this contributed towards the minimising of sexual violence perpetrated by women. This is related to ideas of intersectional invisibility in which being a non-prototypical member of a social group creates social invisibility (Purdie-Vaughns & Eibach, 2008). Prototypical sexual minority group members are White gay men, rendering other identities invisible. This invisibility is compounded for individuals also not prototypical in other groups, such as ethnicity or gender (e.g. Onyx as a Black bisexual woman). Potentially, because men are prototypically perpetrators of sexual violence, women perpetrators, and the experiences of people who are sexually victimised by women, become invisible. This may mean sexual violence experiences are perceived as less valid or significant (Bates et al., 2019), as Anna described.

Participants' accounts of sexual violence described the impact of anti-LGBTQ+ stereotypes in dismissing their experiences; othering them as deviant and/or subjugating them. This is illustrated participants' accounts of the hyper sexualisation of bisexuality and of gay men, and assumptions of promiscuity. Participants suggested these stereotypes functioned to invalidate, ignore or even justify sexual violence. This creates a unique victim blaming experience in which gender and sexuality, core parts of the self, are attributed as the causes of sexual violence. Thus, participants may feel negatively valued by others, facilitating external shame (Gilbert, 2006). For bisexual participants, stereotypes of promiscuity were particularly stigmatising and made environments more dangerous. These stigmatising narratives were used to justify sexual violence victimisation and exclude them from lesbian and gay communities, consistent with prior research with bisexual participants (Klesse, 2005; Koehler, Eyssel, & Nieder, 2018).

These unique victim blaming experiences create LGBTQ+ specific rape myths through negative stereotyping and stigmatising processes. They may reflect distal stressors in the Minority Stress Model, contributing to widening health inequalities (Meyer, 2003). Participants' experiences suggest that stereotypes can function to blame or ignore them, avoiding any wider societal responsibility for victimisation. These experiences of being blamed or ignored as may explain why participants felt structural change, although needed, was so difficult affect.

*4.3.2.2. How participants responded to sexual violence*

Participants descriptions of coping with sexual violence suggested they often made sense of experiences as individuals; highlighting strategies of minimisation and vigilance. Participants discussed how safety intersected with an area's sociodemographic (how diverse they perceived it to be) and with their ethnic identities. This suggests their experiences of sexual violence need to be contextualised within their environments and multiple identities, which may create multiple oppressions. Consistent with this, in research with Black and Latina lesbian and bisexual young women, Chmielewski (2017), emphasised exploring how sexual violence is entrenched in multiple forms of oppression.

Individualised strategies may reflect discourses of individual responsibility in sexual violence, associated with victim blaming, and neoliberal ideologies. This could diminish the responsibility of societal structures to protect participants against sexual violence. McDermott et al., (2008) suggest the minimisation of anti-LGBTQ+ prejudice is a shame avoidance strategy. Potentially, participants may minimise sexual violence to

avoid shame. However, possible experiences of shame should be situated within heteronormative contexts and understandings of the impacts of rape myths, not within participants, as this could be further shaming.

The use of informal support (friendships) to make sense of sexual violence was cited as crucial by participants. However, friends acting as services also created pressure on relationships. This is similar to LGBTQ+ young people whom gained support from friends online for psychological distress (McDermott, 2015). This may suggest the lack of suitable or accessible services.

The negative impacts of sexual violence may be strengthened through its' normalisation and victim blaming discourses, invalidating experiences. This could make it more difficult to make sense of the impacts of sexual violence. Interestingly, participants discussed how sharing experiences of sexual violence could increase compassion through connecting with others. This may act to subvert cultural narratives of self-blame and present alternative ways to make sense of sexual violence experiences.

#### 4.3.3. Research Question 6: How do LGBTQ+ young people describe experiences of services?

Theme two of the thematic analysis was drawn upon to explore research question six, although the stereotypes and stigmatising processes described in theme one also informed this discussion.

Connection as important was further highlighted in participants' descriptions of positive service experiences. They emphasised staff as relatable and services as warm and non-judgemental. This may indicate the importance LGBTQ+ staff, as suggested in prior research (e.g. Love et al., 2017). It raises questions of what information professionals can share with young people, particularly in services with strict boundaries. However, without some social sharing, services may risk contributing to 'us and them' discourses in mental health (Pilgrim, 2005), othering LGBTQ+ young people. Services could explore how they can contribute to the disruption of rape myths and the normalising of sexual violence through the sharing of stories.

Services as safe bases, consistent with attachment theory (Bowlby, 2005), may activate the contentment system, enabling experiences of security (Gilbert, 2009). This extends interpersonal conceptualisations of compassion by suggesting compassion may be facilitated through environments. The themes of acceptance and safety are also present in the content analysis, underscoring their importance to participants.

Additionally, themes of acceptance were found in research of US LGBTQ+ adolescents' service experiences (Ott, 2018). Acceptance by services could reflect participants' desires to be accepted more widely, indicative of heteronormativity.

To create safety, participants' discussed consistency of staff and service accessibility. Wagaman (2014) suggests this is especially important for LGBTQ+ young people whom have experienced transitions and uncertainty, as these stable relationships create connection and reduce isolation. This may be evident in Nero's descriptions of his youth centre feeling like a family. However, the quality and extent of LGBTQ+ service provision has been impacted by austerity policies, increasing the marginalisation and invisibility of LGBTQ+ people (Beninger & Arthur, 2014). Given the invisibility some participants already described, this may compound experiences of being overlooked in services. This could be especially relevant for non-binary people because mainstream are often developed along gender binaries (Clark, Veale, Townsend, Frohard-Dourlent, & Saewyc, 2018), particularly sexual violence services (Rymer & Cartei, 2015).

Frequently, LGBTQ+ young people are positioned as 'hard to reach' (e.g. Hoffman, Freeman, & Swann, 2009; McDermott, Roen, & Piela, 2013; McInroy, 2016). This may be marginalising because 'hard to reach' discourses could mean LGBTQ+ young people are 'easy to ignore' in services (Matthews, Netto, & Besemer, 2012). Thus, participants' descriptions of the challenges they experienced with services was deliberately constructed as services as 'hard to reach', to put the onus onto services for the exclusion of LGBTQ+ young people. These challenges were often associated with the wider stressors' participants experienced, such as stereotyping and discrimination, suggestive of the influence of heteronormativity upon services (Love et al., 2017; Rymer & Cartei, 2015). This meant participants assessed the safety of disclosing their identities and were concerned they may have to educate services regarding their gender and/or sexual identity. These experiences could be fatiguing and deter them from seeking support. Thus, heterosexism created structural barriers in service utilisation for participants, which is already a difficult process for young people (e.g. McGorry, Bates, & Birchwood, 2013). This lack of equitable service access could be a violation of their human rights (Albuquerque et al., 2016).

Stereotypes and rape myths concerning alcohol created fears of blame in services for participants. This may be reflective of beliefs in services regarding who is 'victim worthy', undermining individuals if they are outside of 'ideal victim' parameters (Randall, 2010). Furthermore, Nero described how an implicit tone in services implied

fault, potentially contributing to self-blame/shame. This suggests the influence of rape myths upon staff (Shaw, Campbell, Cain, & Feeney, 2017) has significant implications for LGBTQ+ young people's service experiences. Participants described a focus by services on their identities as reasons for difficulties, as increasing self-blame, again indicative of unique victim blaming experiences and external shame (Gilbert, 2006). This could facilitate internal shame experiences concerning gender or sexual identity (Giordano, 2018). Thus, it may be protective to avoid services to reduce the likelihood shaming experiences.

Participants described how service interactions could feel cold, clinical and transactional. These experiences could put the onus onto young people to change themselves, again connected to experiences of blame and/or that there is something inherently 'wrong' with them. The technical approach of services may de-humanise them and lose the interpersonal relationship, which participants suggested was critical for acceptance. Possibly, this reflects services operating under limited resources as less time may be spent with services users. A lack of listening in services can create distrust (McLeod, 2007). It may increase power imbalances between services and young people, inferred from participants descriptions of experiences of inferiority in services. These experiences may, understandably, reduce service use by LGBTQ+ young people.

Experiences of inferiority may also be created through the positioning of LGBTQ+ young people who do not use services as irresponsible, as Ed described. This may be connected to neoliberal discourses of individual responsibility, which obscure wider structural inequalities and reduce the responsibility of governments to protect disadvantaged populations (Meyer 2015). Individualising service access also minimises intersections between service use and cultural experiences, as Shimeon Lang describes. This suggests the importance of situating participants' service experiences within intersectional frameworks that explores all their identities.

### 4.4. Implications

The study's findings highlight the importance of addressing LGBTQ+ young people's experiences of sexual violence and psychological distress, within sociocultural contexts where heteronormativity is pervasive and sexual violence normalised. Implications at different levels of the system are discussed.

### 4.4.1. Individual Level

The findings suggest experiences of shame and psychological distress may be significant for LGBTQ+ young people whom have experienced sexual violence. The association between compassion and psychological wellbeing suggests that increasing self-compassion could improve psychological wellbeing. Therefore, CFT could improve the psychological wellbeing of LGBTQ+ young people. A Randomised Control Trial for CFT for sexual minority young people is being currently conducted (Pepping et al., 2017), suggesting this is a developing field for LGBTQ+ mental health. However, gender minorities are excluded, and it is unclear if sociocultural contexts will be explored. Moreover, effectiveness of individual interventions may be limited in discriminatory environments. This could be further compounded for individuals who experience multiple forms of oppression (Purdie-Vaughns & Eibach, 2008).

Sharing stories can illustrate everyday acts of resistance to violence (Wade, 1997). Therefore, creating platforms where experiences of sexual violence, anti-LGBTQ+ prejudice and heterosexism can be heard (akin to #metoo movement[1]) may increase connection and compassion with others, consequently reducing distress. However, it is important these are not framed as stories of 'individual resilience' as this disallows victims and can reduce state responsibility to protect disadvantaged groups (Meyer, 2015).

### 4.4.2. Service Level

This study emphasised a wide range of service-related factors and suggests services need to become easier to access. Whilst, this discussion of 'services' does homogenise diverse organisations, it is hoped factors identified may be able to broadly influence how to improve experiences for LGBTQ+ young people seeking support for sexual violence.

Services could review how inclusive they are and recognise intersectional invisibility to support LGBTQ+ young people's utilisation. For example, questioning stereotypes held in services (Love et al., 2017) and the implicit assumptions in service design (e.g. gender binary support) (Rymer & Cartei, 2015). Intersectional frameworks could deepen appreciations of individuals' experiences and identities (Love et al., 2017). Staff training exploring LGBTQ+ young people's experiences and how victim blaming

[1] https://twitter.com/hashtag/metoo

interacts with identity could also increase understanding (Sherriff et al., 2011). Additionally, situating support within informal settings (McDermott et al., 2018) could support LGBTQ+ young people to feel safe by reducing clinical or cold interactions. Engagement with peer support initiatives could de-stigmatise sexual violence and cultivate a culture of sharing experiences.

However, it is important to question why heterosexism persists in services. This is indicative of the stigmatisation of minorities identities and sexual violence. Demonstrating acceptance of gender and sexual identities through explicitly naming entrenched heteronormative structures, could expose how these are privileged in services (Butler, 1999; Chambers, 2007; LeFrançois, 2013). This may begin to subvert the power these structures hold.

#### 4.4.3. Sociocultural Context

As psychologists, our collaborations with communities and critiques of social structures could advance social justice for LGBTQ+ young people, and attend to multiple systems of oppression (Rosenthal, 2016). The findings highlight the unique victim blaming experiences of LGBTQ+ young people who have experienced sexual violence. These represent distal stressors requiring social change in the Minority Stress Model (Meyer, 2015). Targeting biases and stereotypes in legal systems and addressing the invisibility of certain groups may facilitate social change (Hodson, 2019; Murphy & Hine, 2019). The recent inclusion of LGBTQ+ relationships and identities in UK education curriculums could reduce heteronormativity, increase understanding of sexual violence in LGBTQ+ relationships, and may signal hopeful wider social changes (Stonewall, 2019). Challenging the normalisation of sexual violence in the UK media and social institutions is also important (Lockyer & Savigny, 2019; Phipps, Ringrose, Renold, & Jackson, 2018). This research may bring LGBTQ+ young people's perspectives into sexual violence debates that have previously focused on heterosexual women (e.g. Cannon & Buttell, 2015). Acknowledging the historical legacy of anti-LGBTQ+ prejudice and the normalisation of sexual violence (e.g. women as property) in the UK may also expose implicit assumptions that contribute towards the acceptance of LGBTQ+ marginalisation and sexual violence.

## 4.5. Limitations

### 4.5.1. Sample Size and Diversity

The small sample size in the survey reduces the generalisability of findings. It also limited the types of quantitative analysis that could be performed, and the power of the statistical analysis, increasing the likelihood of Type II errors (Field, 2013). The small sample size meant statistical analysis of category frequency in the content analysis was not undertaken because findings would not have generalised reliably to other LGBTQ+ young people (Joffe & Yardley, 2004).

Whilst participants' ethnic background is approximate to UK percentages (Office for National Statistics, 2011), the proportion of people from different ethnic backgrounds are small due to low numbers in the study. There were no participants from Black or Black British backgrounds, although participants with mixed heritages may identify as Black or Black British (as Onyx did). The small numbers of participants from ethnic minorities is problematic given the importance of intersectional frameworks in understanding psychological distress (e.g. Gkiouleka et al., 2018) and because LGBTQ+ literature often excludes perspectives of ethnic minorities (Butler, das Nair, & Thomas, 2010). The term 'LGBTQ+' originates in Western conceptualisations of sexuality and gender, and other cultures may construct sexual and gender identities differently (das Nair & Thomas, 2012). This terminology may have inadvertently contributed towards a lack of representation from ethnic minority groups. Furthermore, this terminology homogenises diverse groups and may not attend to discrimination within the LGBTQ+ community, for example anti-trans and anti-bi prejudice or racism (Antjoule, 2011; Weiss, 2011).

Hester et al. (2012) highlighted their difficulties in the recruitment of LGBTQ+ adults, suggesting careful thought is required to enable larger number of LGBTQ+ people to access research. Conversely, other national research projects have reached significant numbers of LGBTQ+ young people. This may be because projects have greater resources (e.g. McDermott et al., 2018) or are aligned with LGBTQ+ youth services (e.g. METRO Charity, 2016). A partnership approach with LGBTQ+ service providers may increase recruitment, or education providers (e.g. schools and colleges) to engage young people not using these services. The sensitive nature of the research may have impacted on the uptake. However, internet-based designs are recommended as tool to facilitate LGBTQ+ young people's engagement in sensitive research and to engage with diverse LGBTQ+ young people (McDermott et al., 2013). But, due to the online

methodology, it is difficult to gain insights into why individuals did not fully complete the survey, or chose not to participate initially (McInroy, 2016).

### 4.5.2. Design

The cross-sectional and correlational design meant no casual conclusions can be drawn from the study. Thus, proposals that external shame may increase psychological distress and self-compassion could increase psychological wellbeing are unsubstantiated by this analysis. To explore this, and the impacts of sexual violence, longitudinal research is needed. Longitudinal research by sexual assault services in London suggests the wide reaching and significant impacts of sexual violence upon young people (Khadr et al., 2018). However, specific impacts on LGBTQ+ young people or transdiagnostic constructs (e.g. shame and compassion) are not investigated, which could be relevant in understanding outcomes following sexual violence. The thematic analysis was helpful to explore how participants articulated psychological distress associated with sexual violence. Although, the flexibility in thematic analysis may create some inconsistencies in the development of themes describing psychological distress (Nowell, Norris, White, & Moules, 2017). Additionally, both thematic and content analysis are critiqued for fragmentating individual's narratives by organising materials based upon how the researcher believes ideas are connected (Hollway & Jefferson, 2000), and participants in the study may have conceptualised categories or themes differently.

### 4.5.3. Measures

Self-report measures can restrict flexibility in participants' responses and participants may have quantified their experiences differently (Barker, Pistrang, & Elliott, 2002). This limits the reliability of the findings. Although, the validated measures demonstrated good internal validity. However, it may have been useful to explore how LGBTQ+ young people conceptualise experiences of shame and compassion in the survey, particularly as the research was concerned with hearing their experiences. Furthermore, these measures focused on inner experiences, which may have neglected wider impacts on LGBTQ+ young people. Subsequently, understandings of the operations of power structures in their lives may have been limited in this section of the research (Gkiouleka et al., 2018). It could have been helpful to integrate intersectionality and the socio-political context into the quantitative design to further contextualise findings (Gkiouleka et al., 2018; Spierings, 2012).

The sexual violence measures were designed for this study, limiting comparisons to other research. These measures may have been more inclusive of sexual violence experiences (e.g. the inclusion of additional items) than the SVS-LFV/SFV (Koss et al., 2007) it was developed from. However, the category of 'contact sexual violence' in this study is consistent with legal definitions of sexual assault (Sexual Offences Act 2003).

The number of measures may have affected completion rates due to the time required. Given the exploratory and novel nature of the research, gaining the views of as many LGBTQ+ young people as possible was important. Therefore, it may have been useful to omit some measures to shorten the survey. The internal shame measure could have been removed as, whilst it is used to measure internal shame, it is not designed for this purpose. Additionally, internal shame is generated through external shame experiences (Gilbert & Irons, 2009), suggesting external shame as the primary experience. External shame also may have more relevance to LGBTQ+ young people's lives as it is facilitated by exclusion, for example through stigmatising processes.

### 4.6. Reflexive Review

Researcher's engagement with personal reflexivity is important to ethically conduct research (Attia & Edge, 2017; Willig, 2001). I identified in this research as an ally; "*Allies work collectively to contribute to the making of a space in which the person who is subjected to power gets to have their voice heard and listened to*" (Reynolds, 2013, p.56). The privileges' my identities have granted me (e.g. ease of access to services) motivated me to access the power I hold as a trainee clinical psychologist to conduct research which gave voice to LGBTQ+ young people. However, my identities may have affected how participants responded; I considered how the study approach, response and interpretation could have been influenced had I held differing identities (e.g. if I identified as a man or LGBTQ+).

A significant challenge was research recruitment. Consequently, I questioned if I was best placed to conduct this research, as neither a young person or a member of the LGBTQ+ community. The engagement with LGBTQ+ organisations was important to help me further appreciate the nuances and the complexities in the work.

Whilst I was aware of the complexity and potential scale of a mixed methods approach, I underestimated how challenging it would be to capture the quantitative and qualitative elements effectively within the report. Particularly the interview data and exploring how to give sufficient platforms to participants' multiple identities. The experience of conducting the interviews was humbling and inspiring. It has motivated me to explore

how to connect the research with wider campaigns, such as the “Good Night Out Campaign,” which campaigns against sexual violence in social spaces, and to challenge services to be overtly inclusive in my clinical work.

The relevance of shame conceptualisations in sexual violence has encouraged me to explore how transdiagnostic processes can be useful clinically and for social change. A psychological perspective may improve experiences for survivors. For example, the study highlights the impact of shaming/blaming experiences for LGBTQ+ young people through organisational interactions. This could strengthen recent critiques of changes to police consent forms, allowing them access to sexual assault victims’ mobile phones (Big Brother Watch, 2019; Rights Info, 2019; The Guardian, 2019). The process of conducting this research has engaged me with the political importance of psychology to question social policy.

### 4.6. Future Research

This study indicates the need for further UK sexual violence research with LGBTQ+ populations given the experiences of psychological distress and shame reported by participants. Consistent with this, Galop (LGBTQ+ anti-violence charity) are about undertake a national study of the needs and experiences of LGBTQ+ people who have experienced sexual violence (Galop, 2019), emphasising the relevance of this work. The study indicated relationships between shame, self-compassion, psychological distress and wellbeing. With a lager sample, structural equation modelling could investigate the complex relationship between these variables, and shame and self-compassion as possible moderators or meditators of psychological distress and wellbeing.

The study highlighted how participants can feel responsible for coping with sexual violence, which may be strengthened through individually focused research. Therefore, the framing of future sexual violence research with LGBTQ+ young people should enable intersectional explorations of wider sociocultural and political factors to avoid problematising LGBTQ+ young people. Participatory action research (PAR) approaches with LGBTQ+ young people may be a helpful methodology to achieve this (e.g. Wagaman, 2015).

Interview participants recognised and resisted victim blaming narratives connected to their identity, although these still could impact upon wellbeing. It would be useful to explore this unique minority stressor and the conditions under which it is produced. This may inform how resistance to these discourses could be developed in service

structures. Additionally, service improvement initiatives (proposed in section 4.4.2.) could be developed and evaluated with LGBTQ+ young people through PAR methods.

### 4.7. Conclusions

This study was the first UK based exploration of sexual violence experienced by LGBTQ+ young people. The mixed methods approach aimed to deliberately disrupt the individualising of psychological distress by situating the research in wider sociocultural contexts and exploring the role of services. These investigations emphasised the impact of services and cultural narratives in shaping psychological distress and wellbeing for LGBTQ+ young people who have experienced sexual violence.

Whilst the small survey sample size limits generalisations from the quantitative analysis, the findings may still indicate the relevance of shame and compassion constructs for LGBTQ+ young people who have experienced sexual violence. Further investigations of compassion by the self, from others and cultivated through environments may inform how to improve LGBTQ+ young people's experiences and reduce social inequalities. Services can therefore play important roles in shaping compassionate experiences for LGBTQ+ young people. However, results indicate services need to review their structures to address how they create acceptance and safety.

The invisibility and marginalisation created through stereotypes highlights how rape myths and heteronormativity persist in our culture, emphasising the need for further action to address anti-LGBTQ+ prejudice, discrimination and heterosexism. The sharing of stories may be a powerful tool to challenge the normalisation of sexual violence and make structural oppressions more visible. Potentially, services could join with LGBTQ+ young people to actively challenge discourses which condone sexual violence.

Through building on these initial findings, it is hoped that future research will explore how services can work collectively with LGBTQ+ young people to address experiences of psychological distress and shame associated with sexual violence. Moreover, it is hoped that as a collective, we all act to challenge stigma and stereotypes affecting LGBTQ+ young people, both inside and outside of clinical practice.

## 5. REFERENCES


*1 in 2 young people say they are not 100% heterosexual | YouGov*. (2015). Retrieved from https://yougov.co.uk/topics/lifestyle/articles-reports/2015/08/16/half-young-not-heterosexual

Akhtar, S. (2016). *Shame: Developmental, cultural, and clinical realms*. (S. Akhtar, Ed.). London: Karnac.

Allan, S., & Gilbert, P. (1995). A social comparison scale: Psychometric properties and relationship to psychopathology. *Personality and Individual Differences*, *19*(3), 293–299.

Allan, S., Gilbert, P., & Goss, K. (1994). An exploration of shame measures—II: psychopathology. *Personality and Individual Differences*, *17*(5), 719–722.

Allen, S. H., & Mendez, S. N. (2018). Hegemonic Heteronormativity: Toward a New Era of Queer Family Theory. *Journal of Family Theory & Review*, *10*(1), 70–86.

Allsorts Youth Project. (n.d.). Retrieved December 7, 2018, from http://www.allsortsyouth.org.uk/

Anderson, I., & Doherty, K. (2007). *Accounting for rape: Psychology, feminism and discourse analysis in the study of sexual violence*. Hove: Routledge.

Anderson, R. E., Tarasoff, L. A., VanKim, N., & Flanders, C. (2019). Differences in Rape Acknowledgment and Mental Health Outcomes Across Transgender, Nonbinary, and Cisgender Bisexual Youth. *Journal of Interpersonal Violence*,

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology*, *41*(1), 29–42.

Antjoule, N. (2011). *LGBT Intersections - A Charity Perspective*. London. Retrieved from www.galop.org.uk.

Antjoule, N. (2016). *The Hate Crime Report: Homophobia, biphobia and transphobia in the UK*. London. Retrieved from http://www.galop.org.uk/wp-content/uploads/2016/10/The-Hate-Crime-Report-2016.pdf

Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). *Psychometric Properties of the 42-Item and 21-Item Versions of the Depression Anxiety Stress Scales in Clinical Groups and a Community Sample*. *Psychological Assessment* (Vol. 10).

Aosved, A. C., & Long, P. J. (2006). Co-occurrence of Rape Myth Acceptance, Sexism, Racism, Homophobia, Ageism, Classism, and Religious Intolerance. *Sex Roles*, *55*(7–8), 481–492.

Artime, T. M., McCallum, E. B., & Peterson, Z. D. (2014). Men's acknowledgment of their sexual victimization experiences. *Psychology of Men & Masculinity*, *15*(3), 313–323.

Attia, M., & Edge, J. (2017). Be(com)ing a reflexive researcher: a developmental approach to research methodology. *Open Review of Educational Research*, *4*(1), 33–45.

Au, T. M., Dickstein, B. D., Comer, J. S., Salters-Pedneault, K., & Litz, B. T. (2013). Co-occurring posttraumatic stress and depression symptoms after sexual assault: A latent profile analysis. *Journal of Affective Disorders*, *149*(1–3), 209–216.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology: An introduction for students and practitioner* (2nd ed.). Chichester: Wiley.

Bates, E. A., Klement, K. R., Kaye, L. K., & Pennington, C. R. (2019). The Impact of Gendered Stereotypes on Perceptions of Violence: A Commentary. *Sex Roles*.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, (117), 497–529.

Beard, K., Eames, C., & Withers, P. (2017). The role of self-compassion in the well-being of self-identifying gay men. *Journal of Gay & Lesbian Mental Health*, *21*(1), 77–96.

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey. *Counselling and Psychotherapy Research*, *16*(1), 15–23.

Beaumont, E., & Martin, C. J. H. (2015). A narrative review exploring the effectiveness of Compassion Focused Therapy. *Counselling Psychology Review*, *1*, 31–32.

Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, *8*(1), 77–100.

Bellamy, G., Gott, M., & Hinchliff, S. (2011). Controversies and contentions: a gay man conducting research with women about their understandings of sexuality, sex and sexual problems. *Culture, Health & Sexuality*, *13*(6), 699–712.

Bender, S. S., & Fulbright, Y. K. (2013). Content analysis: A review of perceived barriers to sexual and reproductive health services by young people. *The European Journal of Contraception & Reproductive Health Care*, *18*(3), 159–167.

Bendixen, M., Daveronis, J., & Kennair, L. E. O. (2018). The effects of non-physical peer sexual harassment on high school students' psychological well-being in Norway: consistent and stable findings across studies. *International Journal of Public Health*, *63*(1), 3–11.

Beninger, K., & Arthur, S. (2014). *Implications of austerity for LGBT people and services*. Retrieved from www.natcen.ac.uk

Bentall, D., & Pilgrim, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, *8*(3), 261–274.

Big Brother Watch. (2019). Victims Not Suspects – Big Brother Watch. Retrieved April 29, 2019, from https://bigbrotherwatch.org.uk/all-campaigns/victims-not-suspects/

Bockting, W. O. (2009). Transforming the paradigm of transgender health: a field in transition. *Sexual and Relationship Therapy*, *24*(2), 103–107.

Booth, A., Sutton, A., & Papaioannou, D. (2016). *Systematic approaches to a successful literature review* (2nd ed.). London: SAGE.

Bostwick, W., & Hequembourg, A. L. (2013). Minding the Noise: Conducting Health Research Among Bisexual Populations and Beyond. *Journal of Homosexuality*, *60*(4), 655–661.

Bourgeois, P., & Scheper-Hughes, N. (2004). *Violence in war and peace*. Oxford: Blackwell Publishing.

Bowlby, J. (n.d.). *Attachment and loss, Vol. 1: Attachment*. London: Hogarth Press.

Bowlby, J. (2005). *A secure base : clinical applications of attachment theory*. Routledge.

Bowyer, L., Wallis, J., & Lee, D. (2014). Developing a Compassionate Mind to Enhance Trauma-Focused CBT with an Adolescent Female: A Case Study. *Behavioural and Cognitive Psychotherapy*, *42*(02), 248–254.

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

Braun, V., Schmidt, J., Gavey, N., & Fenaughty, J. (2009). Sexual Coercion Among Gay and Bisexual Men in Aotearoa/New Zealand. *Journal of Homosexuality*, *56*(3), 336–360.

Braveman, P. (2006). Health Disparities and Health Equity: Concepts and Measurement. *Annual Review of Public Health*, *27*(1), 167–194.

British Psychological Society. (2017). *Ethics Guidelines for Internet-mediated Research*. Leicester. Retrieved from www.bps.org.uk/publications/policy-and-guidelines/research-guidelines-policy-documents/research-guidelines-poli

Brown, J., & Trevethan, R. (2010). Shame, Internalized Homophobia, Identity Formation, Attachment Style, and the Connection to Relationship Status in Gay Men. *American Journal of Men's Health*, *4*(3), 267–276.

Brown, T. N. T., & Herman, J. L. (2015). *Intimate partner violence and sexual abuse among LGBT people*. Los Angeles, CA.

Burt, M., & Estep, R. (1981). Who is victim? Definitional problems in sexual victimisation. *Victimology*, *6*, 15–28.

Burt, M. R. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology*, *38*(2), 217–230.

Buss, D. M. (2003). *The evolution of desire: Strategies of human mating*. New York: Free Press.

Butler, C., das Nair, R., & Thomas, S. (2010). The colour of queer. In L. Moon (Ed.), *Counselling ideologies: Queer challenges to heteronormativity*. Surrey: Ashgate.

Butler, J. (1999). *Gender Trouble*. New York: Routledge.

Caccioppo, J. T., Berston, G. G., Sheridan, J. F., & McClintock, M. K. (2000). Multilevel integrative analyses of human behavior: Social neuroscience and the complementing nature of social and biological approaches. *Psychological Bulletin*, (126), 829–843.

Cacioppo, J. T., Semin, G. R., & Berntson, G. G. (2004). Realism, Instrumentalism, and Scientific Symbiosis: Psychological Theory as a Search for Truth and the Discovery of Solutions. *American Psychologist*, *59*(4), 214–223.

Campbell, R., Adams, A. E., Wasco, S. M., Ahrens, C. E., & Sefl, T. (2010). "What Has It Been Like for You to Talk With Me Today?": The Impact of Participating in Interview Research on Rape Survivors. *Violence Against Women*, *16*(1), 60–83.

Campbell, R., Greeson, M. R., & Fehler-Cabral, G. (2013). With Care and Compassion. *Journal of Forensic Nursing*, *9*(2), 68–75.

Cannon, C., & Buttell, F. (2015). Illusion of Inclusion: The Failure of the Gender Paradigm to Account for Intimate Partner Violence in LGBT Relationships. *Partner Abuse*, *6*(1), 65–77.

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research and clinical applications*. New York: Guilford Press.

Centre for Disease Control and Prevention, (2010). *The National Intimate Partner & Sexual Violence Survey: An overview of 2010 findings on victimization by sexual orientatio*n. Retrieved from: http://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_victimization_final-a.pdf.

Chambers, S. A. (2007). 'An Incalculable Effect': Subversions of Heteronormativity. *Political Studies*, *55*(3), 656–679.

Chmielewski, J. F. (2017). A Listening Guide Analysis of Lesbian and Bisexual Young Women of Color's Experiences of Sexual Objectification. *Sex Roles*, *77*(7–8), 533–549.

Clark, B. A., Veale, J. F., Townsend, M., Frohard-Dourlent, H., & Saewyc, E. (2018). Non-binary youth: Access to gender-affirming primary health care. *International Journal of Transgenderism*, *19*(2), 158–169.

Clark, T. (2008). `We're Over-Researched Here!': Exploring Accounts of Research Fatigue within Qualitative Research Engagements. *Sociology*, *42*(5), 953–970.

Clarke, A., Friede, T., Putz, R., Ashdown, J., Martin, S., Blake, A., … Stewart-Brown, S. (2011). Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Validated for teenage school students in England and Scotland. A mixed methods assessment. *BMC Public Health*, *11*(1), 487.

Clarke, V., & Braun, V. (2013). *Successful qualitative research : a practical guide for beginners*. SAGE

Coker, T. R., Austin, S. B., & Schuster, M. A. (2010). The Health and Health Care of Lesbian, Gay, and Bisexual Adolescents. *Annual Review of Public Health*, *31*(1), 457–477.

Collier, K. L., van Beusekom, G., Bos, H. M. W., & Sandfort, T. G. M. (2013). Sexual Orientation and Gender Identity/Expression Related Peer Victimization in Adolescence: A Systematic Review of Associated Psychosocial and Health Outcomes. *Journal of Sex Research*, *50*(3–4), 299–317.

Concannon, L. (2008). Citizenship, sexual identity and social exclusion. *International Journal of Sociology and Social Policy*, *28*(9/10), 326–339.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic Masculinity: Rethinking the Concept. *Gender & Society*, *19*(6), 829–859.

Connolly, M. D., Zervos, M. J., Barone, C. J., Johnson, C. C., & Joseph, C. L. M. (2016). The Mental Health of Transgender Youth: Advances in Understanding. *Journal of Adolescent Health*, *59*(5), 489–495.

Cook, D. R. (1994). *Internalized shame scale: Technical manual.* North Tonawanda, NY: Multi-Health Systems, Inc.

Cornish, F., & Gillespie, A. (2009). A Pragmatist Approach to the Problem of Knowledge in Health Psychology. *Journal of Health Psychology*, *14*(6), 800–809.

Coulter, R. W. S., Kenst, K. S., Bowen, D. J., & Scout. (2014). Research Funded by the National Institutes of Health on the Health of Lesbian, Gay, Bisexual, and Transgender Populations. *American Journal of Public Health*, *104*(2), e105–e112.

Coy, M., Kelly, L., & Kanyeredzi, A. (2013). *"Sex without consent, I suppose that is rape"; How young people in England understand sexual consent*. Retrieved from https://www.researchgate.net/publication/320545582

Crawford, P., Gilbert, P., Gilbert, J., Gale, C., & Harvey, K. (2013). The language of compassion in acute mental health care. *Qualitative Health Research, 23*(6), 719-727.

Crews, D., & Crawford, M. (2015). Exploring the Role of Being Out on a Queer Person's Self-Compassion. *Journal of Gay & Lesbian Social Services*. h

Cunha, M., Matos, M., Faria, D., & Zagalo, S. (2012). *Shame Memories and Psychopathology in Adolescence: The Mediator Effect of Shame*. *International Journal of Psychology & Psychological Therapy* (Vol. 12).

D'amico, E., Julien, D., Tremblay, N., & Chartrand, E. (2015). Gay, lesbian, and bisexual youths coming out to their parents: Parental reactions and youths' outcomes. *Journal of GLBT Family Studies, 11(5)*, 411-437.

Daley, A., Solomon, S., Newman, P. A., & Mishna, F. (2007). Traversing the Margins: Intersectionalities in the Bullying of Lesbian, Gay, Bisexual and Transgender Youth. *Journal of Gay & Lesbian Social Services*, *19*(3–4), 9–29.

das Nair, R., & Thomas, S. (2012). Race and Ethnicity. In R. das Nair & C. Butler (Eds.), *Intersectionality, Sexuality and Psychological Therapies: Working with Lesbian, Gay and Bisexual Diversity* (pp. 59–88). Chichester: BPS Blackwell.

Davies, M., Gilston, J., & Rogers, P. (2012). Examining the Relationship Between Male Rape Myth Acceptance, Female Rape Myth Acceptance, Victim Blame, Homophobia, Gender Roles, and Ambivalent Sexism. *Journal of Interpersonal Violence*, *27*(14), 2807–2823.

Davis, T. S., Saltzburg, S., & Locke, C. R. (2009). Supporting the emotional and psychological well being of sexual minority youth: Youth ideas for action. *Children and Youth Services Review*, *31*(9), 1030–1041.

Davy, Z. (2011). *Recognizing Transsexuals: Personal, Political and Medicolegal Embodiment.* Ashgate: Farnham.

de Zulueta, P. (2013). Compassion in healthcare. *Clinical Ethics, 8*(4), 87-90.

DeCou, C. R., Cole, T. T., Lynch, S. M., Wong, M. M., & Matthews, K. C. (2017). Assault-related shame mediates the association between negative social reactions to disclosure of sexual assault and psychological distress. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(2), 166–172.

Denov, M. S. (2003). To a safer place? Victims of sexual abuse by females and their disclosures to professionals. *Child Abuse & Neglect*, *27*(1), 47–61.

Denzin, N. K. (2010). Moments, Mixed Methods, and Paradigm Dialogs. *Qualitative Inquiry*, *16*(6), 419–427.

Denzin, N. K. (2012). Triangulation 2.0 *. *Articles Journal of Mixed Methods Research*, *6*(2), 80–88.

DePalma, R., & Atkinson, E. (2010). The nature of institutional heteronormativity in primary schools and practice-based responses. *Teaching and Teacher Education, 26(8*), 1669–1676.

Dermer, S. B., Smith, S. D., & Barto, K. K. (2010). Identifying and Correctly Labeling Sexual Prejudice, Discrimination, and Oppression. *Journal of Counseling & Development*, *88*(3), 325–331.

Dewey, J. (2008). Propositions, warranted assertibility and truth. In J. Boydston (Ed.), *The later works of John Dewey, 1925-1953* (pp. 168–188). Carbondale: Southern Illinois University Press.

Dorsen, C. (2012). An integrative review of nurse attitudes towards lesbian, gay, bisexual, and transgender patients. *The Canadian Journal of Nursing Research = Revue Canadienne de Recherche En Sciences Infirmieres*, *44*(3), 18–43.

Dwyer, A. (2010). Policing Lesbian, Gay, Bisexual and Transgender Young People: A Gap in the Research Literature. *Current Issues in Criminal Justice*, *22*.

Edwards, K. M., Turchik, J. A., Dardis, C. M., Reynolds, N., & Gidycz, C. A. (2011). Rape Myths: History, Individual and Institutional-Level Presence, and Implications for Change. *Sex Roles*, *65*(11–12), 761–773.

Ellis, S. J. (2008). Diversity and inclusivity at university: a survey of the experiences of lesbian, gay, bisexual and trans (LGBT) students in the UK. *Higher Education*, *57*(6), 732–739.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1),

Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis program. *Behaviour Research Methods, Instruments, & Computers*, *28*, 1–11.

Farmer, P. (1996). On suffering and structural violence: A view from below. *Daedalus, 125*(1), 261-283.

Fehler-Cabral, G., Campbell, R., & Patterson, D. (2011). Adult Sexual Assault Survivors' Experiences With Sexual Assault Nurse Examiners (SANEs). *Journal of Interpersonal Violence*, *26*(18),

Feng, C., Wang, H., Lu, N., Chen, T., He, H., Lu, Y., & Tu, X. M. (2014). Log-transformation and its implications for data analysis. *Shanghai Archives of Psychiatry*, *26*(2), 105–109.

Fergus, S., & Zimmerman, M. A. (2005). Adolescent Resilience: A Framework for Understanding Healthy Development in the Face of Risk. *Annual Review of Public Health*, *26*(1), 399–419.

Field, A. (2013). *Discovering Statistics using IBM SPSS Statistics* (4th ed.). London: Sage.

Fileborn, B. (2012). Sex and the City: Exploring Young Women's Perceptions and Experiences of Unwanted Sexual Attention in Licensed Venues. *Current Issues in Criminal Justice*, *24*(2), 241–260.

Fileborn, B. (2014). Accounting for Space, Place and Identity: GLBTIQ Young Adults' Experiences and Understandings of Unwanted Sexual Attention in Clubs and Pubs. *Critical Criminology*, *22*(1), 81–97.

Flynn, C., Damant, D., Lapierre, S., Lessard, G., Gagnon, C., Couturier, V., & Couturier, P. (2018). When structural violences create a context that facilitates sexual assault and intimate partner violence against street-involved young women. *Women's Studies International Forum, 68*, 94–103.

Ford, J., & Soto-Marquez, J. G. (2016). Sexual Assault Victimization Among Straight, Gay/Lesbian, and Bisexual College Students. *Violence and Gender*, *3*(2), 107–115.

Formby, E. (2015). Limitations of focussing on homophobic, biphobic and transphobic 'bullying' to understand and address LGBT young people's experiences within and beyond school. *Sex Education*, *15*(6), 626–640.

Fowler, F. J. (2014). *Survey research methods* (5th ed.). Los Angeles, CA: SAGE.

Fricker, M. (2007). *Epistemic injustice : power and the ethics of knowing*. New York: Oxford University Press.

Frith, H., & Gleeson, K. (2012). Qualitative data collection: asking the right questions. In D. Harper & A. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 55–68). West Sussex: Wiley-Blackwell.

Frohard-Dourlent, H., Dobson, S., Clark, B. A., Doull, M., & Saewyc, E. M. (2017). “I would have preferred more options”: accounting for non-binary youth in health research. *Nursing Inquiry*, *24*(1),

Frost, D. M. (2017). The Benefits and Challenges of Health Disparities and Social Stress Frameworks for Research on Sexual and Gender Minority Health. *Journal of Social Issues*, *73*(3), 462–476.

Galop. (n.d.). Young People (16-25) – Galop. Retrieved December 7, 2018, from http://www.galop.org.uk/young-people-16-25/

Galop. (2019). Recruiting: Research and Policy Development Officer – Galop. Retrieved May 10, 2019, from https://www.galop.org.uk/recruiting-research-and-policy-development-officer/

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual, and transgender?*

Gavey, N. (2013). *Just Sex? The Cultural Scaffolding of Rape*. Hove: Routledge.

Giddens, A. (1991). *Modernity and self-identity*. Cambridge: Policy Press.

Gilbert. (2009). Introducing Compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*, 199–208.

Gilbert, P. (1989). *Human nature and suffering*. Hove: Lawrence Erlbaum Associates.

Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behaviour psychopathology and culture* (pp. 3–36). New York: Oxford University Press.

Gilbert, P. (2000). The relationship of shame, social anxiety and depression: the role of the evaluation of social rank. *Clinical Psychology & Psychotherapy*, *7*(3), 174–189.

Gilbert, P. (2003). Evolution, Social Roles and the Differences in Shame and Guilt. *Social Research*, (70), 1205–1230.

Gilbert, P. (2006). A biopsychosocial and evolutionary approach to formulation with a special focus on shame. In N. Tarrier (Ed.), *Case Formulation in Cognitive Behaviour Therapy: The treatment of challenging and complex case* (pp. 81–113). East Sussex: Routledge.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199–208.

Gilbert, P., Cheung, M. S.-P., Grandfield, T., Campey, F., & Irons, C. (2003). Recall of threat and submissiveness in childhood: development of a new scale and its relationship with depression, social comparison and shame. *Clinical Psychology & Psychotherapy*, *10*(2), 108–115

Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory*, *12*(4), 507–516.

Gilbert, P., & Irons, C. (2005). Therapies for shame and self-attacking, using cognitive, behavioural, emotional imagery and compassionate mind training. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). London: Routledge.

Gilbert, P., & Irons, C. (2009). Shame, self-criticism, and self-compassion in adolescence. Retrieved from http://self-compassion.org/wp-

Gilbert, P., Irons, C., Olsen, K., Gilbert, J., & McEwan, K. (2006). Interpersonal sensitivities: Their links to mood, anger and gender. *Psychology and Psychotherapy: Theory, Research and Practice*, *79*(1), 37–51.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(3), 239–255.

Gilbert, P., & Miles, J. N. . (2000). Sensitivity to Social Put-Down: it's relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and Individual Differences*, *29*(4), 757–774.

Giordano, S. (2018). Understanding the emotion of shame in transgender individuals – some insight from Kafka.

Gkiouleka, A., Huijts, T., Beckfield, J., & Bambra, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions - A research agenda. *Social Science & Medicine*, *200*, 92–98.

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

Good Night Out Campaign. (n.d.). Retrieved April 29, 2019, from http://www.goodnightoutcampaign.org/

Goss, K., Gildert, P., & Allan, S. (1994). *An exploration of shame measure-I: The Other As Shamer scale*. *Personality and individual Differences* (Vol. 17).

Government Equalities Office. (2018). *LGBT SURVEY SUMMARY REPORT*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722314/GEO-LGBT-Survey-Report.pdf

Graham, J. W. (2009). Missing Data Analysis: Making It Work in the Real World. *Annual Review of Psychology*, *60*(1), 549–576.

Albuquerque, G.A. (2016). Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review. *BMC international health and human rights*, *16*(1), 2.

Greene, D. C., & Britton, P. J. (2015). Predicting Adult LGBTQ Happiness: Impact of Childhood Affirmation, Self-Compassion, and Personal Mastery. *Journal of LGBT Issues in Counseling*, *9*(3), 158–179.

Greene, D. C., & Britton, P. J. (2016). Journal of LGBT Issues in Counseling Predicting Adult LGBTQ Happiness: Impact of Childhood Affirmation, Self-Compassion, and Personal Mastery.

Greeson, M. R., Campbell, R., & Fehler-Cabral, G. (2014). Cold or caring? Adolescent sexual assault victims' perceptions of their interactions with the police. *Violence and Victims*, *29*(4), 636–651.

Greifinger, R., Batchelor, M., & Fair, C. (2013). Improving Engagement and Retention in Adult Care Settings for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth Living with HIV: Recommendations for Health Care Providers. *Journal of Gay & Lesbian Mental Health*, *17*(1), 80–95.

Grubb, A., & Turner, E. (2012). Attribution of blame in rape cases: A review of the impact of rape myth acceptance, gender role conformity and substance use on victim blaming. *Aggression and Violent Behavior*, *17*(5), 443–452.

Gruber, J. E., & Fineran, S. (2008). Comparing the Impact of Bullying and Sexual Harassment Victimization on the Mental and Physical Health of Adolescents. *Sex Roles*, *59*(1–2), 1–13.

Hall, J. H., & Zautra, A. J. (2010). Indicators of community resilience: What are they, why bother? In J. W. Reich, A. J. Zautra, & J. S. Hall (Eds.), *Handbook of adult resilience* (pp. 350–375). New York, NY: Guilford Press.

Hardy, S.-J., & Chakraborti, N. (2015). *LGB&T Hate Crime Reporting: Identifying Barriers and Solutions*.

Harrison, J., Grant, J., & Herman, J. L. (2011). *A Gender Not Listed Here: Genderqueers, Gender Rebels, and OtherWise in the National Transgender Discrimination Survey* (Vol. 2).

Harvey, S., Mitchell, M., Keeble, J., McNaughton Nicholls, C., & Nilufer, R. (2014). *Barriers Faced by Lesbian, Gay, Bisexual and Transgender People in Accessing Domestic Abuse, Stalking and Harassment, and Sexual Violence Services*. Cardiff. Retrieved from http://www.eiapractice.wales.nhs.uk/sitesplus/documents/1126/1 Welsh Govt - 2014 - Barriers faced by LGBT people in accessing domestic abuse%2C stalking and harassment%2C and sexual violence services.pdf

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *American Journal of Public Health*, *100*(3), 452–459.

Healicon, A. (2016). *The politics of sexual violence: Rape, identity and feminism*. New York: Palgrave MacMillan.

Hedges, F. (2005). *An intoduction to systemic therapy with individuals: a social constructionist approach*. Houndmills, Basingstoke: Palgrave MacMillan.

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, *44*, 227–239.

Henry, N., & Powell, A. (2018). Technology-Facilitated Sexual Violence: A Literature Review of Empirical Research. *Trauma, Violence, & Abuse*, *19*(2), 195–208.

Herek, G. M. (2004). Beyond “Homophobia”: Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research and Social Policy*, *1*(2), 6–24.

Herek, G. M. (2007). Confronting Sexual Stigma and Prejudice: Theory and Practice. *Journal of Social Issues*, *63*(4), 905–925.

Herek, G. M., & Garnets, L. D. (2007). Sexual Orientation and Mental Health. *Annual Review of Clinical Psychology*, *3*(1), 353–375.

Hester, M., Williamson, E., Regan, L., Coulter, M., Chantler, K., Gangoli, G., … Green, L. (2012). *Exploring the service and support needs of male, lesbian, gay, bi-sexual and transgendered and black and other minority ethnic victims of domestic and sexual violence: Report prepared for Home Office SRG/06/017*. Retrieved from http://www.crimereduction.homeoffice.gov.uk/violentcrime/dv03a.htm#4

Hlavka, H. (2016). *Speaking of Stigma and the Silence of Shame: Young Men and Sexual Victimization*. *Men and Masculinities* (Vol. 20).

Hlavka, H. R. (2014). Normalizing Sexual Violence. *Gender & Society*, *28*(3), 337–358.

Hodson, L. (2019). Sexual orientation and the European Convention on Human Rights: What of the “L” in LGBT? *Journal of Lesbian Studies*, 1–14.

Hoffman, N. D., Freeman, K., & Swann, S. (2009). Healthcare Preferences of Lesbian, Gay, Bisexual, Transgender and Questioning Youth. *Journal of Adolescent Health*, *45*(3), 222–229.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently : free association, narrative and the interview method*. SAGE.

Hoxmeier, J. C. (2016). Sexual Assault and Relationship Abuse Victimization of Transgender Undergraduate Students in a National Sample. *Violence and Gender*, *3*(4), 202–207.

Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Hudson-Sharp, N., & Metcalf, H. (2016). *Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/539682/160719_REPORT_LGBT_evidence_review_NIESR_FINALPDF.pdf

Hughes, E., Rawlings, V., & McDermott, E. (2018). Mental Health Staff Perceptions and Practice Regarding Self-Harm, Suicidality and Help-Seeking in LGBTQ Youth: Findings from a Cross-Sectional Survey in the UK. *Issues in Mental Health Nursing*, *39*(1), 30–36.

Hunter, S. C., Houghton, S., & Wood, L. (2015). Positive Mental Well-being in Australian Adolescents: Evaluating the Warwick-Edinburgh Mental Well-being Scale. *The Australian Educational and Developmental Psychologist*, *32*(02), 93–104.

Independent Mental Health Taskforce. (2016). *THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Ingraham, C. (2006). Thinking Straight, Acting Bent: Heteronormativity and Homosexuality. In K. Davis, M. Evans, & J. Lorber (Eds.), *Handbook of gender and women's studies* (pp. 307–321). London: Sage.

Jackson, S. (2006). Interchanges: Gender, sexuality and heterosexuality: The complexity (and limits) of heteronormativity. *Feminist Theory*, *7*(1), 105–121.

Joffe, H., & Yardley, L. (2004). Content and Thematic Analysis. In D. Marks & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 56–68). SAGE.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher*, *33*(7), 14–26.

Johnstone, L. (2013). Diagnosis and Formulation. In J. Cromby, D. Harper, & P. Reavey (Eds.), *Psychology, Mental Health, and Distress* (pp. 101–115).

Jones-Chesters, M. (2007). Models: A pragmatic perspective. *Journal of Critical Psychology, Counselling and Psychotherapy*, *7*(4), 247–257.

Kahle, L. (2018). Feminist and queer criminology: A vital place for theorizing LGBTQ youth. *Sociology Compass*, *12*(3),

Kaufman, G. (1989). *The psychology of shame: Theory and treatment of shame-based syndromes*. New York: Springer.

Keng, S.-L., & Kenny Liew, W. L. (2016). Trait Mindfulness and Self-Compassion as Moderators of the Association Between Gender Nonconformity and Psychological Health. *Mindfulness*, *8*(3), 615–626.

Keyes, C. L. M. (2002). The Mental Health Continuum: From Languishing to Flourishing in Life. *Journal of Health and Social Behavior*, *43*(2), 207.

Keyes, C. L. M. (2006). The Subjective Well-Being of America's Youth: Toward a Comprehensive Assessment. - PsycNET. *Adolescent & Family Health*, *4*(1), 3–11.

Khadr, S., Clarke, V., Wellings, K., Villalta, L., Goddard, A., Welch, J.,Viner, R. (2018). Mental and sexual health outcomes following sexual assault in adolescents: a prospective cohort study. *The Lancet Child & Adolescent Health*, *2*(9), 654–665.

Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. P. (2013). Drop the language of disorder. *Evidence-Based Mental Health*, *16*(1), 2–3.

Kinderman, P., Schwannauer, M., Pontin, E., & Tai, S. (2011). The development and validation of a general measure of well-being: the BBC well-being scale. *Quality of Life Research*, *20*(7), 1035–1042.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, *8*(1), 70.

Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A Meta-Analysis of Compassion-Based Interventions: Current State of Knowledge and Future Directions. *Behavior Therapy*, *48*(6), 778–792.

Klesse, C. (2005). Bisexual Women, Non-Monogamy and Differentialist Anti-Promiscuity Discourses. *Sexualities*, *8*(4), 445–464.

Koehler, A., Eyssel, J., & Nieder, T. O. (2018). Genders and Individual Treatment Progress in (Non-)Binary Trans Individuals. *The Journal of Sexual Medicine*, *15*(1), 102–113.

Koss, M. ., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., … White, J. (2006a). *Sexual Experiences Survey - Long Form Victimization (SES-LFV)*. Tucson, AZ. Retrieved from http://www.midss.org/content/sexual-experiences-survey-long-form-victimization-ses-lfv

Koss, M. P. (2000). Blame, shame, and community: Justice responses to violence against women. *American Psychologist*, *55*(11), 1332–1343.

Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., … White, J. (2006b). *Sexual Experiences Survey - Short Form Victimization (SES-SFV)*. Tucson, AZ.

Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., … White, J. (2007). Revising the SES: A Collaborative Process to Improve Assessment of Sexual Aggression and Victimization. *Psychology of Women Quarterly*, *31*(4), 357–370.

Kuyper, L., de Wit, J., Adam, P., & Woertman, L. (2012). Doing More Good than Harm? The Effects of Participation in Sex Research on Young People in the Netherlands. *Archives of Sexual Behavior*, *41*(2), 497–506.

Langenderfer-Magruder, L., Walls, N. E., Kattari, S. K., Whitfield, D. L., & Ramos, D. (2016a). Sexual Victimization and Subsequent Police Reporting by Gender Identity Among Lesbian, Gay, Bisexual, Transgender, and Queer Adults. *Violence and Victims*, *31*(2), 320–331.

Langenderfer-Magruder, L., Walls, N. E., Kattari, S. K., Whitfield, D. L., & Ramos, D. (2016b). Sexual Victimization and Subsequent Police Reporting by Gender Identity Among Lesbian, Gay, Bisexual, Transgender, and Queer Adults. *Violence and Victims*, *31*(2), 320–331.

Lasch, C. (1991). *The culture of Narcissism*. New York: Norton.

Leaviss, J., & Uttley, L. (2015). Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychological Medicine*, *45*(05), 927–945.

LeFrançois, B. A. (2013). Queering Child and Adolescent Mental Health Services: The Subversion of Heteronormativity in Practice. *Children & Society*, *27*(1), 1–12.

Lewis, M. (2003). The role of the self in shame social research. *An International Quarterly of the Social Sciences*, *70*, 1181–1204.

Lockard, A. J., Hayes, J. A., Neff, K. M., & Locke, B. D. (2014). Self-Compassion Among College Counseling Center Clients : An Examination of Clinical Norms and Group Differences.

Lockyer, S., & Savigny, H. (2019). Rape jokes aren't funny: the mainstreaming of rape jokes in contemporary newspaper discourse. *Feminist Media Studies*, 1–16.

Lonsway, K. A., & Fitzgerald, L. F. (1995). Attitudinal antecedents of rape myth acceptance: A theoretical and empirical reexamination. *Journal of Personality and Social Psychology*, *68*(4), 704–711.

Love, G., De Michele, G., Giakoumidaki, C., Sánchez, E. H., Lukera, M., & Cartei, V. (2017). Improving access to sexual violence support for marginalised individuals: findings from the lesbian, gay, bisexual and trans* and the black and minority ethnic communities. *Critical and Radical Social Work*, *5*(2), 163–179.

Lovibond, P. F., & Lovibond, S. H. (1995). *The Structure Of Negative Emotional States: Comparison Of The Depression Anxiety Stress Scales (Dass) With The Beck Depression And Anxiety Inventories*. *Behap. Res. Ther* (Vol. 33).

Lup, K., Trub, L., & Rosenthal, L. (2015). Instagram #Instasad?: Exploring Associations Among Instagram Use, Depressive Symptoms, Negative Social Comparison, and Strangers Followed. *Cyberpsychology, Behavior, and Social Networking*, *18*(5), 247–252.

Matos, M., Carvalho, S. A., Cunha, M., Galhardo, A., & Sepodes, C. (2017). Psychological Flexibility and Self-Compassion in Gay and Heterosexual Men: How They Relate to Childhood Memories, Shame, and Depressive Symptoms. *Journal of LGBT Issues in Counseling*, *11*(2), 88–105.

Matos, M., & Pinto-Gouveia, J. (2010). Shame as a traumatic memory. *Clinical Psychology & Psychotherapy*, *17*(4).

Matthews, P., Netto, G., & Besemer, K. (2012). “Hard-to-Reach” or ‘Easy-to-Ignore’? A rapid review of place-based policies and equality.

Mayhew, S. L., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: a case series report. *Clinical Psychology & Psychotherapy*, *15*(2), 113–138.

Mayor of London, Office for Policing and Crime, & NHS England. (2016). *Sexual Violence Against Children & Young People*. London. Retrieved from www.mbarc.co.uk

Mays, V. M., & Cochran, S. D. (2001). Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States. *American Journal of Public Health*, *91*(11), 1869–1876.

McCauley, H. L., Coulter, R. W., Bogen, K. W., & Rothman, E. F. (2018). Sexual Assault Risk and Prevention Among Sexual and Gender Minority Populations. In L. M. Orchowski & C. A. Gidycz (Eds.), *Sexual Assault Risk Reduction and Resistance: Theory, Research & Practice* (pp. 333–352). London: Elsevier.

McClinton Appollis, T., Lund, C., de Vries, P. J., & Mathews, C. (2015). Adolescents’ and adults’ experiences of being surveyed about violence and abuse: a systematic review of harms, benefits, and regrets. *American Journal of Public Health*, *105*(2),

McDermott, E. (2015). Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the 'failed' self. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *19*(6), 561–577.

McDermott, E., Hughes, E., & Rawlings, V. (2018). Norms and normalisation: understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. *Culture, Health & Sexuality*, *20*(2), 156–172.

McDermott, E., & Roen, K. (2012). Youth on the Virtual Edge. *Qualitative Health Research*, *22*(4), 560–570. https://doi.org/10.1177/1049732311425052

McdDermott, E., Roen, K., & Piela, A. (2013). Hard-to-Reach Youth Online: Methodological Advances in Self-Harm Research. *Sexuality Research and Social Policy*, *10*(2), 125–134.

McDermott, E., Roen, K., & Scourfield, J. (2008a). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality*, *10*(8), 815–829.

McDermott, E., Roen, K., & Scourfield, J. (2008b). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality*, *10*(8), 815–829.

McDonald, K. (2018). Social Support and Mental Health in LGBTQ Adolescents: A review of the literature. *Issues in Mental Health Nursing*, *39*(1), 16–29.

McGorry, P., Bates, T., & Birchwood, M. (2013). Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK. *British Journal of Psychiatry*, *202*(s54), 30–35.

McInroy, L. B. (2016). Pitfalls, Potentials, and Ethics of Online Survey Research: LGBTQ and Other Marginalized and Hard-to-Access Youths. *Social Work Research*, *40*(2), 83–94.

McKeever, N. (2018). Can a Woman Rape a Man and Why Does It Matter? *Criminal Law and Philosophy*, 1–21.

McLean, L., Bambling, M., & Steindl, S. R. (2018). Perspectives on Self-Compassion From Adult Female Survivors of Sexual Abuse and the Counselors Who Work With Them. *Journal of Interpersonal Violence*.

McLeod, A. (2007). Whose agenda? Issues of power and relationship when listening to looked-after young people. *Child & Family Social Work*, *12*(3), 278–286.

Menning, C. L., & Holtzman, M. (2014). Processes and Patterns in Gay, Lesbian, and Bisexual Sexual Assault. *Journal of Interpersonal Violence*, *29*(6), 1071–1093.

Mereish, E. H., & Poteat, V. P. (2015). A relational model of sexual minority mental and physical health: The negative effects of shame on relationships, loneliness, and health. *Journal of Counseling Psychology*, *62*(3), 425–437.

METRO Charity. (2016). *Youth Chances: Integrated Report*. Retrieved from https://metrocharity.org.uk/sites/default/files/2017-04/National Youth Chances Intergrated Report 2016.pdf

Meyer, I. H. (1995). Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behavior*, *36*(1), 38.

Meyer, I. H. (2001). Why lesbian, gay, bisexual, and transgender public health? *American Journal of Public Health*, *91*(6), 856–859.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697.

Meyer, I. H. (2007). Prejudice and Discrimination as Social Stressors. In I. H. Meyer & M. E. Northridge (Eds.), *The Health of Sexual Minorities* (pp. 242–267). Boston, MA: Springer US.

Meyer, I. H. (2015). Resilience in the Study of Minority Stress and Health of Sexual and Gender Minorities. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 209–213.

Meyer, I. H., Schwartz, S., & Frost, D. M. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine*, *67*(3), 368–379.

Miles-McLean, H., Liss, M., Erchull, M. J., Robertson, C. M., Hagerman, C., Gnoleba, M. A., & Papp, L. J. (2015). “Stop Looking at Me!”: Interpersonal Sexual Objectification as a Source of Insidious Trauma. *Psychology of Women Quarterly*, *39*(3), 363–374.

Mitchell, K. J., Ybarra, M. L., & Korchmaros, J. D. (2014a). Sexual harassment among adolescents of different sexual orientations and gender identities. *Child Abuse & Neglect*, *38*(2), 280–295.

Mitchell, K. J., Ybarra, M. L., & Korchmaros, J. D. (2014b). Sexual harassment among adolescents of different sexual orientations and gender identities. *Child Abuse & Neglect*, *38*(2), 280–295.

Monro, S., & Richardson, D. (2010). Intersectionality and Sexuality: The Case of Sexuality and Transgender Equalities Work in UK Local Government. In Y. Taylor, S. Hines, & M. . Casey (Eds.), *Theorizing Intersectionality and Sexuality* (pp. 99–118). London: Palgrave Macmillan.

Mooney, C. Z., & Duval, R. D. (1993). *Bootstrapping : a nonparametric approach to statistical inference*. London: Sage Publications.

Moradi, B., Mohr, J. J., Worthington, R. L., & Fassinger, R. E. (2009). Counseling psychology research on sexual (orientation) minority issues: Conceptual and methodological challenges and opportunities. *Journal of Counseling Psychology*, *56*(1), 5–22.

Morgan, D. L. (2014). Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, *20*(8), 1045–1053.

Moylan, C. A., & Javorka, M. (2018). Widening the Lens: An Ecological Review of Campus Sexual Assault. *Trauma, Violence, & Abuse*,

Mule, N. J., Ross, L. E., Deeprose, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT health and wellbeing through inclusive policy development. *International Journal for Equity in Health*, *8*(1), 18.

Murchison, G. R., Boyd, M. A., & Pachankis, J. E. (2017). Minority Stress and the Risk of Unwanted Sexual Experiences in LGBQ Undergraduates. *Sex Roles*, *77*(3–4), 221–238.

Muris, P., Meesters, C., Herings, A., Jansen, M., Vossen, C., & Kersten, P. (2017). Inflexible Youngsters: Psychological and Psychopathological Correlates of the Avoidance and Fusion Questionnaire for Youths in Nonclinical Dutch Adolescents. *Mindfulness*, *8*(5), 1381–1392.

Muris, P., Meesters, C. M. G., Pierik, A., & Kock, B. de. (2016). Good for the Self: Self-Compassion and Other Self-Related Constructs in Relation to Symptoms of Anxiety and Depression in Non-clinical Youths.

Murphy, A., & Hine, B. (2019). Investigating the demographic and attitudinal predictors of rape myth acceptance in U.K. Police officers: developing an evidence-base for training and professional development. *Psychology, Crime & Law*, *25*(1), 69–89.

Murray, C., Mobley, A. K., Buford, A., & Seaman-DeJohn, M. (2008). Same-Sex Intimate Partner Violence; Dynamics, Social Context, and Counseling Implications. *Journal of LGBT Issues in Counseling*, *1*(4), 7–30.

Nadal, K. L., Issa, M.-A., Leon, J., Meterko, V., Wideman, M., & Wong, Y. (2011). Sexual Orientation Microaggressions: “Death by a Thousand Cuts” for Lesbian, Gay, and Bisexual Youth. *Journal of LGBT Youth*, *8*(3), 234–259.

Nadal, K. L., Rivera, D. P., & Corpus, M. J. H. (2010). Sexual Orientation and Transgender Microagressions. In D. W. Sue (Ed.), *Microaggressions and Marginality: Manifestation, Dynamics, and Impact* (pp. 217–240). Hoboken, New Jersey: John Wiley & Sons, Ltd.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex and the birth of the self*. New York: Norton.

National Union of Students. (2010). Hidden Marks: A study of women students' experiences of harassment, stalking, violence and sexual assault. *2011*. Retrieved from https://www.nus.org.uk/Global/NUS_hidden_marks_report_2nd_edition_web.pdf

Neff, K. (2016). Test how self-compassionate you are. Retrieved May 4, 2019, from https://self-compassion.org/test-how-self-compassionate-you-are/

Neff, K. D. (2003). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity*, *2*(3), 223–250.

Neff, K. D., & Dahm, K. A. (2015). Self-Compassion: What It Is, What It Does, and How It Relates to Mindfulness. In *Handbook of Mindfulness and Self-Regulation* (pp. 121–137). New York, NY: Springer New York.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, *41*(1), 139–154.

Neff, K. D., & McGehee, P. (2010). Self-compassion and Psychological Resilience Among Adolescents and Young Adults. *Self and Identity*, *9*(3), 225–240.

Neff, K. D., & Vonk, R. (2009). Self-Compassion Versus Global Self-Esteem: Two Different Ways of Relating to Oneself. *Journal of Personality*, *77*, 1.

Ng Fat, L., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS): findings from the Health Survey for England. *Quality of Life Research*, *26*(5), 1129–1144.

NHS England. (2018). *Strategic direction for sexual assault and abuse services: Lifelong care for victims and survivors: 2018 - 2023*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf

Norton, P. J. (2007). Depression Anxiety and Stress Scales (DASS-21): Psychometric analysis across four racial groups. *Anxiety, Stress & Coping*, *20*(3), 253–265.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, *16*(1),

Office for National Statistics. (2011). *2011 Census General Report*. Retrieved from https://www.ons.gov.uk/census/2011census/howourcensusworks/howdidwedoin2011/2011censusgeneralreport

Office for National Statistics. (2017). *Sexual offences in England and Wales: year ending March 2017*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017#which-groups-of-people-are-most-likely-to-be-victims-of-sexual-assault

Office for National Statistics. (2018). *Sexual offending: victimisation and the path through the criminal justice system*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffendingvictimisationandthepaththroughthecriminaljusticesystem/2018-12-13

Ortiz-Martínez, Y., & Ríos-González, C. M. (2017). Need for more research on and health interventions for transgender people. *Sexual Health*, *14*(2), 196.

Osman, A., Wong, J. L., Bagge, C. L., Freedenthal, S., Gutierrez, P. M., & Lozano, G. (2012). The Depression Anxiety Stress Scales-21 (DASS-21): Further Examination of Dimensions, Scale Reliability, and Correlates. *Journal of Clinical Psychology*, *68*(12), 1322–1338.

Ott, V. E. (2018). Youth voice in service acceptability: Experiences of lesbian, gay, bisexual, and transgender adolescents. *Journal of Gay & Lesbian Social Services*, 1–7.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science & Medicine*, *57*, 13–24.

Patton, M. (1990). *Qualitative evaluation and research methods*. Newbury Park: Sage.

Pauley, G., & McPherson, S. (2010). The experience and meaning of compassion and self-compassion for individuals with depression or anxiety. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(2), 129–143.

Payne, E., & Smith, M. (2012). Rethinking Safe Schools Approaches for LGBTQ Students: Changing the Questions We Ask. *Multicultural Perspectives, 14(4),* 187–193. https://doi.org/10.1080/15210960.2012.725293

Pepping, C. A., Lyons, A., McNair, R., Kirby, J. N., Petrocchi, N., & Gilbert, P. (2017). A tailored compassion-focused therapy program for sexual minority young adults with depressive symotomatology: study protocol for a randomized controlled trial. *BMC Psychology*, *5*(1), 5.

Phipps, A., Ringrose, J., Renold, E., & Jackson, C. (2018). Rape culture, lad culture and everyday sexism: researching, conceptualizing and politicizing new mediations of gender and sexual violence. *Journal of Gender Studies*, *27*(1), 1–8.

Pilgrim, D. (2005). *Key concepts in mental health*. London: SAGE.

Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology*, *25*(2), 281–290.

Polit, D. E., & Beck, C. . (2006). *Essentials of Nursing Research*. Philadelphia: Lippincott Williams & Wilkins.

Potter, S. J., Fountain, K., & Stapleton, J. G. (2012). Addressing Sexual and Relationship Violence in the LGBT Community Using a Bystander Framework. *Harvard Review of Psychiatry*, *20*(4), 201–208.

Priebe, G., Bäckström, M., & Ainsaar, M. (2010). Vulnerable adolescent participants' experience in surveys on sexuality and sexual abuse: Ethical aspects. *Child Abuse & Neglect*, *34*(6), 438–447.

Priebe, G., & Svedin, C. G. (2012). Online or off-line victimisation and psychological well-being: a comparison *Eur Child Adolesc Psychiatry*, *21*, 569–582.

Probyn, E. (2005). *Blush : faces of shame*. University of Minnesota Press.

Project De-Shame. (2017). *Young people's experiences of online sexual harassment: A cross-country report*. Retrieved from https://www.childnet.com/ufiles/Project_deSHAME_Dec_2017_Report.pdf

Public Health England. (2017). *Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England Final Report*. London.

Purdie-Vaughns, V., & Eibach, R. P. (2008). Intersectional Invisibility: The Distinctive Advantages and Disadvantages of Multiple Subordinate-Group Identities. *Sex Roles*, *59*(5–6), 377–391.

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy*, *18*(3), 250–255.

Randall, M. (2010). Sexual Assault Law, Credibility, and "Ideal Victims": Consent, Resistance, and Victim Blaming. *Canadian Journal of Women and the Law*, *22*(2), 397–433.

Rescher, N. (2005). Pragmatism. In T. Honderich (Ed.), *The Oxford Companion to Philosophy* (2nd ed.). New York: Oxford University Press.

Retzinger, S. (1998). Shame in the therapeutic relationship. In P. Gilbert & J. Miles (Eds.), *Body shame: Conceptualisation, research and treatment* (pp. 206–222). Oxford: Oxford University Press.

Reynolds, V. (2013). 'Leaning In' as Imperfect Allies in Community Work. *Narrative and Conflict: Explorations in Theory and Practice*, *1*(1), 53–75.

Richards, C., Bouman, W. P., Seal, L., Barker, M. J., Nieder, T. O., & T'Sjoen, G. (2016). Non-binary or genderqueer genders. *International Review of Psychiatry*, *28*(1), 95–102.

Rights Info. (2019). Rape Victims Silenced By Requirement To Submit Mobile Phone Data. Retrieved April 29, 2019, from https://rightsinfo.org/rape-victims-silenced-by-requirement-to-submit-mobile-phone-data/

Robertson, M. A. (2014). "How Do I Know I Am Gay?": Understanding Sexual Orientation, Identity and Behavior Among Adolescents in an LGBT Youth Center. *Sexuality & Culture*, *18*(2), 385–404.

Rollè, L., Giardina, G., Caldarera, A. M., Gerino, E., & Brustia, P. (2018). When Intimate Partner Violence Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. *Frontiers in Psychology*, *9*, 1506.

Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist*, *71*(6), 474–485.

Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The Prevalence of Sexual Assault Against People Who Identify as Gay, Lesbian, or Bisexual in the United States: A Systematic Review. *Trauma, Violence, & Abuse*, *12*(2), 55–66.

Russell, G. M., & Bohan, J. S. (2006). The Case of Internalized Homophobia: Theory and/as Practice. *Theory & Psychology*, *16*(3), 343–366.

Ryan, R. M., & Deci, E. L. (2001). On Happiness and Human Potentials: A Review of Research on Hedonic and Eudaimonic Well-Being. *Annual Review of Psychology*, *52*(1), 141–166.

Ryan, W. S., Legate, N., & Weinstein, N. (2015). Coming out as lesbian, gay, or bisexual: The lasting impact of initial disclosure experiences. *Self and Identity, 14(5)*, 549-569.

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23(4)*, 205-213.

Rymer, S., & Cartei, V. (2015). Supporting transgender survivors of sexual violence: learning from users' experiences. *Critical and Radical Social Work*, *3*(1), 155–164.

Sabina, C., & Ho, L. Y. (2014). Campus and College Victim Responses to Sexual Assault and Dating Violence. *Trauma, Violence, & Abuse*, *15*(3), 201–226.

Sable, M. R., Danis, F., Mauzy, D. L., & Gallagher, S. K. (2006). Barriers to Reporting Sexual Assault for Women and Men: Perspectives of College Students. *Journal of American College Health*, *55*(3), 157–162.

Sarkar, N. N., & Sarkar, R. (2005). Sexual assault on woman: Its impact on her life and living in society. *Sexual and Relationship Therapy*, *20*(4), 407–419.

Schelbe, L., Chanmugam, A., Moses, T., Saltzburg, S., Williams, L. R., & Letendre, J. (2015). Youth participation in qualitative research: Challenges and possibilities. *Qualitative Social Work: Research and Practice*, *14*(4), 504–521.

Scheper-Hughes, N. (2006). Dangerous and Endangered Youth: Social Structures and Determinants of Violence. *Annals of the New York Academy of Sciences, 1036(1)*, 13–46.

Scourfield, J., Roen, K., & McDermott, L. (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: resilience, ambivalence and self-destructive behaviour. *Health & Social Care in the Community*, *16*(3), 329–336.

Sedgwick, E. K., & Frank, A. (2003). *Touching feeling : affect, pedagogy, performativity*. Duke University Press.

Seligowski, A. V., Miron, L. R., & Orcutt, H. K. (2015). Relations Among Self-Compassion, PTSD Symptoms, and Psychological Health in a Trauma-Exposed Sample. *Mindfulness*, *6*(5), 1033–1041.

Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, *16*(1), 67.

Sexual Offences Act 2003. UK Government. Retrieved from https://www.legislation.gov.uk/ukpga/2003/42/contents

Shaw, J., Campbell, R., Cain, D., & Feeney, H. (2017). Beyond surveys and scales: How rape myths manifest in sexual assault police records. *Psychology of Violence*, *7*(4), 602–614.

Sherriff, N. S., Hamilton, W. E., Wigmore, S., Giambrone, B. L. B., Tunstall, B., Hall, C., … Browne, K. (2011). 'What Do You Say To Them?'; Investigating And Supporting The Needs Of Lesbian, Gay, Bisexual, Trans, And Questioning (Lgbtq) Young People Young People In Focus. *Journal Of Community Psychology*, *39*(8), 939–955.

Sigurvinsdottir, R., & Ullman, S. E. (2016). Sexual Assault in Bisexual and Heterosexual Women Survivors. *Journal of Bisexuality*, *16*(2), 163–180.

Smail, D. (2005). *Power, interest and psychology: Elements of a social materialist understanding of distress*. PCCS books.

Smith, B. (2015). The Existence of a Hidden Curriculum in Sex and Relationships Education in Secondary Schools. *British Education Studies Association Journals*, *1*(1), 42–55.

Smith, C. P., Cunningham, S. A., & Freyd, J. J. (2016). Sexual violence, institutional betrayal, and psychological outcomes for LGB college students. *Translational Issues in Psychological Science*, *2*(4), 351–360.

Spierings, N. (2012). The inclusion of quantitative techniques and diversity in the mainstream of feminist research. *European Journal of Women's Studies*, *19*(3), 331–347.

Steenkamp, M. M., Dickstein, B. D., Salters-Pedneault, K., Hofmann, S. G., & Litz, B. T. (2012). Trajectories of PTSD symptoms following sexual assault: Is resilience the modal outcome? *Journal of Traumatic Stress*, *25*(4), 469–474.

Stemple, L., Flores, A., & Meyer, I. H. (2017). Sexual victimization perpetrated by women: Federal data reveal surprising prevalence. *Aggression and Violent Behavior*, *34*, 302–311.

Stewart-Brown, S., Platt, S., Tennant, A., Maheswaran, H., Parkinson, J., Weich, S., Clarke, A. (2011). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a valid and reliable tool for measuring mental well-being in diverse populations and projects. *Journal of Epidemiology & Community Health*, *65*(Suppl 2), A38–A39.

Stewart-Brown, S., Tennant, A., Tennant, R., Platt, S., Parkinson, J., & Weich, S. (2009). Internal construct validity of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a Rasch analysis using data from the Scottish Health Education Population Survey. *Health and Quality of Life Outcomes*, *7*(1), 15.

Stonewall. (2015). *AN INTRODUCTION TO SUPPORTING LGBT YOUNG PEOPLE A GUIDE FOR SCHOOLS*. Retrieved from www.stonewall.org.uk/get-involved/education

Stonewall. (2016). *Do Ask, Do Tell: Capturing data on sexual orientation and gender identity globally*. Retrieved from https://www.stonewall.org.uk/sites/default/files/do_ask_do_tell_guide_2016.pdf

Stonewall. (2019). Historic announcement on LGBT inclusion in England's schools. Retrieved May 10, 2019, from https://www.stonewall.org.uk/about-us/news/historic-announcement-lgbt-inclusion-england's-schools

Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Violent Behavior*, *14*(3), 170–179.

Suarez, E., & Gadalla, T. M. (2010). Stop Blaming the Victim: A Meta-Analysis on Rape Myths. *Journal of Interpersonal Violence*, *25*(11), 2010–2035.

Sun, J. (2014). Mindfulness in Context: A Historical Discourse Analysis. *Contemporary Buddhism*, *15*(2), 394–415.

Szabó, M. (2010). The short version of the Depression Anxiety Stress Scales (DASS-21): Factor structure in a young adolescent sample. *Journal of Adolescence*, *33*(1), 1–8.

Tabachnick, B. G., & Fidell, L. S. (2013). *Using Multivariate Statistics* (6th ed.). Essex: Pearson Education.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford Press.

Tangney, J. P., & Fischer, K. W. (1995). *The self-conscious emotions: shame, guilt, embarrassment, and pride*. New York: Guilford Press.

The British Psychological Society. (2014). *Code of Human Research Ethics*. Leicester. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy - Files/BPS Code of Human Research Ethics.pdf

The Guardian. (2019, April 29). Rape cases 'could fail' if victims refuse to give police access to phones. Retrieved April 29, 2019, from https://www.theguardian.com/society/2019/apr/29/new-police-disclosure-consent-forms-could-free-rape-suspects

Thorne, N., Witcomb, G. L., Nieder, T., Nixon, E., Yip, A., & Arcelus, J. (2018). A comparison of mental health symptomatology and levels of social support in young treatment seeking transgender individuals who identify as binary and non-binary. *International Journal of Transgenderism*, 1–10.

Todahl, J. L., Linville, D., Bustin, A., Wheeler, J., & Gau, J. (2009). Sexual Assault Support Services and Community Systems. *Violence Against Women*, *15*(8), 952–976.

Tomsen, S., & Mason, G. (2001). Engendering homophobia: violence, sexuality and gender conformity. *Journal of Sociology*, *37*(3), 257–273.

Turchik, J. A., & Edwards, K. M. (2012). Myths about male rape: A literature review. *Psychology of Men & Masculinity*, *13*(2), 211–226.

Turchik, J. A., Hebenstreit, C. L., & Judson, S. S. (2016). An Examination of the Gender Inclusiveness of Current Theories of Sexual Violence in Adulthood. *Trauma, Violence, & Abuse*, *17*(2), 133–148.

Ullman, S. E. (1996). Social Reactions, Coping Strategies, and Self-Blame Attributions in Adjustment to Sexual Assault. *Psychology of Women Quarterly*, *20*(4), 505–526.

van der Bruggen, M., & Grubb, A. (2014). A review of the literature relating to rape victim blaming: An analysis of the impact of observer and victim characteristics on attribution of blame in rape cases. *Aggression and Violent Behavior*, *19*(5), 523–531.

Vidal, M. E., & Petrak, J. (2007). Shame and adult sexual assault: a study with a group of female survivors recruited from an East London population. *Sexual and Relationship Therapy*, *22*(2), 159–171.

Wade, A. (1997). Small Acts of Living: Everyday Resistance to Violence and Other Forms of Oppression. *Contemporary Family Therapy*, *19*(1), 23–39.

Wagaman, M. A. (2014). Understanding Service Experiences of LGBTQ Young People Through an Intersectional Lens. *Journal of Gay & Lesbian Social Services*, *26*(1), 111–145.

Wagaman, M. A. (2015). Changing Ourselves, Changing the World: Assessing the Value of Participatory Action Research as an Empowerment-Based Research and Service Approach With LGBTQ Young People. *Child & Youth Services*, *36*(2), 124–149.

Wager, N. M. (2012). Respondents' Experiences of Completing a Retrospective Web-Based, Sexual Trauma Survey: Does a History of Sexual Victimization Equate With Risk for Harm? *Violence and Victims*, *27*(6), 991–1004.

Walch, S. E., Ngamake, S. T., Bovornusvakool, W., & Walker, S. V. (2016). Discrimination, internalized homophobia, and concealment in sexual minority physical and mental health. *Psychology of Sexual Orientation and Gender Diversity*, *3*(1), 37–48.

Walsh, W. A., Banyard, V. L., Moynihan, M. M., Ward, S., & Cohn, E. S. (2010). Disclosure and Service Use on a College Campus After an Unwanted Sexual Experience. *Journal of Trauma & Dissociation*, *11*(2), 134–151.

Walsh, Z. (2016). A Meta-Critique of Mindfulness Critiques: From McMindfulness to Critical Mindfulness (pp. 153–166). Springer, Cham.

Walton, M. T., Lykins, A. D., & Bhullar, N. (2016). Beyond Heterosexual, Bisexual, and Homosexual: A Diversity in Sexual Identity Expression. *Archives of Sexual Behavior*, *45*(7), 1591–1597.

Warner, J., Mckeown, É., Griffin, M., Johnson, K., Ramsay, A., Cort, C., & King, M. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. *British Journal of Psychiatry*, *185*(06), 479–485.

Weiss, J. (2011). Reflective Paper: GL Versus BT: The Archaeology of Biphobia and Transphobia Within the U.S. Gay and Lesbian Community. *Journal of Bisexuality*, *11*(4), 498–502.

Weiss, K. G. (2010). Too Ashamed to Report: Deconstructing the Shame of Sexual Victimization. *Feminist Criminology*, *5*(3), 286–310.

Welch, S., Collings, S. C. D., & Howden-Chapman, P. (2000). Lesbians in New Zealand: Their Mental Health and Satisfaction with Mental Health Services. *Australian & New Zealand Journal of Psychiatry*, *34*(2), 256–263.

Wells, G. B. (2004). Lesbians in Psychotherapy. *Journal of Psychology & Human Sexuality*, *15*(2–3), 101–116.

Wells, G. B., & Hansen, N. D. (2003). Lesbian Shame. *Journal of Homosexuality*, *45*(1), 93–110.

West, C. (1995). Theory, pragmatisms, and politicsitle. In R. Hollinger & D. Depew (Eds.), *Pragmatism: From progressivism to postmodernism* (pp. 314–3226). Westport, CT: Praeger.

White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, *147*, 222–231.

WHO | Global status report on violence prevention 2014. (2018). *WHO*. Retrieved from https://www.who.int/violence_injury_prevention/violence/status_report/2014/en/

Wilkinson, S., Joffe, H., & Yardley, L. (2004). Qualitative Data Collection: Interviews and Focus Groups. In D. F. Marks & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 39–55). London.

Willemsen, J., Markey, S., Declercq, F., & Vanheule, S. (2011). Negative emotionality in a large community sample of adolescents: the factor structure and measurement invariance of the short version of the depression anxiety stress scales (DASS-21). *Stress and Health*, *27*(3), e120–e128.

Williams, T., Connolly, J., Pepler, D., & Craig, W. (2005). Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents. *Journal of Youth and Adolescence*, *34*(5), 471–482.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Wyss, S. E. (2004). 'This was my hell': the violence experienced by gender non-conforming youth in US high schools. *International Journal of Qualitative Studies in Education*, *17*(5), 709–730.

Yadavaia, J. E., & Hayes, S. C. (2012). Acceptance and Commitment Therapy for Self-Stigma Around Sexual Orientation: A Multiple Baseline Evaluation. *Cognitive and Behavioral Practice*, *19*(4), 545–559.

Yoon, E., Stiller Funk, R., & Kropf, N. P. (2010). Sexual Harassment Experiences and Their Psychological Correlates Among a Diverse Sample of College Women. *Affilia*, *25*(1), 8–18.

YouGov. (2018). How young are “young people”? And at what age does a person become “old”? | YouGov. Retrieved December 7, 2018, from https://yougov.co.uk/topics/politics/articles-reports/2018/03/06/how-young-are-young-people-and-what-age-does-perso

Youth | METRO Charity. (n.d.). Retrieved December 7, 2018, from https://metrocentreonline.org/youth

## 6. APPENDICES

### Appendix A: Literature Review One: LGBTQ+ Young People's Experiences of Sexual Violence

Search terms pertaining to sexual violence included; 'sex crimes', 'sexual assault', 'sexual harassment', 'unwanted sexual contact'. Search terms pertaining to LGBTQ+ young people included; 'youth', 'young people', 'students', 'LGBT', 'transgender', 'lesbian', 'gender non-conforming'.

Inclusion and exclusion criteria were used to identify relevant publications to reduce bias:

Inclusion criteria:

- Studies that included some measure or description of psychological distress
- Studies that included lesbian, gay, bisexual, trans or queer young people aged 13+
- Studies which explicitly measured or described experiences of sexual violence

Exclusion criteria:

- Studies which did not separate experiences of sexual violence from other experiences of violence
- Studies not written in English

Abstracts of all the studies were read and their reference lists reviewed. 39 studies were retrieved from EBSCO (5 met the inclusion criteria), 56 were retrieved from Scopus (1 met the inclusion criteria), and 1 from Google Scholar. As a result, the literature review contained 7 studies.

## Appendix B: Literature Review Two: UK LGBTQ+ People and Shame or Compassion

Search terms pertaining to shame or compassion included ‘shame’, ‘internal shame’ ‘compassion’, ‘compassion focused therapy’. Search terms pertaining to LGBTQ+ people included; ‘LGBT’, ‘queer’, ‘gay’.

Inclusion and exclusion criteria were used to identify relevant publications to reduce bias:

Inclusion criteria:

- Studies that explored shame and/or compassion
- Studies that included lesbian, gay, bisexual, trans or queer young people aged 13+

Exclusion criteria:

- Studies not based in a UK context
- Studies not written in English

Abstracts of all the studies were read and their reference lists reviewed. 42 studies were retrieved from EBSCO (1 met the inclusion criteria), 7 were retrieved from Scopus (2 met the inclusion criteria, 1 was the same study as retrieved from EBSCO). The literature review subsequently contained 2 studies.

## Appendix C: Literature Three: LGBTQ+ Experiences of Services for Sexual Violence

Search terms pertaining to services included ‘health care services’ ‘community services ‘health care utilisation’. Search terms pertaining to LGBTQ+ people included; ‘LGBT’, ‘queer’, ‘gay’. Search terms pertaining to sexual violence included; ‘sex crimes’, ‘sexual assault’.

Inclusion and exclusion criteria were used to identify relevant publications to reduce bias:

Inclusion criteria:

- Studies or reports with LGBTQ+ groups
- Studies or reports which investigated experiences of services for sexual violence or barriers to services for sexual violence

Exclusion criteria:

- Studies not based in a UK context
- Studies not written in English

Abstracts of all the studies were read and their reference lists reviewed. 42 studies were retrieved from EBSCO (1 met the inclusion criteria), 84 were retrieved from Scopus (2 met the inclusion criteria). 1 study was retrived from a Google search of grey literature. The literature review therefore contained 4 publications.

## Appendix D: Ethical Approval

**School of Psychology Research Ethics Committee**

**NOTICE OF ETHICS REVIEW DECISION**

**For research involving human participants**
**BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology**

REVIEWER: Helena Bunn
SUPERVISOR: Trishna Patel
STUDENT: Sophie Jones
**Course**: Professional Doctorate in Clinical Psychology
Title of proposed study: TBC
DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

| Approved with minor amendments |
|---|

Minor amendments required *(for reviewer)*:
Please assure consistency related to the interview phase - In Participant information sheet (pp22) and Interview - Participant information sheet (p27), Sophie mentions about Skype interview or Skype / Face time (p28), nonetheless previously there were a number of options mentioned (including telephone).

Please mention about how (if) you record the interview in the Interview - Participant information sheet.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.
Student's name (Typed name to act as signature): Sophie Jones
Student number: U1622872
Date: 10/07/2018
(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)
ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*
Has an adequate risk assessment been offered in the application form?
YES / NO
Please request resubmission with an adequate risk assessment
If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH
Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

Reviewer comments in relation to researcher risk (if any).

**Reviewer** (Typed name to act as signature): H Bunn
**Date**: 4.7.18
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee
RESEARCHER PLEASE NOTE:
For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.
For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

## Appendix E: Participant Information Sheet - Survey


**Participant information sheet**
**Experiences of shame, compassion and sexual violence for LGBTQ young people**
Hello,

Thank you for logging on. I'm Sophie Jones and I am a trainee Clinical Psychologist studying at the University of East London and I would like you take part in this research project.

It's important you know why the research project is being done and what to expect. This page explains the project – please read through the information before you decide if you want to take part. You might want to talk about it with people you trust.

If you have any questions or worries you can contact me – my details are at the bottom of the page.

There are two parts: 1. This online survey, 2. Skype interview. If you complete the survey, you can offer to complete a Skype interview (but you don't have to – you can complete the survey only). If you offer to be interviewed, I will send you another information sheet about the interview, and you can decide if you would like to be interviewed after this reading it. Between 8 – 12 people who offer to be interviewed will be chosen randomly and contacted by me by 31/03/2019.

**What is the purpose of the study?**

- To investigate feelings of shame, compassion, and experiences of sexual violence, and these affect psychological distress and wellbeing.
- To explore LGBTQ+ young peoples' experiences of services and how services can be improved

This is important because LGBTQ young people experience more sexual violence than straight young people and, due to other negative experiences (e.g. homophobia or transphobia), can feel more shame. It is hoped that the findings of the study will improve services for LGBTQ young people.

Sexual violence is:

- Any type of sexual harassment, like sexual name calling e.g. 'slut', or threatening to do something sexually to you.
- Someone touching you without your consent e.g. groping you without your permission like squeezing your bum.
- Sexual assault or rape such as forced oral sex, when someone has sex with you without your consent e.g. because you are asleep or because they force themselves on you.

The people that do this to you could be someone you know, like a partner or a friend, or a stranger.

**Why have I been invited?**
Because you identify as lesbian, gay, bisexual, transgender, queer or questioning and you are aged 16 – 25 and have experienced sexual violence one or more times.

**Do I have to take part?**
No. Participation is completely voluntary and you can withdraw without giving a reason. If you withdraw while completing the survey (e.g. by logging off) all your information will be deleted. If you withdraw after submitting the survey, it is not possible to delete your information as its anonymous and I will not be able to identify you.

**What will I be asked to do if I agree to take part?**
You will be asked to complete 9 online questionnaires. There are no right or wrong answers. You can take breaks and come back to the survey. The survey should take around 20-30 minutes.

**Are there any disadvantages or risks to taking part?**
Some of the questionnaires will ask about difficult experiences, feelings and thoughts. This can be upsetting and it can help to take breaks – you can 'pause' the survey.
At the bottom of this page there are services you can contact for support. This information will also be displayed when you submit the survey. You can also contact me if you are feeling worried about the survey.

**Compensation**
Everyone who completes the survey will be in a draw to win one of four £15 Amazon vouchers. If you are interviewed, you will receive a £5 Amazon voucher.

**Complaints**
If you have any concerns, you can contact me, Sophie Jones, or the project supervisor, Dr Trishna Patel. Our details are at the bottom of the page. If you would like to make a formal complaint please contact Dr Mark Finn Chair of the UEL School of Psychology Research Ethics Sub-committee. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk).

**Will the information I provide remain confidential?**
All the information you provide is completely confidential. You do not need to provide any identifying information. To be in the draw to win an Amazon voucher you need to provide some contact details (e.g. email address or mobile number). However, this will be stored separately from your survey data.
If you offer to participate in the interviews, your contact data will be stored separately from your survey data and there will be no way of identifying the survey data submitted as yours. Only myself and my supervisor will have access to the anonymous survey data and this will be password protected on a computer system.
If you are interviewed, you will be given a pseudonym (a fake name) and potentially identifiers (e.g. names of local services) will be changed. Again, only myself and my research supervisor will have access to the anonymised interview data and this will be password protected on a computer system.

**What will happen to the results of the research study?**
The results of the research project will be written up a doctoral thesis and submitted for publication in psychological journals. The findings will also be published and distributed across support services and it is hoped it will inform how services support LGBTQ young people. Your identity will be anonymous in all written documents of this project. The data will be stored securely for three years and then deleted.

**Who can I contact following the study if I have any questions?**
The researcher, Sophie Jones, can be contacted at:
School of Psychology
The University of East London Stratford Campus
Water Lane
London 95 E15 4LZ
E-mail: u1622872@uel.ac.uk

The research supervisor, Dr Trishna Patel, can be contacted at:
School of Psychology
The University of East London Stratford Campus
Water Lane
London E15 4LZ
Email: t.patel@uel.ac.uk

***Support services***
**LGBTQ services:**
**Stonewall**
***Website - http://www.stonewall.org.uk/***
***Phone number - 08000 50 20 20 (Mon-Fri 9:30am - 5:30pm)***
***Email – info@stonewall.org.uk***
A national campaigning organisation which also provides a directory of local services for support and advice for LGBTQ people http://www.stonewall.org.uk/help-advice/whats-my-area
**Galop**
***Website - http://www.galop.org.uk/***
***Phone – 0800 999 5428 (National LGBT domestic violence helpline)***
***Email – help@galp.org.uk***
The LGBT+ anti-violence charity, it supports LGBTQ people who have experienced hate crimes, sexual violence, or domestic abuse. They can support you if you have problems with the police or criminal justice system and you can anonymously report hate incidents.

**LGBTQ Foundation**
***Website - http://lgbt.foundation/***
***Phone number - 0345 3 30 30 30 (9am - 9pm Mon - Fri, 10am - 6pm Sat)***
***Email - helpline@lgbt.foundation***
An advice, support and information service for LGBTQ people. Based in Manchester but if you live elsewhere you can still use telephone and email services and there's a lot of information on their website, including guides if you have been affected by sexual violence http://lgbt.foundation/information-advice/sexual-violence/

**The Metro Centre**
***Website -*** *http://www.metrocentreonline.org/*
***Phone Number – 020 8305 5000***
***Email –*** *hello@metrocharity.org.uk*
The Metro Centre provides health, community and support services to LGBTQ people in London and across the South East.

**Mental health services:**

**Mind**
***Website -*** *https://www.mind.org.uk*
***Phone number - 0300 123 3393***
***Text - 86463***
***Email -*** *info@mind.org.uk*
A national mental health charity which provides information and support. Their website also lists LGBTQ mental health services here - https://www.mind.org.uk/information-support/guides-to-support-and-services/lgbtq-mental-health/useful-contacts

**The NHS**
***Website -*** *https://www.nhs.uk/Livewell/LGBhealth/Pages/Mentalhealth.aspx*
The NHS provides free healthcare, counselling and support to everyone in the UK, you can access free support through your GP.

**Sexual violence support services:**

**The Survivors Trust**
***Website -*** *http://thesurvivorstrust.org/*
***Phone - 0808 801 0818***
***Email – info@thesurvivorstrust.org***
The Survivors Trust is an 'umbrella agency' for rape, sexual violence and childhood sexual abuse support services throughout the UK and Ireland. This means they provide a detailed directory of different support services for the impact of rape, sexual violence and childhood sexual abuse, including national helplines - http://thesurvivorstrust.org/national-helplines/ and local services - http://thesurvivorstrust.org/find-support/

**Safe Line**
***Website -*** *https://www.safeline.org.uk/*
***Phone - 0808 800 5008 (10am – 4pm, Mon, Weds, Fri, 8am – 8pm Tues & Fri, 10am – 12 noon Sat)***
***Email –*** *support@safeline.org.uk*
A national charity supporting survivors of rape and sexual abuse, includes information specifically for men, women, young people and people with disabilities. They are based in Warwickshire but can provide telephone support for those based elsewhere.

**Rape Crisis England & Wales (for people who identify as women or girls)**
***Website –*** *https://rapecrisis.org.uk/*
***Phone – 0808 802 9999 between (12 noon - 2.30pm and 7 - 9.30pm every day)***
***Email - rcewinfo@rapecrisis.org.uk***
Rape Crisis England & Wales is a feminist organisation which promotes the needs rights of women and girls who have experienced sexual violence. They provide a directory of Rape Crisis services for women and girls which are run by women https://rapecrisis.org.uk/centres.php. They also provide information specifically for people who have experienced sexual harassment - https://rapecrisis.org.uk/sexualharassment.php

**Survivors UK (for people who identify as men or boys)**
***Website -*** *https://www.survivorsuk.org/*
***Phone – 02035983898 (9-5, Mon – Fri)***
***Email – info@survivorsuk.org***
***Chat via SMS text - 020 3322 1860O, or chat via Whatsapp - 074 9181 6064***
Support services for men and boys who have survived rape and sexual abuse. They provide counselling services in London and web and text chat support for those based elsewhere. Their website includes a directory of other support services - https://www.survivorsuk.org/ways-we-can-help/national-database/

## Appendix F: Participant Information Sheet – Interview

**Interview - Participant information sheet**
**Experiences of shame, compassion and sexual violence for LGBTQ young people**

Hello,

Following the survey, you have offered to be interviewed as part of this research project. Just to remind you of why the project is being done and what to expect, please read this information before you decide if you want to take part, and you might want to talk about it with people you trust.

If you have any questions or worries you can contact me – my details are at the bottom of the page.

There are two parts: 1. This online survey (which you have already completed - thank you), 2. Skype interview.

**What is the purpose of the study?**

- To investigate feelings of shame, compassion, and experiences of sexual violence, and these affect psychological distress and wellbeing.
- To explore LBGTQ young peoples' experiences of services and how services can be improved.

This is important because LGBTQ young people experience more sexual violence than straight young people and, due to other negative experiences (e.g. homophobia or transphobia), can feel more shame. It is hoped that the findings of the study will improve services for LGBTQ young people.

Sexual violence is:

- Any type of sexual harassment, like sexual name calling e.g. 'slut', or threatening to do something sexually to you.
- Someone touching you without your consent e.g. groping you without your permission like squeezing your bum.
- Sexual assault or rape such as forced oral sex, when someone has sex with you without your consent e.g. because you are asleep or because they force themselves on you.
-

The people that do this to you could be someone you know, like a partner or a friend, or a stranger.

**Why have I been invited?**

Because you identify as lesbian, gay, bisexual, transgender, queer or questioning and you are aged 16 – 25 and have experienced sexual violence one or more times.

**Do I have to take part?**

No. Participation is completely voluntary and you can withdraw without giving a reason. If you withdraw during our interview (for example, you can tell me you don't want to take part anymore), all the information you have given will be erased. If you decide later that you would like to withdraw you can contact me (contact details at the bottom of the page) and your information will be deleted up until 31/03/2019, after this the data will have been analysed and it won't be possible to change it.

**What will I be asked to do if I agree to take part?**

We will arrange a good time for us to speak over Facetime or Skype (whichever you prefer). We will need roughly one hour, but it's helpful to block out an hour and 30 minutes in case we need any extra time. I will ask you briefly about type of sexual violence you experienced (e.g. name calling, bullying or rape) and open questions about your experiences of services and ideas about what could be improved. You do not have to answer any questions you don't want to.

**Are there any disadvantages or risks to taking part?**

The interview will ask you more your experiences of services. This could be upsetting and I will ask you how you're doing during our interview and ask if you would like to take a break, if at any point you would like to have a break please just let me know.

**Compensation**

I will send you a £5 Amazon voucher – either by post or an electronic voucher via Facebook or email.

**Complaints**

If you have any concerns, you can contact me, Sophie Jones, or the project supervisor, Dr Trishna Patel. Our details are at the bottom of the page. If you would like to make a formal complaint please contact Dr Mark Finn Chair of the UEL School of Psychology Research Ethics Sub-committee. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk).

**Will the information I provide remain confidential?**

If you are interviewed, you will be given a pseudonym (a fake name) and potentially identifiers (e.g. names of local services) will be changed. Again, only myself and my research supervisor will have access to the anonymised interview data and this will be password protected on a computer system.

**What will happen to the results of the research study?**

The results of the research project will be written up a doctoral thesis and submitted for publication in psychological journals. The findings will also be published and distributed across support services and it is hoped it will inform how services support LGBTQ young people. Your identity will be anonymous in all written documents of this project. The data will be stored securely for three years and then deleted.

**Who can I contact following the study if I have any questions?**

The researcher, Sophie Jones, can be contacted at:

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The research supervisor, Dr Trishna Patel, can be contacted at:

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***Support services***

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***Phone number - 08000 50 20 20 (Mon-Fri 9:30am - 5:30pm)***

***Email – info@stonewall.org.uk***

A national campaigning organisation which also provides a directory of local services for support and advice for LGBTQ people http://www.stonewall.org.uk/help-advice/whats-my-area

**Galop**

***Website -*** *http://www.galop.org.uk/*

***Phone – 0800 999 5428 (National LGBT domestic violence helpline)***

***Email – help@galp.org.uk***

The LGBT+ anti-violence charity, it supports LGBTQ people who have experienced hate crimes, sexual violence, or domestic abuse. They can support you if you have problems with the police or criminal justice system and you can anonymously report hate incidents.

**LGBTQ Foundation**

***Website -*** *http://lgbt.foundation/*

***Phone number - 0345 3 30 30 30 (9am - 9pm Mon - Fri, 10am - 6pm Sat)***

***Email - helpline@lgbt.foundation***

An advice, support and information service for LGBTQ people. Based in Manchester but if you live elsewhere you can still use telephone and email services and there's a lot of information on their website, including guides if you have been affected by sexual violence http://lgbt.foundation/information-advice/sexual-violence/

**The Metro Centre**

***Website -*** *http://www.metrocentreonline.org/*

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***Text - 86463***
***Email -*** *info@mind.org.uk*
A national mental health charity which provides information and support. Their website also lists LGBTQ mental health services here - https://www.mind.org.uk/information-support/guides-to-support-and-services/lgbtq-mental-health/useful-contacts

**The NHS**
***Website -*** *https://www.nhs.uk/Livewell/LGBhealth/Pages/Mentalhealth.aspx*
The NHS provides free healthcare, counselling and support to everyone in the UK, you can access free support through your GP.

**Sexual violence support services:**

**The Survivors Trust**
***Website -*** *http://thesurvivorstrust.org/*
***Phone - 0808 801 0818***
***Email – info@thesurvivorstrust.org***
The Survivors Trust is an 'umbrella agency' for rape, sexual violence and childhood sexual abuse support services throughout the UK and Ireland. This means they provide a detailed directory of different support services for the impact of rape, sexual violence and childhood sexual abuse, including national helplines - http://thesurvivorstrust.org/national-helplines/ and local services - http://thesurvivorstrust.org/find-support/

**Safe Line**
***Website -*** *https://www.safeline.org.uk/*
***Phone - 0808 800 5008 (10am – 4pm, Mon, Weds, Fri, 8am – 8pm Tues & Fri, 10am – 12 noon Sat)***
***Email –*** *support@safeline.org.uk*
A national charity supporting survivors of rape and sexual abuse, includes information specifically for men, women, young people and people with disabilities. They are based in Warwickshire but can provide telephone support for those based elsewhere.

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***Website –*** *https://rapecrisis.org.uk/*
***Phone – 0808 802 9999 between (12 noon - 2.30pm and 7 - 9.30pm every day)***
***Email - rcewinfo@rapecrisis.org.uk***
Rape Crisis England & Wales is a feminist organisation which promotes the needs rights of women and girls who have experienced sexual violence. They provide a directory of Rape Crisis services for women and girls which are run by women https://rapecrisis.org.uk/centres.php. They also provide information specifically for people who have experienced sexual harassment - https://rapecrisis.org.uk/sexualharassment.php

**Survivors UK (for people who identify as men or boys)**
***Website -*** *https://www.survivorsuk.org/*
***Phone – 02035983898 (9-5, Mon – Fri)***
***Email – info@survivorsuk.org***
***Chat via SMS text - 020 3322 1860O, or chat via Whatsapp - 074 9181 6064***
Support services for men and boys who have survived rape and sexual abuse. They provide counselling services in London and web and text chat support for those based elsewhere. Their

website includes a directory of other support services - https://www.survivorsuk.org/ways-we-can-help/national-database/

**Appendix G: Consent Forms**

**Survey:**

**Consent Form**

1. I have the read the information sheet relating to the above research study and can save a copy for my records by right clicking and selecting "Save as...". The nature and purposes of the research have been explained to me. I have had the opportunity to discuss the details and ask questions about this information via the contact details provided. I understand what is being proposed and the procedures I will be involved in have been explained to me.
- Please tick box ☐

2. I understand that my involvement in this study, and data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. The information sheet has explained to me what will happen to my data once the research study has been completed and I understand this.
- Please tick box ☐

3. I now freely and fully consent to participate in the study which has been fully explained to me.
- Please tick box ☐

4. Having given this consent, I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that it is not possible to withdraw my data after the survey has been submitted as it will have been entered anonymously into the dataset.
- Please tick box ☐

**Consent to participate in this research study can only be taken when all the boxes have been ticked**

**Consent Form – Interview**

1. I have the read the information sheet relating to the above research study. The nature and purposes of the research have been explained to me. I have had the opportunity to discuss the details and ask questions about this information with the researcher. I understand what is being proposed and the procedures I will be involved in have been explained to me.

2. I understand that my involvement in this study, and data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. The information sheet has explained to me what will happen to my data once the research study has been completed and I understand this.

3. I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that it is not possible to withdraw my data after the data has been analysed has been submitted as it will not be possible to extract my information. However, no direct quotes from me will be used if I withdraw my data

4. I now freely and fully consent to participate in the study which has been fully explained to me.

Participant's Name (BLOCK CAPITALS) …….

Participant's Signature ……..

Researcher's Name (BLOCK CAPITALS) ……..

Researcher's Signature ……

Date: …….

## Appendix H: Participant Debrief Sheets

**Participant Debrief Sheet – Survey**

Thank you for participating in this research. My contact details are below if you would like to contact me about anything in the project. You might also wish to get in touch to find out about the results of the study.

I would like to remind you again that:

- All the information you gave is anonymous and will not be connected to you.
- The results will be written up into an article and might be published in psychological journals.
- The results will be shared with different support services, LGBTQ groups and other organisations, to hopefully shape how services support LGBTQ young people and highlight the experiences of LGBTQ young people.
- It is not possible to withdraw your information from the survey as it is anonymous. However, if you have offered to be interviewed and later change your mind, please contact me and I'll remove your details.

I know it may be difficult to think about the experiences I have asked you about, and there is information about different services which can support you at the end of this page. You can also contact me if you have any worries about anything in this survey.

Thank you again for taking part,

Best wishes,

Sophie

***Support services***

**LGBTQ services:**

**Stonewall**
***Website - http://www.stonewall.org.uk/***
***Phone number - 08000 50 20 20 (Mon-Fri 9:30am - 5:30pm)***
***Email – info@stonewall.org.uk***
A national campaigning organisation which also provides a directory of local services for support and advice for LGBTQ people http://www.stonewall.org.uk/help-advice/whats-my-area

**Galop**
***Website - http://www.galop.org.uk/***
***Phone – 0800 999 5428 (National LGBT domestic violence helpline)***
***Email – help@galp.org.uk***
The LGBT+ anti-violence charity, it supports LGBTQ people who have experienced hate crimes, sexual violence, or domestic abuse. They can support you if you have problems with the police or criminal justice system and you can anonymously report hate incidents.

**LGBTQ Foundation**
***Website - http://lgbt.foundation/***
***Phone number - 0345 3 30 30 30 (9am - 9pm Mon - Fri, 10am - 6pm Sat)***

***Email - helpline@lgbt.foundation***
An advice, support and information service for LGBTQ people. Based in Manchester but if you live elsewhere you can still use telephone and email services and there's a lot of information on their website, including guides if you have been affected by sexual violence http://lgbt.foundation/information-advice/sexual-violence/

**The Metro Centre**
***Website - http://www.metrocentreonline.org/***
***Phone Number – 020 8305 5000***
***Email – hello@metrocharity.org.uk***
The Metro Centre provides health, community and support services to LGBTQ people in London and across the South East.

**Mental health services:**

**Mind**
***Website - https://www.mind.org.uk***
***Phone number - 0300 123 3393***
***Text - 86463***
***Email - info@mind.org.uk***
A national mental health charity which provides information and support. Their website also lists LGBTQ mental health services here - https://www.mind.org.uk/information-support/guides-to-support-and-services/lgbtq-mental-health/useful-contacts

**The NHS**
***Website - https://www.nhs.uk/Livewell/LGBhealth/Pages/Mentalhealth.aspx***
The NHS provides free healthcare, counselling and support to everyone in the UK, you can access free support through your GP.

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A national charity supporting survivors of rape and sexual abuse, includes information specifically for men, women, young people and people with disabilities. They are based in Warwickshire but can provide telephone support for those based elsewhere.

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Rape Crisis England & Wales is a feminist organisation which promotes the needs rights of women and girls who have experienced sexual violence. They provide a directory of Rape Crisis services for women and girls which are run by women https://rapecrisis.org.uk/centres.php. They also provide information specifically for people who have experienced sexual harassment - https://rapecrisis.org.uk/sexualharassment.php

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Support services for men and boys who have survived rape and sexual abuse. They provide counselling services in London and web and text chat support for those based elsewhere. Their website includes a directory of other support services - https://www.survivorsuk.org/ways-we-can-help/national-database/

**Participant Debrief Sheet – interview**

Thank you for participating in this research. My contact details are below if you would like to contact me about anything in the project. You might also wish to get in touch to find out about the results of the study.

I would like to remind you again that:

- All the information you gave will be anonymised and will not be connected to you. You will be given a pseudonym (fake name) when the interview is written up.
- The results will be reported in an article and might be published in psychological journals.
- The results will be shared with different support services, LGBTQ groups and other organisations, to hopefully shape how services support LGBTQ young people and highlight the experiences of LGBTQ young people.
- You can withdraw at any time and your information will be deleted up until 31/03/2019, after this date the data will have been analysed and it won't be possible to change it.

I know it may be difficult to think about the experiences I have asked you about and there is information about different services which can support you at the end of this page. You can also contact me if you have any worries about anything in this interview.

Thank you again for taking part,

Best wishes,

Sophie

School of Psychology
The University of East London Stratford Campus
Water Lane
London 95 E15 4LZ
E-mail: u1622872@uel.ac.uk

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***Email - rcewinfo@rapecrisis.org.uk***
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**Appendix I: Measures**

The Other As Shamer and Social Comparison Scales are subject to copyright and as such not reproduced here, but can be accessed on https://compassionatemind.co.uk/resourcesresources/scales

Similarly, the DASS-21 can be accessed online.

Explicit permission has been granted to reproduce the below measures in research reporting:

Short Warwick Edinburgh Mental Well-Being Scale

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

| STATEMENTS | None of the time | Rarely | Some of the time | Often | All of the time |
|---|---|---|---|---|---|
| I've been feeling optimistic about the future | 1 | 2 | 3 | 4 | 5 |
| I've been feeling useful | 1 | 2 | 3 | 4 | 5 |
| I've been feeling relaxed | 1 | 2 | 3 | 4 | 5 |
| I've been dealing with problems well | 1 | 2 | 3 | 4 | 5 |
| I've been thinking clearly | 1 | 2 | 3 | 4 | 5 |
| I've been feeling close to other people | 1 | 2 | 3 | 4 | 5 |
| I've been able to make up my own mind about things | 1 | 2 | 3 | 4 | 5 |

Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

Short Self Compassion Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

| Almost Never | 1 | 2 | 3 | 4 | 5 | Almost Always |
|---|---|---|---|---|---|---|

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens, I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I

am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me, I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy

are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. Clinical Psychology & Psychotherapy. 18, 250-255.

Sexual Violence Questionnaires & Instructions

The following questions are about sexual violence which includes:

- Sexual harassment – like someone using sexual name calling or harassing you with sexual comments,
- If someone touches you in a sexual way without your consent
- if someone tries to make you do something sexual with them,
- if someone rapes you.

These questions can be personal and there are support agencies you can contact at the end of the survey. Also, your information is completely confidential and anonymous. Please tick the box to tell us how often people have been sexually violent towards you.

The last 12 months means 12 months ago from today. The number of times since the age of 14 is the number of times since your 14th birthday. 3+ means this has been done to you more than three times. If you are not sure how many times a person or people did this to you, that's ok, please chose the number you think is most likely.

The first section asks you about sexual harassment experiences which could be online, through text or messaging apps (e.g. whatsapp), over the phone, or in person, and the second section asks you about sexual assault and attempted sexual assault experiences.

Non-Contact Sexual Violence

| | **Number of times in the last 12 Months:** | | | | **Number of times since the age of 14:** | | | |
|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| A. Someone stared at me in a sexual way or looked at the sexual parts of my body | | | | | | | | |
| B. Someone made comments of a sexual nature about my body or appearance e.g. 'body shaming' | | | | | | | | |
| C. Someone sent me sexual or obscene materials such as pictures, jokes, online, by message or in the post. -- *Do not include mass mailings or spam*. | | | | | | | | |
| D. Someone showed me pornographic pictures when I had not agreed to look at them. | | | | | | | | |
| E. Someone made sexual, obscene or discriminatory comments to me e.g. shouting words at me such as 'faggot' or 'slut' | | | | | | | | |
| F. Someone watched me while I was undressing, was nude, or was having sex, without my consent. | | | | | | | | |
| G. Someone took photos or videotapes of me when I was undressing, was nude, or was having sex, without my consent. | | | | | | | | |
| H. Someone showed me the private areas of their body (e.g. butt, penis, or breasts) without my consent | | | | | | | | |
| I. Someone made sexual motions to me, *such as* grabbing their crotch, pretending to masturbate, or imitating oral sex without my consent | | | | | | | | |
| J. Someone masturbated in front of me without my consent | | | | | | | | |
| K. Someone bullied me about my sexuality or gender | | | | | | | | |
| L. Someone shared sexual images or videos of me without my consent ('revenge porn') | | | | | | | | |
| M. Someone harassed, pressured, threatened or blackmailed me to | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| share sexual images or videos of myself | | | | | | | | |
| N. Someone spread sexual rumours about me | | | | | | | | |
| O. Someone made sexual threats (e.g. rape threats) to me | | | | | | | | |
| P. Someone shared my sexuality or gender identity with others without my consent ('outed' me) | | | | | | | | |

How these experiences happen to you? Tick all that apply

in person / online / phone calls / text messages /
Private messages sent through message apps or online (e.g. Whatapp, Instagram Chat, Facebook Messager, Twitter) /
Messages sent through dating/hook-up apps (e.g. Grindr, Tinder) / Other

What was the gender of the person or persons who did these things to you?

| |
|---|
| Man/men |
| Woman/women |
| Men and women |
| I don't know |
| I reported no experiences |

Were these people/person that did these things? (tick all that apply)

Partners / friends / family / other people you know/knew / strangers / other

The next section asks about sexual violence experiences. These may have occurred because a person or people:

- Told lies, or threatened you, or continually pressured you, or made you false promises
- Used physical force, such as pinning you down, having a weapon, or using their weight to hold you down
- Took advantage of you when you were asleep, or drunk or high
- Got angry with you, or criticised your sexuality or attractiveness, or showed their displeasure when you said no
- Used their authority over you, e.g. a boss or a teacher
- Threatened to physically harm you or someone close to you

Contact Sexual Violence

| Item 1:<br>Someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or bum) or removed some of my clothes without my consent (but did not attempt sexual penetration). | Number of times in the last 12 Months: | | | | Number of times since the age of 14: | | | |
|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 2:<br>Someone had oral sex with me or made me have oral sex with them without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 3:<br>Someone made me touch the private areas of their body (lips, breast/chest, crotch or bum) without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 4:<br>Someone put their penis into my bum, or someone inserted fingers or objects into my bum without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 5:<br>Even though it didn't happen, someone TRIED to have oral sex with me or made me have oral sex with them without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 6:<br>Even though it didn't happen, someone TRIED to put their penis into my bum, or someone tried to stick in objects or fingers into my bum without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 7:<br>Even though it didn't happen, someone TRIED to make me touch the private areas of their body (lips, breast/chest, crotch or bum) without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 8:<br>Even though it didn't happen, someone TRIED to fondle, grab, kiss, or rub up against the private areas of my body (lips, breast/chest, crotch or bum) or remove some of my clothes without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |

The next section of questions only applies if you have a vagina. Please tick the appropriate box and you will be moved through the survey to correct section for you.

I have a vagina / I do not have a vagina

| Item 1:<br>Someone put their penis into my vagina, or someone inserted fingers or objects into my vagina without my consent. | Number of times in the last 12 Months: | | | | Number of times since the age of 14: | | | |
|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |
| Item 2:<br>Even though it didn't happen, someone TRIED to put their penis into my vagina, or someone tried to stick in fingers or objects into my vagina without my consent. | 0 | 1 | 2 | 3+ | 0 | 1 | 2 | 3+ |

What was the gender of the person or persons who did these things to you?

| | |
|---|---|
| Man/men | |
| Woman/women | |
| Men and women | |
| I don't know | |
| I reported no experiences | |

Were these people/person that did these things (tick all that apply)

Partners / friends / family / other people you know/knew / strangers / other

How often did a person or people use any of the below tactics to do these things to you (tick all that apply):

| Tactic | Never | Once | Twice | Three times | Four or more times |
|---|---|---|---|---|---|
| Told lies, or threatened you, or continually pressured you, or made you false promises | | | | | |
| Used physical force, such as pinning you down, having a weapon, or using their weight to hold you down | | | | | |
| Took advantage of you when you were asleep, or drunk or high | | | | | |
| Got angry with you (but didn't use physical force), or criticised your sexuality or attractiveness, or showed their displeasure when you said no | | | | | |
| Used their authority over you, e.g. a boss or a teacher | | | | | |
| Threatened to physically harm you or someone close to you | | | | | |
| Tactic not listed here | | | | | |

Are there any other experiences you would like us to know about which have not been mentioned? [open question]

Service Experience Measure

Please circle a number on the scale to indicate how you felt in the service. You can answer the questions below about every service (please click 'add responses for another service' at the bottom of the page) you used or chose one service which you feel the strongest about.

**Service Name:** [Enter service name here e.g. the police, drop-in centre]

1. The staff in the service believed me

1 2 3 4 5
Not at all Completely

2. I felt the service showed compassion (kindness and warmth) towards me and my experience

1 2 3 4 5
Not at all Completely

3. I felt my gender was respected

1 2 3 4 5
Not at all Completely

4. I felt my sexual orientation was respected

1 2 3 4 5
Not at all Completely

5. Staff had a negative attitude towards me and my experience because of my gender

1 2 3 4 5
Not at all Completely

6. Staff had a negative attitude towards me and my experience because of my sexual orientation

1 2 3 4 5
Not at all Completely

7. Staff had a negative attitude towards me and my experience for other reasons

1 2 3 4 5
Not at all Completely

**What were these reasons?**
[Open question]

**Is there anything else you would like to say about your experiences of services?**
[open question]

Qualitative Survey Questions

1. What do you think makes LGBTQ young people more likely to go to services for support after they have experienced sexual violence?
   [open question]
2. What makes LGBTQ young people less likely to go to services for support after experiencing sexual violence?
   [open question]
3. When someone or people have been sexually violent towards you, have you been able to report it to a service?
   [Yes/Usually/Some of the time/No/Prefer not to answer].
   If no, what stopped you?

Demographic Questionnaire

*This demographic information was verbally taken in interviews*

1. How old are you?
   16 17 18 19 20 21 22 23 24 25

2. What do you do? Tick all that apply

| | | | |
|---|---|---|---|
| At college | At university | At school | Working full time |
| Working part time | Doing an apprenticeship | Job hunting | Volunteering |
| Looking after children or someone else (carer) | Not working due to disability or mental health issues | Other – please describe [open text box] | |

3. How would you describe your ethnicity?
   [Open question]

4. What is your sexual orientation?

| | | | |
|---|---|---|---|
| Bi | Gay Man | Gay Woman/Lesbian | heterosexual/straight |
| Queer | Questioning | prefer not to say | Prefer to self describe [open text box] |

5.What best describes your gender identity?

| | | | | |
|---|---|---|---|---|
| Man | Woman | Non-Binary | Prefer not to say | Prefer to self describe [open text box] |

6. Do you identify as transgender?

| | | | |
|---|---|---|---|
| Yes | No | Prefer not to say | Prefer to self describe [open text box] |

**Appendix J: Construction Process of Measures**

Three measures were constructed for this research project. The process of constructing each measure is outlined below.

1. Non-Contact Sexual Violence Measure:

- The first 10 items on the SVS long form victimisation describe sexual harassment experiences ('non-contact' sexual violence) which formed the basis of the sexual harassment questionnaire.
- Eight additional items were added from Project De-Shame (Project De-Shame, 2017) which investigated online sexual harassment experienced by young people in Europe. These were included due to the increasing awareness and frequency of online sexual harassment, especially among young people, which is not represented in the SVS items. Additionally, Project De-Shame included items relating specifically to sexual and gender identity which were included due to their relevance to LGBTQ+ young people but were amended to include all methods of harassment, rather than exclusively online (e.g. '*someone bullied me about my sexuality or gender'*).
- Following the pilot stage and discussion of the sexual harassment items, 16 items were included in the final 'non-contact' questionnaire.
- Participants were reminded that sexual harassment experiences '*could be online, through text or messaging apps (e.g. whatsapp), over the phone, or in person'* prior to completing the questionnaire.
- Subsequently participants were asked the methods of harassment at the end of the questionnaire. This included dating/hook-up apps which have not previously been investigated.

2. Contact Sexual Violence Measure:

- Items in the SVS-SFV describe sexual assault and rape and attempted sexual assault and rape.
- All items in the SVS-SF were retained, although two items, which only apply if participants have a vagina, were re-worded from '*if you are a male...*' to '*if you have a vagina*'. This was following discussion in the pilot phase because the term 'male' may exclude non-binary people, there may be trans men who have not medically transitioned, and the use of 'male' could cause confusion and/or offence.
- Additionally, the item '*someone made me touch the private areas of their body (lips, breasts/chest, crotch or bum) without my consent'* was added, as participants in the pilot phase felt young people may be coerced into sexually touching others.
- This also meant the attempted version of this item was included ('even though it didn't happen, someone TRIED to fondle, kiss, or rub up against the private areas of my body (lips, breast/chest, crotch or bum) or remove some of my clothes without my consent.').
- Similarly, in the pilot phase, it was queried why there was no attempted item for 'someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or bum) or removed some of my clothes without my consent (but did not attempt sexual penetration)', as this could be invalidating for young people who have experienced this, therefore an attempted item was added.
- The SVS-SF and SVS-SL ask participants to report what tactics were used (e.g. force) to sexually assault or attempt to sexually assault participants for each item. However, this was amended to only include an item which only asks about

tactics used overall and the frequency used instead. This was following careful consideration of the possible fatigue of questionnaires, and the increased potential for distress as this would require participants to think in more detail about sexual violence experiences.

Finally, participants were able to complete an open question which asked; '*Are there any other sexual violence/harassment experiences you would like us to know about which have not been mentioned?*' to ensure participants felt they had been able to express all their experiences. These could then be categorised as contact or non-contact sexual violence incidences.

This led to the development of the 16-item non-contact sexual violence measure, and 12-item contact sexual violence (sexual assault and rape and attempted sexual assault and rape) measure.

3. Service Experience Measure

The service experience measure consisted of 7 statements which were ranked according to the degree to which they described the participant's experience of service. The name of service could be entered a free text box and participants responded to each statement using a 1 (not at all) – 5 (completely) Likert scale. This format was selected because it is the scale used most frequency on other measures used in the study (e.g. SSCS and SWEMWBS). This ensures consistently and means participants do not have to adjust their approach to rating for each measure.

- Statement 1 '*The staff in the service believed me'* was included because, if young people did not feel believed, this may impact on all other experiences of the service as it is a critical factor in the experience of disclosure of sexual violence (e.g. Denov, 2003; Ullman, 1996; Walsh, Banyard, Moynihan, Ward, & Cohn, 2010).
- Statement 2 related to compassion experienced in the service, which was defined as warmth and kindness, in line with lay people's conceptualisation of compassion and compassion focused therapy (Gilbert, 2009; Neff & Dahm, 2015; Pauley & McPherson, 2010).
- Statements 3 and 4 were designed to ascertain if participants felt their gender and sexuality were respected as respectful interactions indicate staff are approving of and comfortable with LGBTQ+ experiences (Nadal, Rivera, & Corpus, 2010)
- Statements 5 & 6 regarding staff attitudes towards sexuality and gender collected additional information regarding possible anti-LGBTQ+ prejudice. Additionally, a high correlation between these four items would be expected and therefore the validity of the questionnaire can be checked (Fowler, 2014).
- Statement 7 enquired if participants had negative experiences for other reasons to ascertain other reasons for difficult experience. Participants were able to describe these experiences in subsequent free text box.

  Participants could complete this measure for up to four services. The service experience questionnaire was limited to four services because a review of college age participants indicated if participants do disclose sexual violence to services, it is usually to one or two services (Sabina & Ho, 2014). A total score for each service was computed by reverse scoring items 5 – 7 (e.g. 2 = 4) and

summing these scores with the scores on items 1 – 4. Higher scores indicate more positive service experiences.

**Appendix K: Semi-Structured Interview**

1. How might services make it more difficult for LGBTQ+ young people to use them if they would like support with sexual violence?
- *Possible follow up question: Could this create experiences of shame?*

2. How do you think services could best support LGBTQ young people who have experienced sexual violence?
- *Possible follow up question: How could services create a compassionate (e.g. warm, kind) atmosphere?*

3. Are there any examples from your experiences (if used services) that you would like to talk about? [These might have been discussed in the previous questions]

We can either talk a bit about your experiences of sexual violence & harassment or talk more generally about LGBTQ+ experiences of sexual violence – depending on what you feel comfortable with.

*Own Experiences*

4. Would it be ok to say a bit about your experiences of sexual violence?
5. What feelings came up for you?
6. Were there things that helped you or made it worse?

   *Possible follow ups: were you able to be kind towards yourself? Was anyone compassionate towards you?*
7. How do you think other people would make sense of your experience?
8. What you do think the ideas are in our society about your experiences of sexual violence?

*More Generally*

4. What kinds of sexual violence do you think LGBTQ+ young people face?
5. What kind of feelings might that bring up for them?
6. How do you think other people might respond?

   *Possible follow up: Would this help or hinder?*
7. How do you think other people might explain someone's experiences of sexual violence or harassment?
8. What you do think the ideas are in our society about LGBTQ young people's experiences of sexual violence?

9. Is there anything else that you think is important that we haven't talked about?

**Appendix L: Recruitment Strategy and Materials**

- Facebook page created https://www.facebook.com/LGBTQexperiences

Facebook post:

*Are you 16-25 and identify as LGBTQ+? Have you faced sexual violence or harassment? I am researching your experiences to explore your feelings, promote awareness and improve services. Please complete this anonymous survey https://tinyurl.com/LGBTQexpsurvey*
*Please share! Thank you x*

Description provided on Facebook page:

> *Why am I doing this research?*
>
> *I want to explore the experiences LGBTQ+ young people have had of sexual violence and harassment because:*
>
> *LGBTQ+ young people can get missed out of the #metoo conversation. I want to change this.*
>
> *No one has done this in the UK before. I think it's important we understand how sexual violence and harassment affects LGBTQ+ young people in the UK, so we can tell our support services what people might need.*
>
> *I am interested in understanding feelings of shame - shame others might make us feel, shame services might make us feel, and shame we might feel about our experiences. I want to explore how compassion (kindness and warmth) from others, services, and ourselves might make a difference to feelings of shame.*
>
> *The survey takes around 20 minutes and runs until March 2019. Please share - https://tinyurl.com/LGBTQexpsurvey*
>
> *I want to get as many LGBTQ+ young peoples' voices heard as I can!*
> *Thanks for reading x*

- Twitter Account created @LGBTQ+SexualViolenceResearch

Examples of Twitter Posts:

> *"16-25 & identify as #LGBTQ? Have you ever faced sexual violence & harassment? Complete anon. survey https://tinyurl.com/LGBTQexpsurvey by Uni of East London to understand & challenge shame & improve support. Please RT & get involved!"*

Examples of Tweets by National Union of Students Women's Campaign and the by National Union of Students LGBT Campaign:

@nuswomcam
@NUS_LGBT

"*@ResearchLgbtq is undertaking research exploring LGBTQ+ young people's experiences of sexual harassment and violence. If you're 16-25 and want to get involved, you can take part in an anonymous survey from the University of East London - https://tinyurl.com/LGBTQexpsurvey"*

This was retweeted by LGBT+ Disability @LGBTDisability and several personal Twitter Accounts.

- Emails

The below email and subsequent follow up email were sent to a large number of organisations, this included organisations which worked with specific minority groups (e.g. LGBTQ+ groups for ethnic minority people and people with disabilities). Individiaul orgasnisations are not provided as this includes small youth groups which could compromise the anonymity of participants. Types of organisation are outlined below:

- 58 LGBTQ+ Youth Organisations
- 28 Generic Youth Organisations
- 10 Sexual Violence Organisations
- 30 LGBTQ+ Organisations
- 50 University Organisations, predominately LGBTQ+ societies

*A total of 176 Organisations were contacted through email. Responses were received from 39 organisations.*

<u>Initial Email:</u>

Dear XXX,

Hello, I'm Sophie, I'm a trainee clinical psychologist at the University of East London.

I'm emailing to ask for your help to promote my thesis research project;

***LGBTQ+ young people's experiences of sexual violence, shame, compassion and services***

In the project I'm exploring the relationships between sexual violence experiences, feelings of shame and compassion and how services respond to LGBTQ+ young people. The research is in two parts – an online survey and Skype interviews. Anyone who completes the survey can then offer to be interviewed.

I'm recruiting young people aged 16 – 25 who identify as LGBTQ+ and have experienced sexual violence or harassment once or more. I've made two posters advertising the research (please see attached, please don't judge my lack of design skills!). I would really appreciate it if you could circulate these to students and others.

If you are able to advertise the survey on social media that would be brilliant. E.g. using templates such as – "*Calling all LGBTQ+ young people aged 16-25. Have you faced sexual harassment/violence? Get involved in research which explores your experiences by taking part in an anonymous survey by the University of East London - https://tinyurl.com/LGBTQexpsurvey*" or "*LGBTQ+ 16 -25 year olds: Have you experienced sexual harassment/violence? Take this survey to improve support and services - https://tinyurl.com/LGBTQexpsurvey*" I'm also on twitter as @researchlgbtq and the facebook page is @LGBTQexperiences.

The reasons for the research project are (apologies if I'm telling you info you already know):

- LGBTQ+ young people are more likely to be survivors of sexual violence and harassment than straight young people. However, research in this area is very limited.
- Feelings of shame can be common after sexual violence/harassment and services can create/add to feelings of shame by their responses to young people (e.g. police, sexual health services). LGBTQ+ young people are more likely to have negative experiences of services due to discrimination or prejudice.
- Shame is also an emotion that can be associated with experiences of homophobia, biphobia and transphobia, putting LGBTQ+ young people at greater risk of experiencing feelings of shame.
- Research suggests that compassion for yourself and from services can reduce shame feelings and psychological distress.

The research aims are:

- To develop more understanding of how sexual violence and harassment impacts on LGBTQ+ young people,
- Investigate the relationships between shame, compassion, psychological distress and wellbeing for LGBTQ+ young people, to inform clinical interventions and support,
- To explore LGBTQ young people's experiences of services to improve services and share best practice.

The survey is anonymous, and all service names will also be anonymised. The research has ethical approval from the University of East London and is open until March 2019. Young people don't need to have used services to take part.

I'm really happy to have an informal phone call to discuss the research in more detail and answer any questions, just let me know the best time to contact you.

Thank you so much for taking the time to read this and any help you're able to give will be greatly appreciated. My hope is the research can contribute to highlighting the experiences of LGBTQ+ young people and improving services and support.

Very best wishes,

Sophie

Sophie Jones
Trainee Clinical Psychologist
School of Psychology
The University of East London Stratford Campus
Water Lane
London E15 4LZ

E-mail: u1622872@uel.ac.uk

Follow Up Email:

Dear XXX,

Happy 2019! I hope you had a lovely break,

I'm just emailing to follow up on the below email, it would be really helpful if you were able to circulate the research project to any contacts and LGBTQ+ students who may have experienced sexual violence and harassment. I'm very keen to hear as many views and experiences as possible and plan to create a document which can inform support for LGBTQ+ young people based on the project findings.

This is the link to the anonymous survey https://tinyurl.com/LGBTQexpsurvey which takes about 20 mins to complete.

I would really like the project to be as meaningful and useful as possible for LGBTQ+ young people and those who work with them, and I value any help and input you are able to give.

Just let me know if you would like any more info or have any questions,

Many Thanks,

Sophie

Sophie Jones
Trainee Clinical Psychologist
School of Psychology
The University of East London Stratford Campus
Water Lane
London E15 4LZ
E-mail: u1622872@uel.ac.uk

- Posters created for the project
  Poster One

Poster Two


EXPLORING COMPASSION.
UNDERSTANDING SHAME.
IN RESPONSE TO SEXUAL VIOLENCE
THE EXPERIENCES AND VIEWS OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER AND QUESTIONING YOUNG PEOPLE
Has anyone grabbed your bum when you didn't want them to?
Has anyone made unwanted sexual comments towards you?
Has anyone made you have sex when you didn't want to?
Has anyone bullied you about your sexuality or gender?
Has anyone taken advantage of you sexually?
These are types of sexual violence and harassment.
LGBTQ young people are more likely to be survivors of sexual violence and harassment than straight young people. We want to understand the impact of this and how services responded. If you identify as LGBTQ, are aged between 16 – 25 & anyone has ever sexually harassed you or been sexually violent towards you we want to hear from you.
Complete the anonymous survey at
https://tinyurl.com/LGBTQexpsurvey
Everyone who completes the service will be entered into a draw to win 1 of 4 £15 Amazon.com vouchers. Check our twitter @ResearchLgbtq & facebook @LGBTQexperiences or Contact Sophie at U1628872@UEL.ac.uk for more info.

## Appendix M: 'Non-Completers' Demographic Characteristics

Table 9: Demographic characteristics of non-completers

| Characteristics | N | % |
|---|---|---|
| ***Age*** | | |
| 16 - 18 | 4 | 12.90 |
| 19 – 22 | 17 | 54.84 |
| 23 – 25 | 10 | 32.26 |
| ***Ethnicity*** | | |
| Asian/British Asian | 2 | 6.45 |
| Any other mixed/multiple ethnic background | 0 | 0.00 |
| Black/Black British | 2 | 6.45 |
| White – English, Northern Irish, Scottish, Welsh | 23 | 74.19 |
| Any other White Background | 4 | 12.90 |
| Prefer not to say | 0 | 0.00 |
| ***Occupation**** | | |
| School student | 0 | 0.00 |
| College student | 3 | 9.68 |
| University student | 18 | 58.06 |
| Working full time | 6 | 19.35 |
| Working part time | 5 | 16.13 |
| Job hunting | 5 | 16.13 |
| Not working due to disability or mental health issues | 3 | 9.68 |
| Volunteering | 2 | 6.45 |
| ***Sexual Identity*** | | |
| Lesbian/gay woman | 8 | 25.81 |
| Gay man | 7 | 22.58 |
| Bisexual | 6 | 19.35 |
| Queer | 5 | 16.13 |
| Pansexual | 2 | 6.45 |
| Asexual | 1 | 3.23 |
| Heterosexual/straight | 2 | 6.45 |
| ***Gender Identity*** | | |
| Woman | 15 | 48.39 |
| Man | 12 | 38.71 |
| Non-binary | 3 | 9.68 |
| Questioning | 1 | 3.23 |
| ***Transgender Identity*** | | |
| Yes | 9 | 29.03 |
| No | 20 | 64.52 |
| Questioning | 2 | 6.45 |
| Gender fluid/queer | 0 | 0.00 |
| Prefer not to say | 0 | 0.00 |

**participants could select multiple occupations*

Table 9 suggests most participants were aged 19 – 22 (54.84%), the second most represented group were aged 23 – 25 (32%). The majority of participants were from White ethnic backgrounds (74%) and tended to be university students (58%). There was a roughly equal spread of participants' with gay, lesbian and bisexual gender identities (7%, 8%, 6% respectively). Almost one third of participants identified as transgender (29%). The proportion of participants' gender identities was slightly higher for women than men (48% and 39%, respectively) and lower for non-binary participants (10%).

**Appendix N: Stages of Survey Withdrawal**

Table 10 suggests that most participants withdrew prior to completing the sexual violence measures. This supports the rationale for placing these at the end of the questionnaire battery, as positioning may have given participants increased time to decide if they would like to proceed to these measures.

Table 10: Stages of survey withdrawal

| Stage of Survey Withdrawal | N | % |
|---|---|---|
| Completion of consent form | 7 | 9.46 |
| Completion of demographic questionnaire | 8 | 10.81 |
| Completion of shame measures | 8 | 10.81 |
| Completion of shame and self-compassion measures | 2 | 2.70 |
| Completion of all shame, self-compassion, wellbeing and distress measures | 5 | 6.76 |
| Completion of all shame, self-compassion, wellbeing and distress measures and sexual violence non-contact questionnaire | 3 | 4.05 |
| Completion of all measures and sexual violence questionnaires | 4 | 5.41 |
| Completion of measures and sexual violence questionnaires. Partial completion of services questionnaire | 1 | 1.35 |
| Total | 38 | 51.35 |

**Appendix O: Services Questionnaire Results**

Higher scores indicate more positive interactions. Scores can range from 5 – 35. This indicates that most participants engaged with the police. Those who engaged with a Therapist, Sexual Health Clinics and Rape Crisis Charity had more positive interactions.

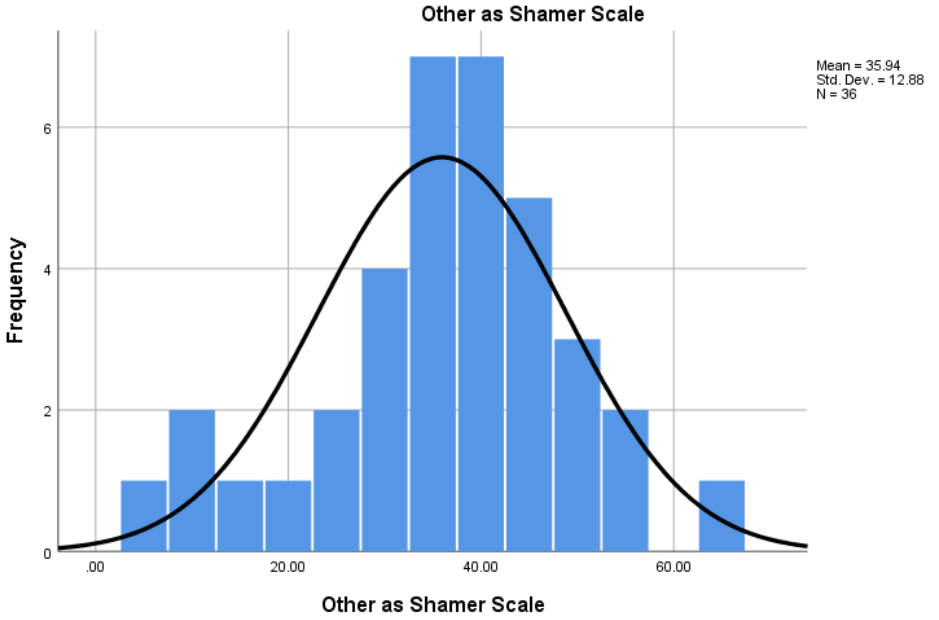
Table 11: Participant data for service questionnaire

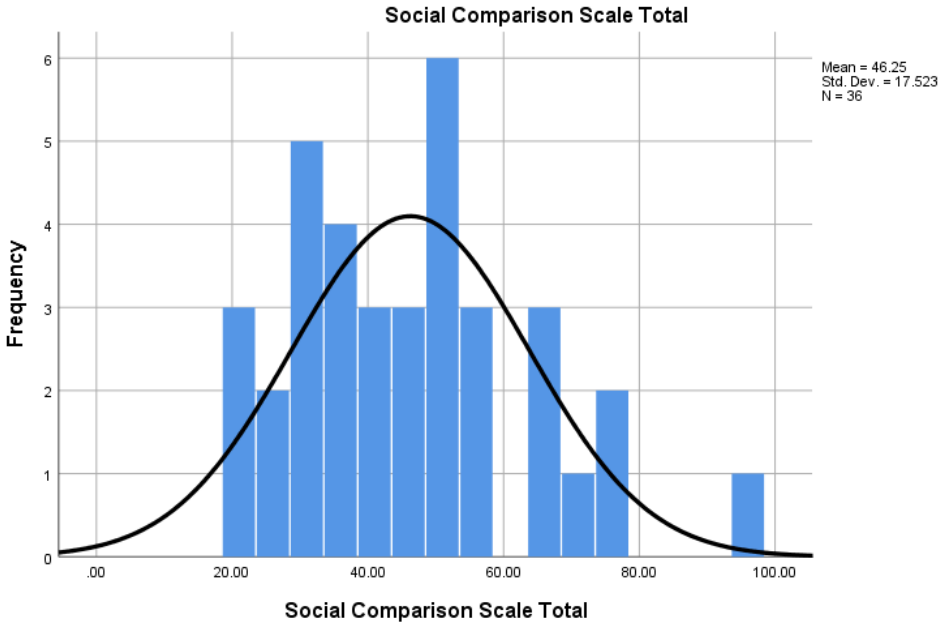
| Participant | Type of service | Score |
|---|---|---|
| 1 | Therapist | 35 |
| 2 | Sexual Health Clinic | 35 |
| 3 | Rape Crisis Charity | 32 |
| 4 | Social Services | 25 |
| 5 | Police | 35 |
| 6 | Police | 34 |
| 7 | Police | 31 |
| 8 | Police | 19 |
| 9 | University | 17 |

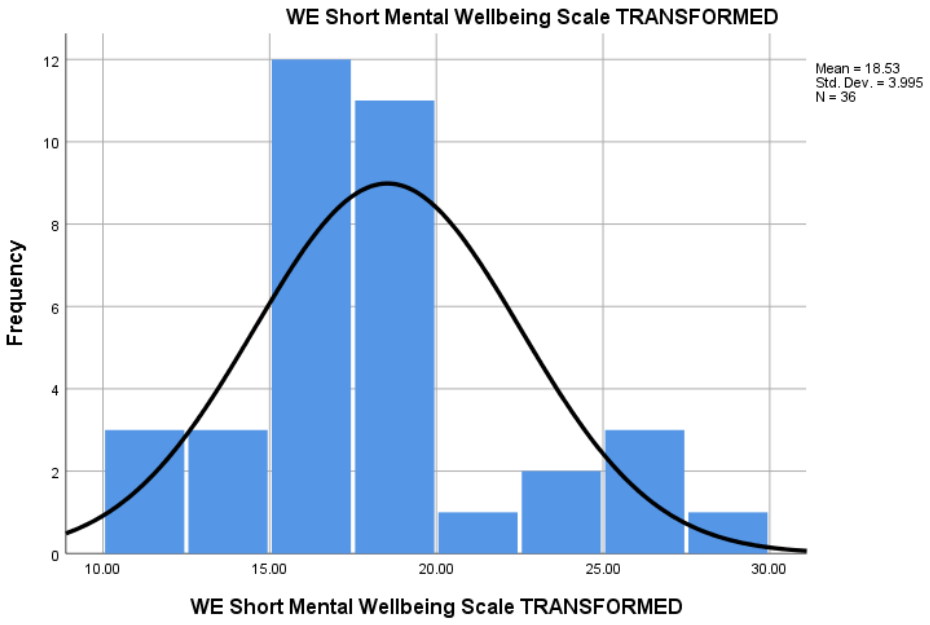
A mean score for police was calculated = 29.75

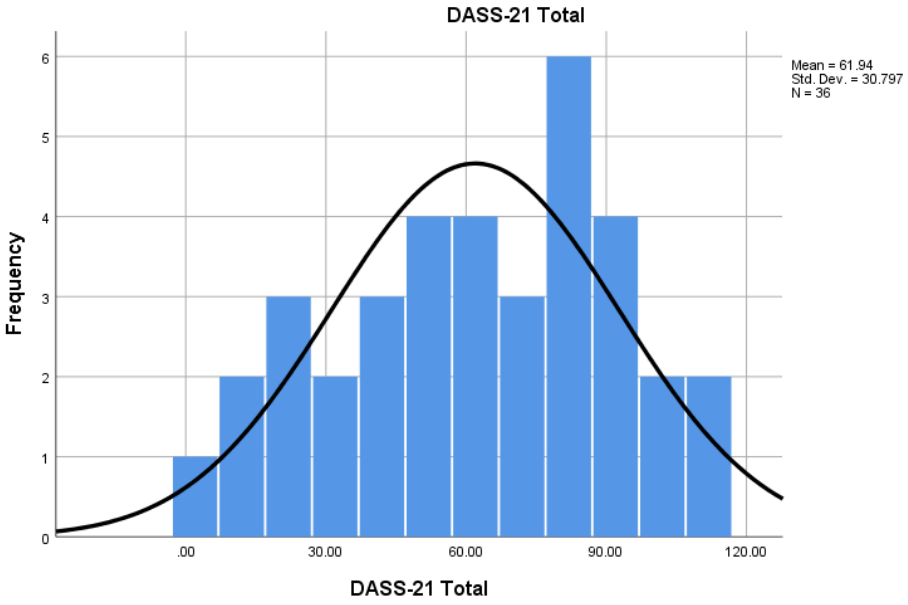
## Appendix P: The Distribution of Variables

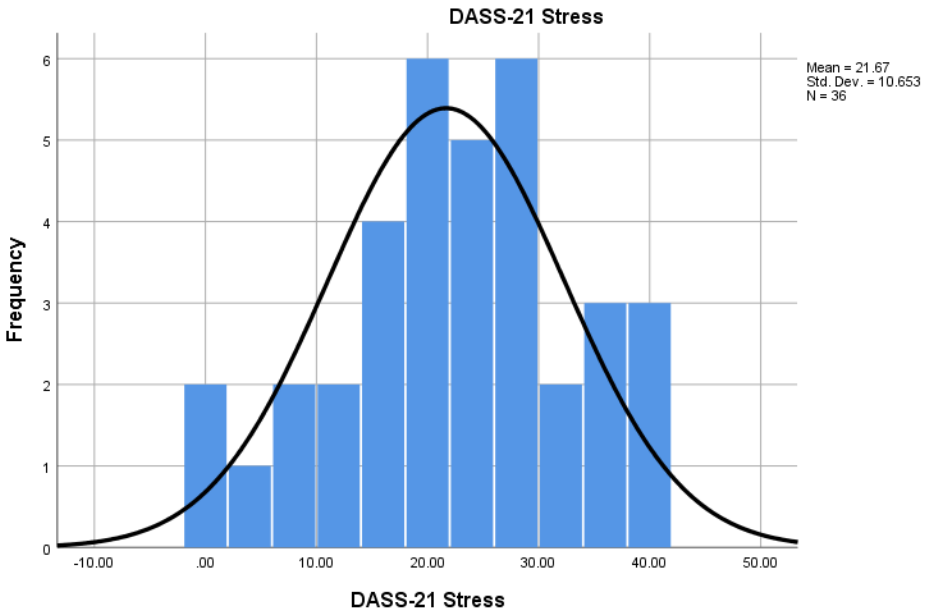
Histograms

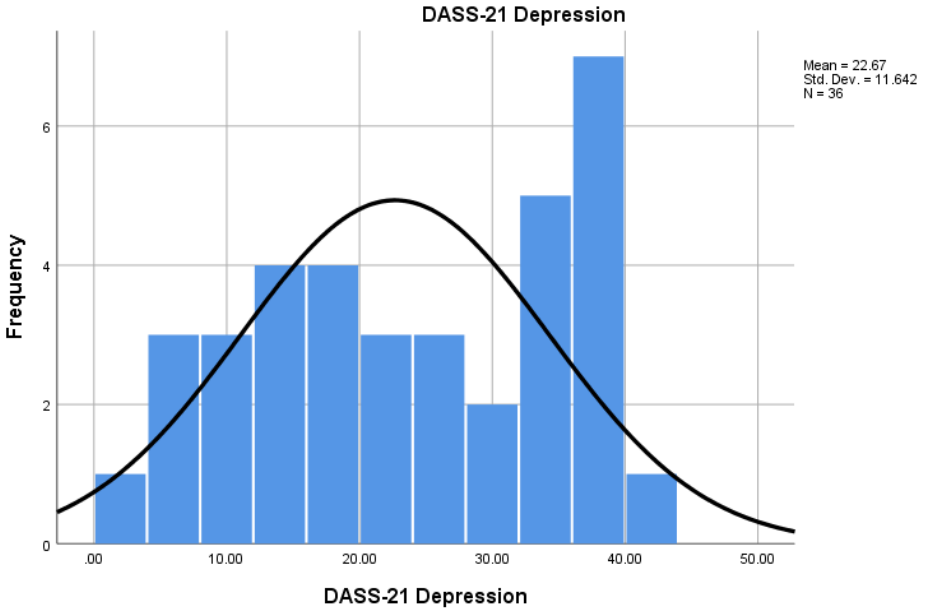


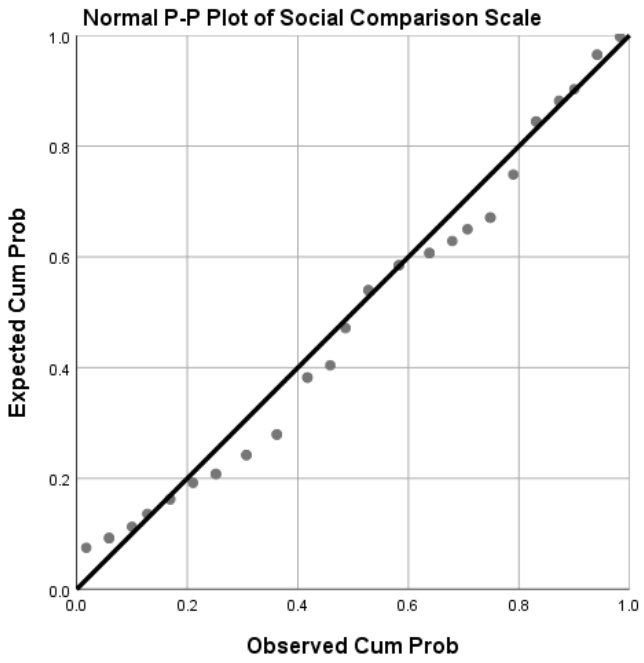

WE Short Mental Wellbeing Scale TRANSFORMED
Mean = 18.53
Std. Dev. = 3.995
N = 36
Frequency
0
2
4
6
8
10
12
10.00
15.00
20.00
25.00
30.00
WE Short Mental Wellbeing Scale TRANSFORMED

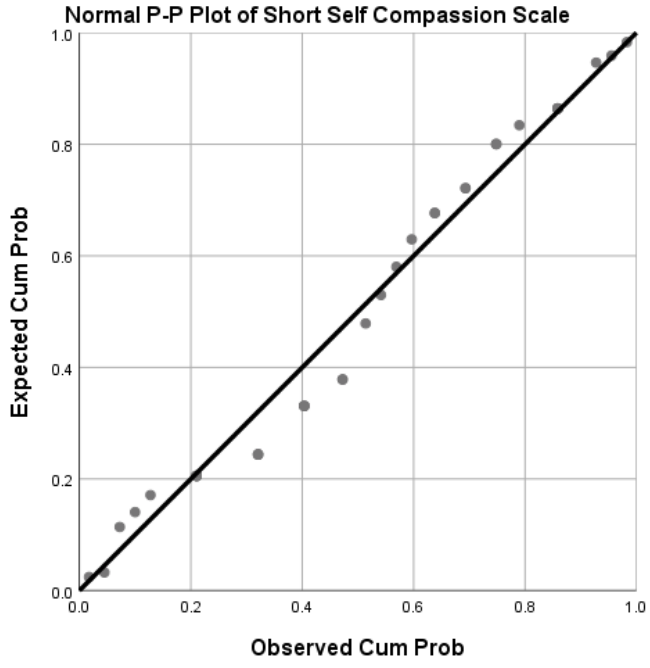

DASS-21 Total
Mean = 61.94
Std. Dev. = 30.797
N = 36
Frequency
0
1
2
3
4
5
6
.00
30.00
60.00
90.00
120.00
DASS-21 Total

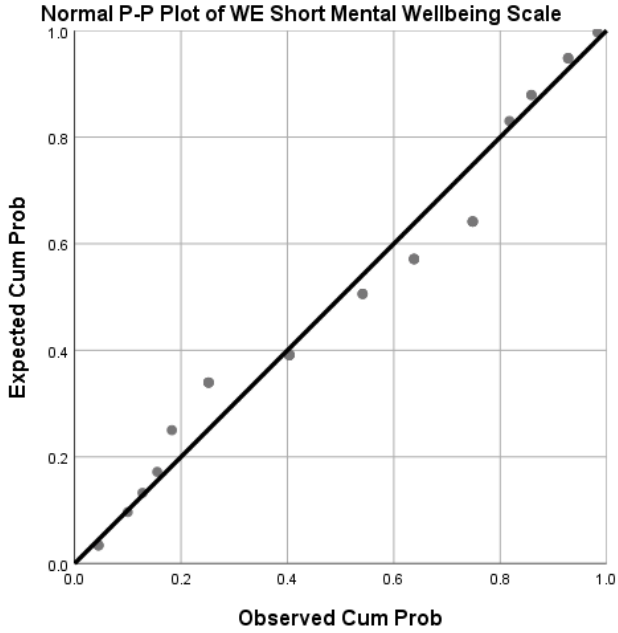

DASS-21 Stress
Mean = 21.67
Std. Dev. = 10.653
N = 36
Frequency
0
1
2
3
4
5
6
-10.00
.00
10.00
20.00
30.00
40.00
50.00
DASS-21 Stress

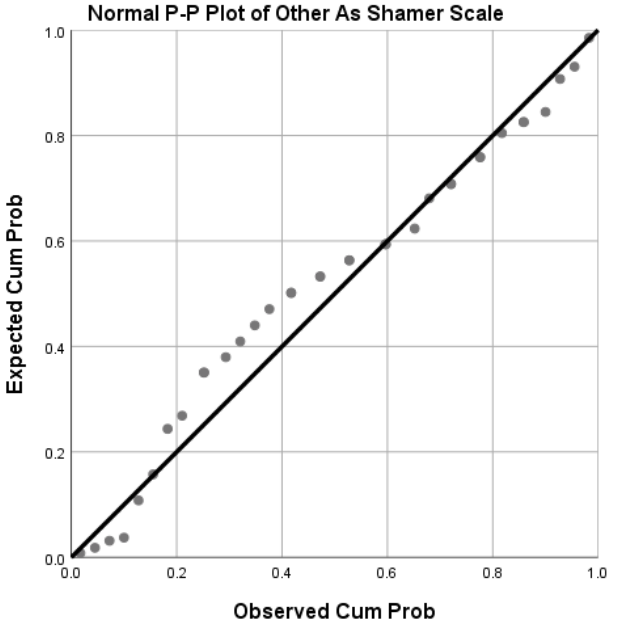

DASS-21 Depression
Mean = 22.67
Std. Dev. = 11.642
N = 36
Frequency
0
2
4
6
.00
10.00
20.00
30.00
40.00
50.00
DASS-21 Depression

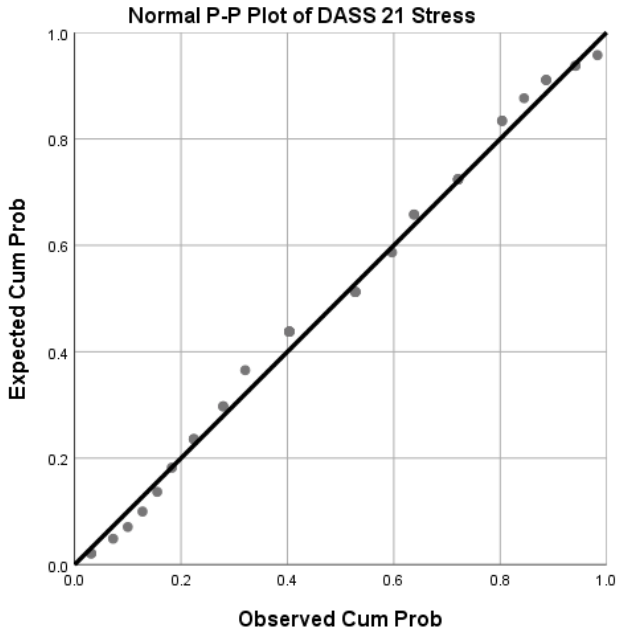
P-P Plots

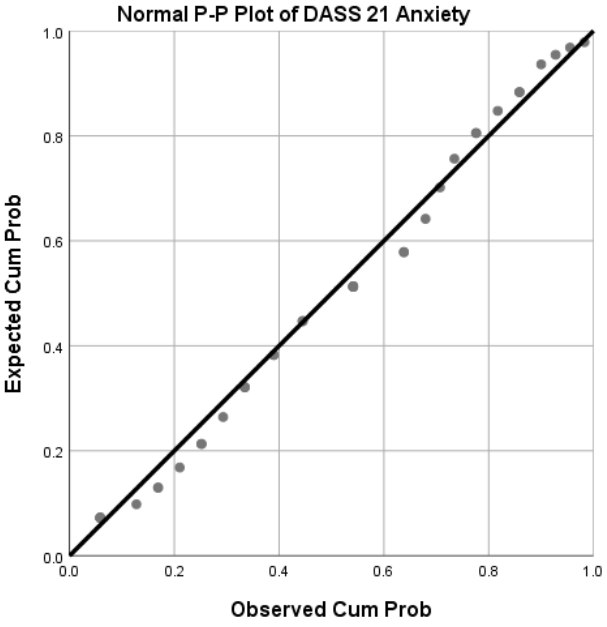

Normal P-P Plot of Social Comparison Scale
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

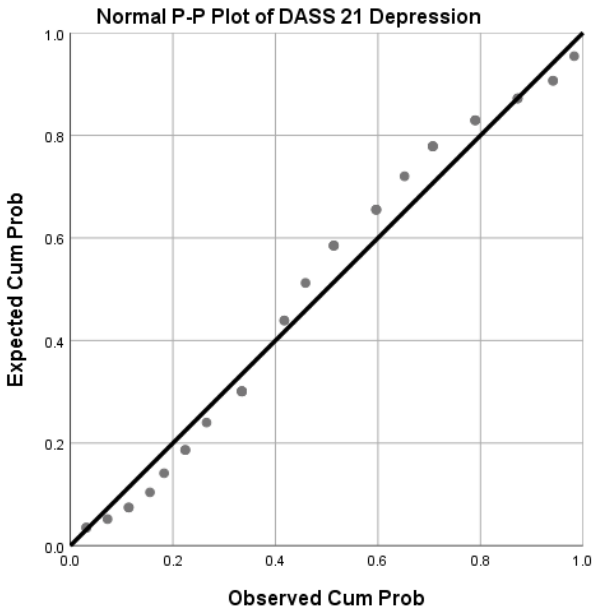

Normal P-P Plot of Short Self Compassion Scale
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

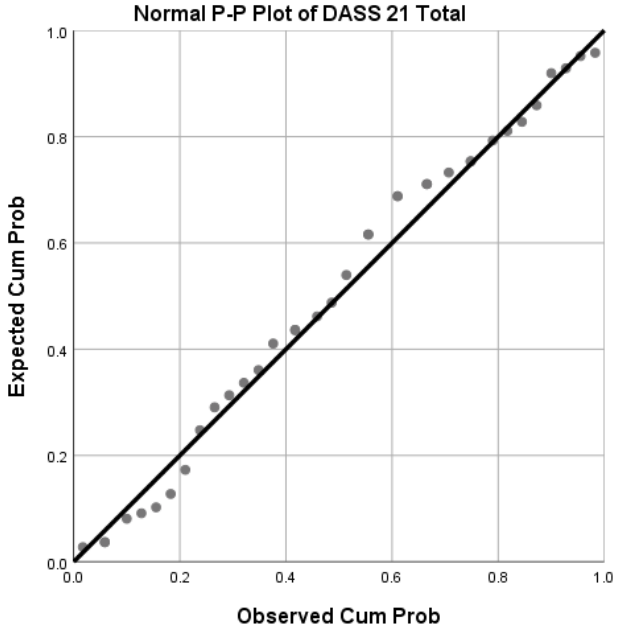

Normal P-P Plot of WE Short Mental Wellbeing Scale
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0


Normal P-P Plot of Other As Shamer Scale
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0


Normal P-P Plot of DASS 21 Stress
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

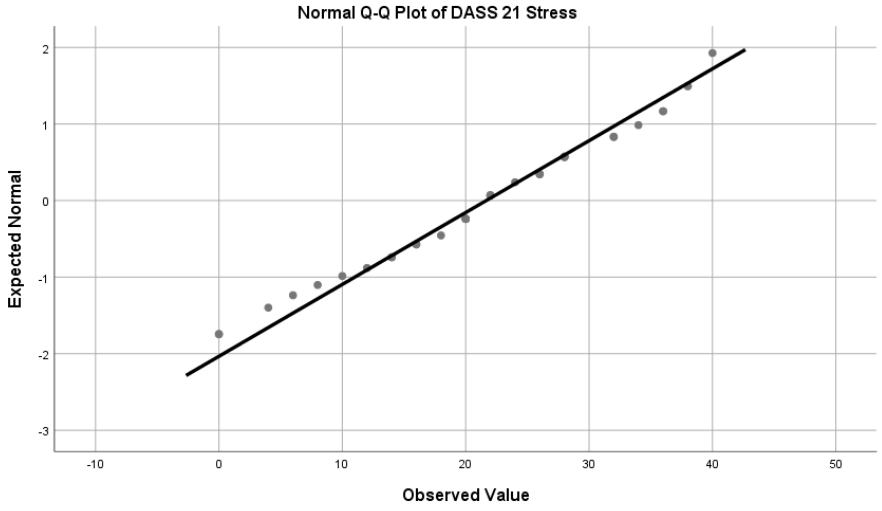

Normal P-P Plot of DASS 21 Anxiety
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

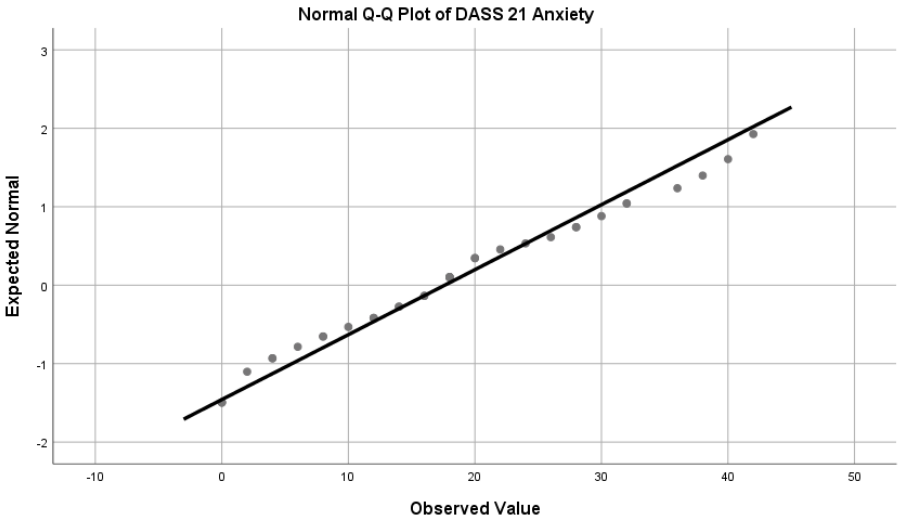

Normal P-P Plot of DASS 21 Depression
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

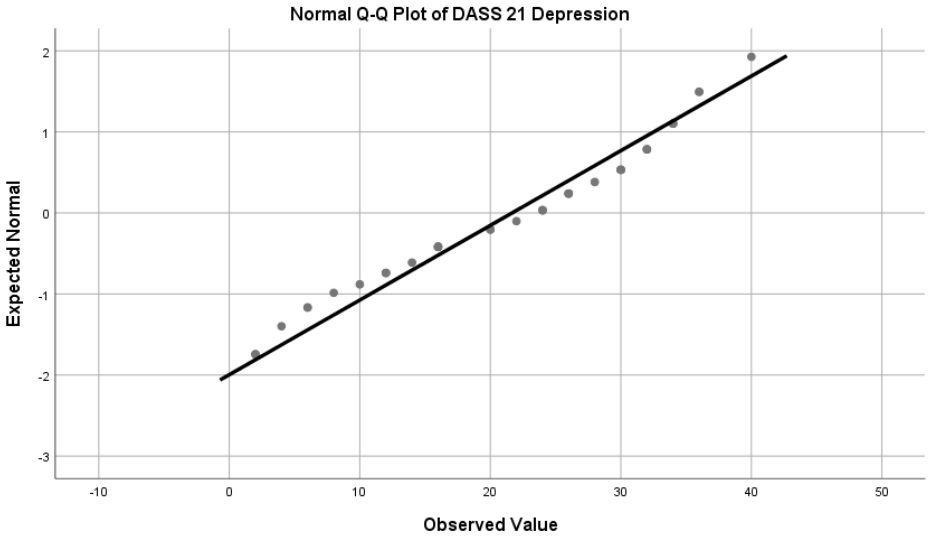

Normal P-P Plot of DASS 21 Total
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0

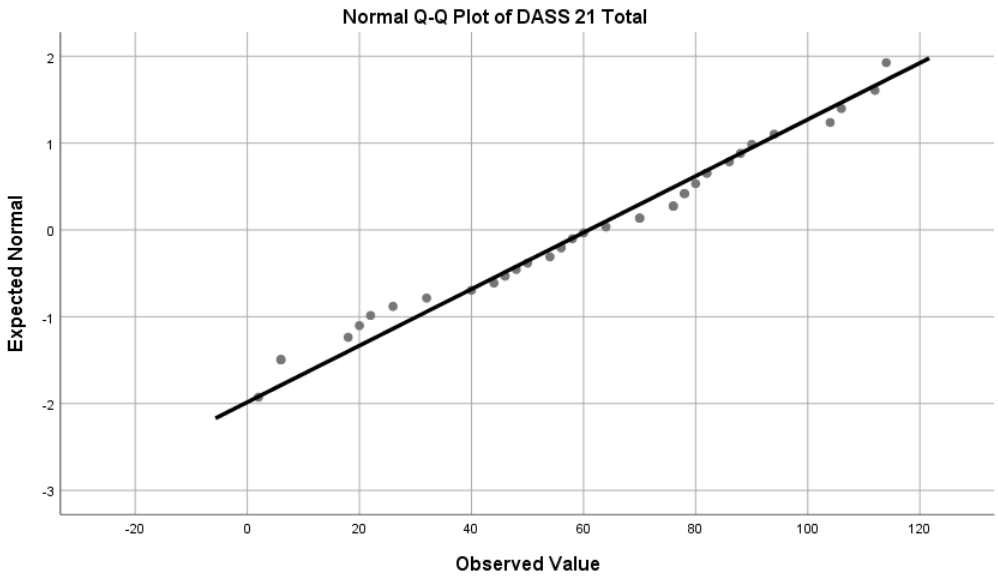
Q-Q Plots

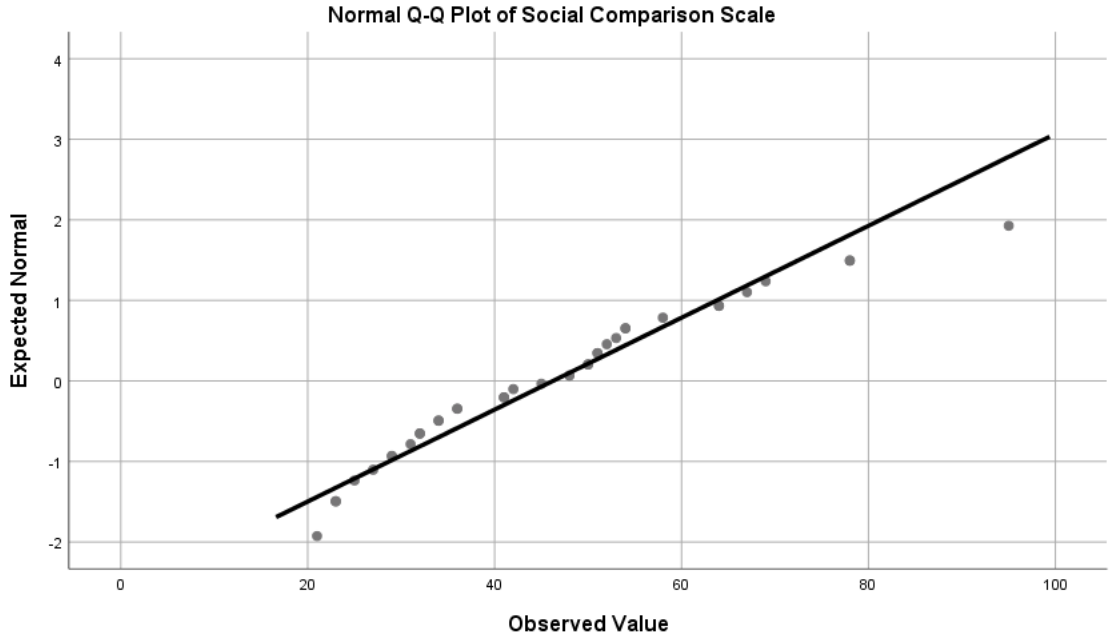

Normal Q-Q Plot of Other As Shamer Scale
Expected Normal
Observed Value
3
2
1
0
-1
-2
-3
0
20
40
60

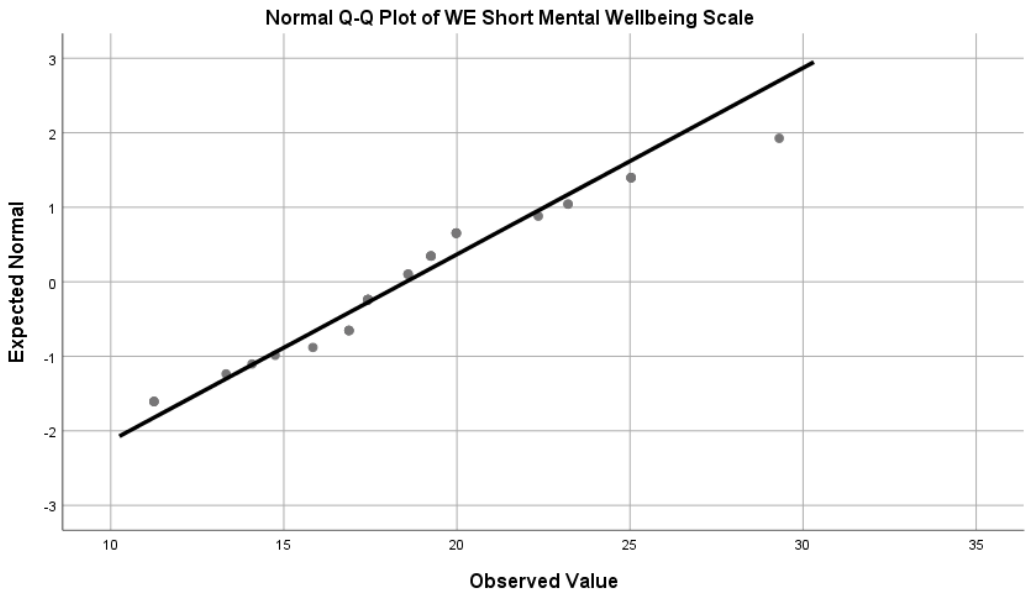

Normal Q-Q Plot of DASS 21 Stress
Expected Normal
Observed Value
2
1
0
-1
-2
-3
-10
0
10
20
30
40
50

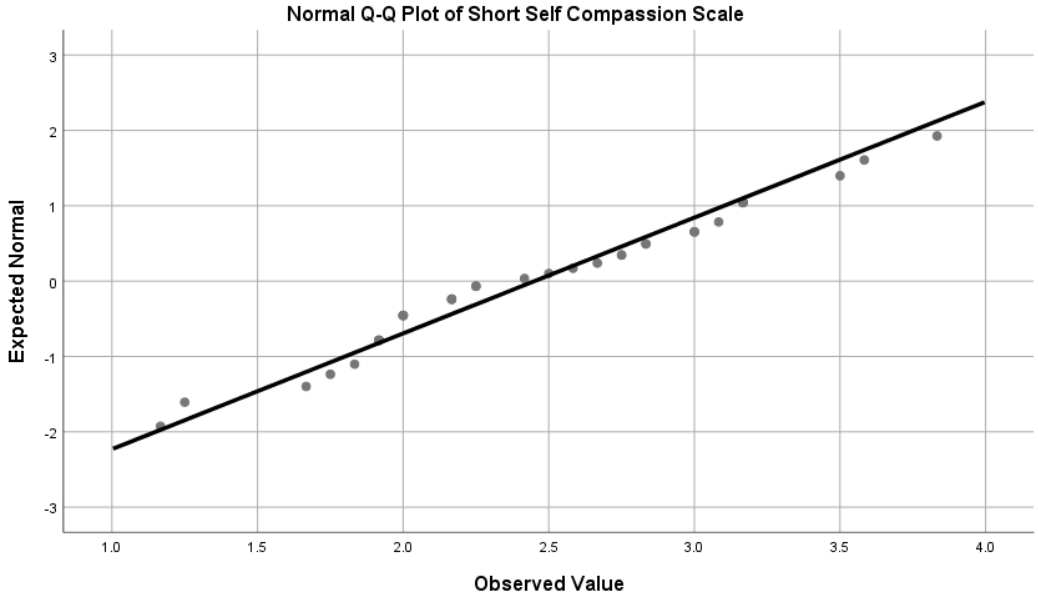

Normal Q-Q Plot of DASS 21 Anxiety
Expected Normal
Observed Value
3
2
1
0
-1
-2
-10
0
10
20
30
40
50


Normal Q-Q Plot of DASS 21 Depression
Expected Normal
Observed Value
2
1
0
-1
-2
-3
-10
0
10
20
30
40
50


Normal Q-Q Plot of DASS 21 Total
Expected Normal
Observed Value
2
1
0
-1
-2
-3
-20
0
20
40
60
80
100
120


Normal Q-Q Plot of Social Comparison Scale
Expected Normal
Observed Value
4
3
2
1
0
-1
-2
0
20
40
60
80
100


Normal Q-Q Plot of WE Short Mental Wellbeing Scale
Expected Normal
Observed Value
3
2
1
0
-1
-2
-3
10
15
20
25
30
35


Normal Q-Q Plot of Short Self Compassion Scale
Expected Normal
Observed Value
3
2
1
0
-1
-2
-3
1.0
1.5
2.0
2.5
3.0
3.5
4.0

## Appendix Q: Z Scores for Non-Normally Distributed Variables

| SWEMWBS - Z Scores | DASS 21 Depression – Z Scores |
|---|---|
| -0.41 | -1.78 |
| 0.01 | -1.60 |
| 1.17 | -1.60 |
| -1.82 | -1.43 |
| -0.28 | -1.26 |
| -0.28 | -1.26 |
| -1.82 | -1.09 |
| 0.36 | -0.92 |
| 1.63 | -0.92 |
| -0.28 | -0.74 |
| 0.36 | -0.74 |
| 0.01 | -0.57 |
| 0.18 | -0.57 |
| 0.18 | -0.40 |
| 0.36 | -0.40 |
| -1.82 | -0.23 |
| -0.28 | -0.23 |
| -0.28 | -0.06 |
| 0.01 | 0.29 |
| 0.96 | 0.29 |
| 1.17 | 0.29 |
| -0.67 | 0.46 |
| -0.41 | 0.46 |
| -1.11 | 0.80 |
| 0.18 | 0.80 |
| 0.18 | 0.80 |
| 2.70 | 0.80 |
| -0.28 | 0.97 |
| -1.30 | 1.15 |
| -0.41 | 1.15 |
| -0.41 | 1.15 |
| -0.28 | 1.15 |
| 1.63 | 1.15 |
| -0.95 | 1.32 |
| 0.36 | 1.32 |
| 1.63 | 1.49 |

**Appendix R: Content Analysis**

The below outlines the initial ideas identified in response to survey questions, these were then categorised based upon shared meanings across ideas. Some ideas related to multiple categories, and therefore were categorised twice (e.g. 'Explicitly LGBTQ' relates to 'acceptance' and 'safe spaces' categories).

What makes LGBTQ+ young people more likely to use services?

| Response | Frequency | Categorised as |
|---|---|---|
| Acceptance | 10 | Acceptance |
| Safe spaces | 13 | Safe spaces |
| Supportive people around them | 5 | Acceptance |
| Explicitly LGBTQ | 11 | Explicitly LGBTQ |
| Friends used the service | 1 | Acceptance & Safe spaces |
| Respectful | 3 | Acceptance & Safe spaces |
| If need medical support | 1 | Accessibility of services |
| Knowledge services and how they can help | 5 | Accessibility of services |
| Knowing what sexual violence is | 3 | Understanding sexual violence |
| Open about sex and sexuality | 1 | Understanding sexual violence |
| Availability of services | 3 | Accessibility of services |
| Not feeling judged | 5 | Acceptance |

And what makes LGBTQ+ young people less likely to use services?

| Response | Frequency | Categorised as |
|---|---|---|
| Perpetrator preventing reporting | 1 | Relationship with perpetrator |
| Anti-LGBTQ+ prejudice | 9 | Anti-LGBTQ+ prejudice |
| Discrimination | 14 | Discrimination |
| Relationship with perpetrator | 4 | Relationship with perpetrator |
| Assumptions about sexual violence (men always perpetrators, men can't be raped) | 9 | Heteronormativity |
| Shame | 8 | Shame |
| Embarrassment | 3 | Emotional impact |
| Pressure report | 1 | Confidentiality & safe space |
| Concerns about confidentiality | 4 | Confidentiality |
| Feeling overwhelmed | 1 | Emotional impact |
| Believing should deal with it alone | 2 | Emotional impact |
| Not seeing sexual violence as serious | 5 | Normalisation of sexual violence |
| Doubting self | 2 | Emotional impact |
| Guilt | 1 | Emotional impact |
| Stigma | 3 | Discrimination |
| Fear of being outed | 5 | Anti-LGBTQ+ prejudice |
| Not understanding if experiences were sexual violence | 3 | Normalisation of sexual violence |
| Don't want family to know | 2 | Family relationships |
| Services far away | 2 | Accessibility of services |
| Won't be taken seriously | 3 | Normalisation of sexual violence |
| Lack of coordination between services | 1 | Accessibility of services |
| Not being understood | 2 | Not being believed |
| Not being believed | 5 | Not being believed |
| Affiliated with the police or government | 1 | Accessibility of services |

What stopped you reporting sexual violence?

| Response | Frequency | Categorised as |
|---|---|---|
| Family didn't want me to | 1 | Family relationships |
| Too young | 4 | Too young |
| Not bad enough | 1 | Normalisation of sexual violence |
| Didn't know who did it | 1 | Relationship with perpetrator |
| Manipulated by perpetrator | 2 | Relationship with perpetrator |
| Services wouldn't take it seriously | 1 | Normalisation of sexual violence |
| Didn't realise was sexual violence | 3 | Normalisation of sexual violence |
| Fear | 2 | Emotional impact |
| Didn't know what services were out there | 1 | Accessibility of services |
| Didn't want to be blamed | 3 | Fear of blame |
| Didn't know consequences for perpetrator | 2 | Relationship with perpetrator |
| Didn't know how to talk about it | 2 | Understanding sexual violence |
| Didn't want to go through criminal justice system | 1 | Accessibility of services |
| Told by others it's not a big deal | 1 | Normalisation of sexual violence |
| Didn't see it as important | 2 | Normalisation of sexual violence |
| Happened with a relative | 1 | Relationship with perpetrator |
| Didn't want to deal with/repressed it | 1 | Emotional impact |
| Felt ashamed | 1 | Shame |
| Knowing it won't make a difference | 1 | Normalisation of sexual violence |

## Appendix S: Initial Codes

| | |
|---|---|
| Anger in response to sexual violence - feeling violated | Accept a lower standard - associated with self-worth |
| Anxiety | Accessibility of services |
| As we get older we should know how to prevent sexual violence | Accessing services as a non-binary person |
| Asking the wrong questions | Bi Stereotypes - sleeping around |
| Avoidance of services | Biological or medical models of gender |
| Awareness of other experiences | Biphobia |
| Being able and supported to talk about sexual violence | Boundaries between sexual violence and sex |
| Being able to relate to staff in services | Boundaries with professionals |
| Being able to trust services | Can't identify perpetrators |
| Being different | Can't rely on others |
| Being drunk | Care and compassion from friends |
| Being made to feel uncomfortable | Cities vs. rural areas |
| Being open about identity | Clubs as predatory environment |
| Belief of sexual violence as commonplace | Coercion, identity used against you |
| beliefs about services | Communication with friends |
| Disclosure to others | Complexities of religious attitudes |
| Disgust in response to sexual violence | Concerns about accessing mainstream services |
| Distrust of services | Consent |
| Drink spiking is normalised | Desire for connections to gay community |
| Emotional impact | Desire for justice in face of sexual violence |
| Emotional impact of not being believed | Desire to be cool |
| Emotional impact of young people supporting each other | Detachment from sexual violence experiences |
| Emotions can be shameful | Different identities will have different service needs and experiences |
| everyday precautions we have to take to try and be safe | Different standards for different gender identities |
| Exclusion from spaces due to identity | Difficult to believe without physical evidence |
| Experience in schools | Difficulties of talking about sexual violence by women |
| Experience is abnormal | Difficulty in naming sexual violence |
| Experiences of sexual violence changes your core being | Disclosure in services |
| Experiences of being believed and heard | Fears that services won't be accepting of your identity |
| Experiences of sexual violence changes your core being | Feeling dismissed due to identity |
| Experiences of stalking | Feeling exposed and invaded due to sexual violence |

| | |
|---|---|
| External factors bring shame onto people | Feeling in shock following sexual violence |
| External support networks | Feeling invisible as a lesbian woman who has experienced sexual violence |
| Failures by system | Feeling respected by others |
| Families don't talk about lgbt sex | Feeling separate from wider community |
| Family attitudes | Feeling under pressure in services |
| Family relationships and responsibility | Feelings of rejection |
| Fear | First experience in services sets the tone |
| Fear of repercussions from others | Focus on legality of sexual violence at expense of emotional impact |
| fears of being pitied | Frequency of sexual violence especially harassment |
| Fears that services won't be accepting of your identity | Friends as family |
| Feeling dismissed due to identity | Friends have to play the role of services |
| Feeling exposed and invaded due to sexual violence | Gay culture |
| Feeling in shock following sexual violence | Hate crimes |
| Feeling invisible as a lesbian woman who has experienced sexual violence | Having to educate services |
| Feeling respected by others | Having to ignore sexual harassment |
| Feeling separate from wider community | Having to justify self to services |
| Feeling under pressure in services | Heteronormative ideas |
| Feelings of rejection | Hierarchy of sexual violence |
| First experience in services sets the tone | Homogenising LGBTQ people |
| Focus on legality of sexual violence at expense of emotional impact | Homophobia |
| Frequency of sexual violence especially harassment | Hook up culture |
| Friends as family | Hopes for the future |
| Friends have to play the role of services | Impact on stereotypes on participants |
| Gay culture | Impact on trust |
| Hate crimes | Impacts of other parts of identity on sexual or gender identity - intersectionality |
| Having to educate services | Importance of consistent staff |
| Having to ignore sexual harassment | Importance of LGBTQ specific services |
| Having to justify self to services | Importance of on-going support |
| Heteronormative ideas | Importance of connections within LGBTQ communities |
| Hierarchy of sexual violence | Increased education and training for services |
| Homogenising LGBTQ people | Independence |
| Homophobia | Individual resilience |

| | |
|---|---|
| Hook up culture | Individual strategies to protect self |
| Hopes for the future | Individualising - avoids societal responsibility |
| Lesbian stereotypes | Inexperience - uncertainty about sex |
| LGBT staff | Insecurity |
| LGBTQ Education in schools | Interactions with cultural ideas |
| LGBTQ people not being accepted by others incl services | Interactions with racism |
| LGBTQ young people are 'slut shamed' | Invasive |
| Life changing impacts | Isolation in experience |
| Living in my identity is dangerous and radical action | Judgement by services |
| Loss of control or power | Judgements from others |
| Making a joke of experiences | Lack of awareness of young person's perspective |
| Making assumptions | Lack of care towards young person's experience |
| Masculinity | lack of knowledge about lgbt sex |
| Media representation of sexual violence | Lack of knowledge about services |
| Media representations of LGBTQ | Legal obstacles |
| Minimisation to protect from distress or shame | Normalisation of sexual violence |
| Minimise sexual violence as life very complex | Not being able to access services due to identity can create shame |
| Minimised | Not being able to plan service use as future unknown and long waiting lists |
| My experiences could be worse | Not being believed |
| Need for peer type support | Not being heard or listened to |
| Need to ensure safety of friends | Not knowing what to do |
| Need to perform power to protect self | Not seeing the whole person |
| Need to tackle roots of sexual violence | Obscuring perpetrator |
| Needing to assert self in services to ensure quality | Other people have responsibility |
| Needing to deal with issues alone | Othering |
| Negative assumptions about how services may be | Others have false or phobic ideas about me |
| Neoliberal | Our society is sexualised which can normalise sexual violence and harassment |
| Questioning self | Overcoming shame |
| Quick response needed | People don't expect you to queer |
| Racism in LGBTQ community | People in minority identities have to educate and challenge others |
| Raising awareness of sexual violence | People should seek for permission for sex, not assume |
| Relationships as one sided | People want to turn bisexual people gay or straight |

| | |
|---|---|
| Relationships should be a certain way | Performing gay stereotype or assumptions |
| Religion and forgiveness | Physical service environment |
| Researching services and other strategies to ensure safe | Pleasure & sex |
| Responsible | Pressures to have sex |
| Restricting what you do to prevent sexual violence | Pressures to prove identity |
| Re-telling stories | privilege |
| Right to sex | Procedural failures |
| Risk | Psychological distress |
| Risk as shameful | Service promotion |
| Risk of invalidation | Service quality |
| Safety | Service resources |
| Secondary trauma | Service use - What others say about services |
| Secrecy | Services - lack of emotion |
| Self-Blame - Rape Myths | Services actions as shaming |
| Self-compassion | Services and staff affected by phobic societal views |
| Sense of perspective | Services as confidential |
| Service - importance of inclusive atmosphere | Services as informal |
| Service - technical, mechanical | Services as intimidating |
| Service attitudes as implicit | Services as knowledgeable |
| Service focus on identity not sexual violence | Services as multi-functional |
| Service promotion | Services as open |
| Service quality | Services as secure base |
| Service resources | Services as too clinical |
| Service use - What others say about services | Services as understanding |
| Services - lack of emotion | Services aware of their limitations |
| Services actions as shaming | Services can have taboo discussions |
| Services and staff affected by phobic societal views | Services could act to reduce stigma and promote LGBTQ |
| Services as confidential | Services create relationships with others |
| Services as informal | Services giving choices and options |
| Services as intimidating | Services making assumptions |
| Services as knowledgeable | Services might think we're less deserving of support |
| Services as multi-functional | Services need to be involved with all parts of the person and their experience |
| Services as open | Services need to consider all minority identities |
| Services as secure base | Societal Standards you have to uphold |

| | |
|---|---|
| Services as too clinical | Societal values as a means of policing behaviour |
| Services as understanding | Society not ready to accept all LGBTQ identities |
| Services aware of their limitations | Society will resist overt acceptance of LGBTQ identities |
| Services can have taboo discussions | Socio-political context of area |
| Services could act to reduce stigma and promote LGBTQ | Someone believes they have a right to my body |
| Services create relationships with others | Staff as frank |
| Services giving choices and options | Staff as open |
| Services making assumptions | Staff in services need to be authentic and genuine |
| Services might think we're less deserving of support | Staff in services to be clear it was not your fault, reassure and build confidence |
| Services need to be involved with all parts of the person and their experience | Staff need to be experienced |
| Services need to consider all minority identities | Stigma |
| Time needed to process | Straight men believe lesbian or bisexual women are there for their pleasure |
| Trans women viewed as promiscuous | Supportive friendships |
| Transphobia | Talking about sexual violence and identity can dishonour families |
| Trauma | Tension between connecting to community due to rejection from society but feeling coerced |
| Uncertainty about how to feel in response to sexual violence | The agenda of the service |
| Uncertainty if experiences are sexually violent | The impacts of sexual violence need more recognition |
| undermined | The Me Too movement |
| Us and them positioning | The more sexual harassment happens in clubs, the more it gets accepted as the norm |
| Validated through friend | The need to be aware of assumptions and biases and challenge these |
| Victim blaming | The process of supporting friends helps to support yourself |
| Vigilance is needed to protect against threat of sexual violence | The support system in marginalised groups |
| Warmth in services | There are correct ways to have sex |
| We have a responsibility to speak out | There is a correct way to be victim - services & society |
| We have battle society on sexual violence | You are not alone in sexual violence |
| We should use services | Young people educating others about identities and societal views |

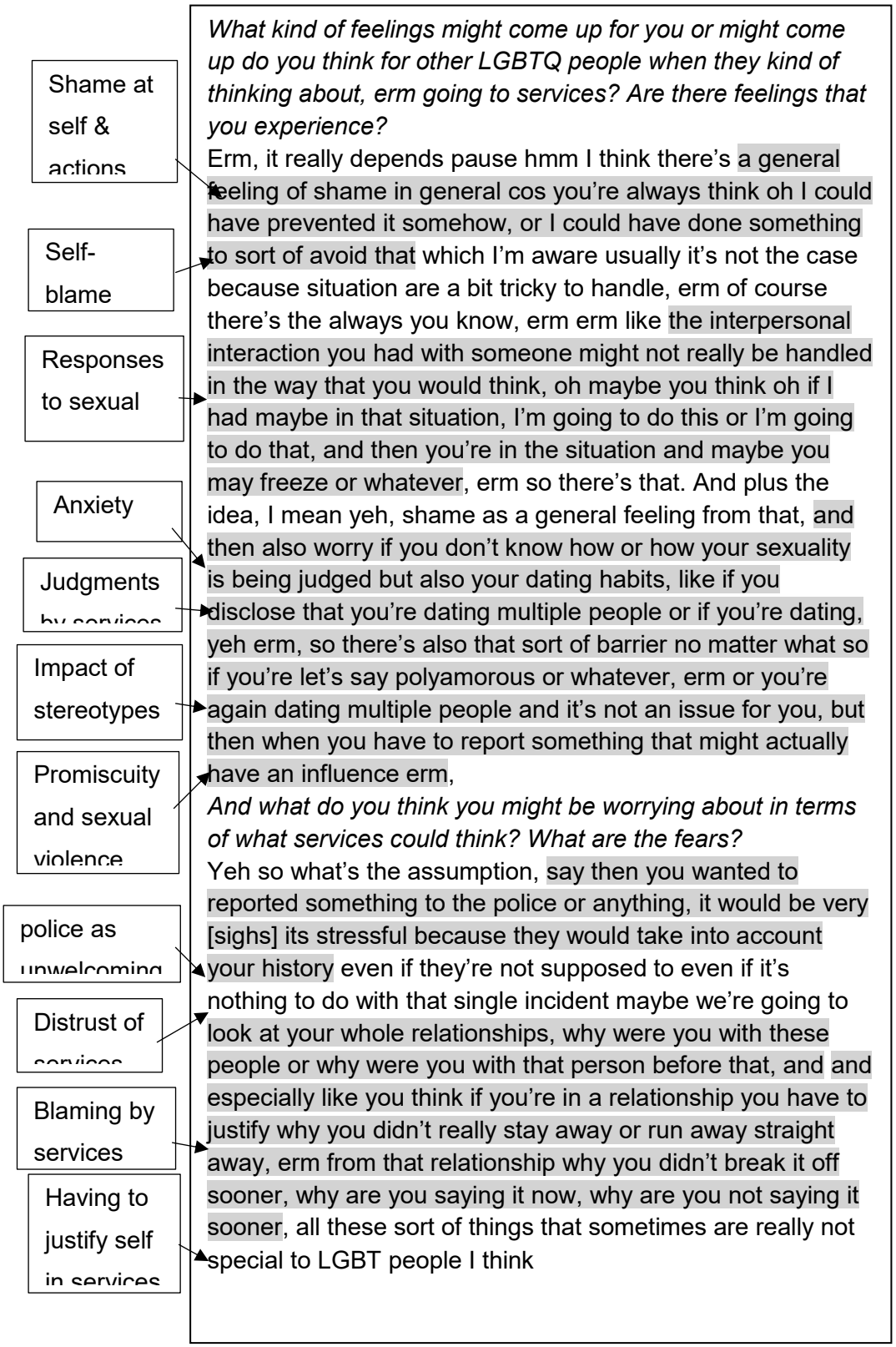
| | |
|---|---|
| What compassionate services look like | Young people having difficult conversations which are less visible in wider society |
| What is right or wrong | Young person's experience less important |
| What we learn about as children | Your identity is the reason for sexual violence |
| what we need from services | White Gay Men's privilege |
| What you were wearing - rape myth | Women as sexual object - the male gaze |
| when sexual violence is prioritised by friends - impact | Women should be desirable - harassment is wanted |
| Wording in services | |

## Appendix T: Intermediate Codes

| | |
|---|---|
| Avoidance of services | Psychological distress |
| Distrust of services | Racism in LGBTQ community |
| Failures by system | Responsible |
| Fear | Re-telling stories |
| Heteronormative ideas | Risk |
| Hierarchy of sexual violence | Safety |
| Independence | Secondary trauma |
| Individual resilience | Stigma |
| Individualising - avoids societal responsibility | There is a correct way to be victim - services & society |
| Insecurity | Wording in services |
| Judgements from others | Being positioned as different |
| Loss of control or power | Consent |
| Making assumptions | Disclosure to others |
| Masculinity | Experiences of victim blaming which creates self blame and shame |
| Minimised | Hate crimes and sexual violence |
| Not seeing the whole person | Homophobia, Biphobia, Transphobia |
| How our identity interacts with our experience in services and society | How services can be warm and compassionate |
| Ideas about gay culture | Ideas about how sex and relationships should be |
| Importance of peer support, LGBTQ services and staff | In clubs sexual violence is common and normalised |
| Interaction with LGBTQ identity and cultural, family or religious beliefs | More education is needed about LGBTQ+ issues and experiences |
| My identity is sexualised (stereotypes) and objectified (male gaze) | Normalisation of sexual violence. Sexual violence is routine and expected by LGBTQ communities |
| Not being believed | People believe we can be deserving of sexual violence |
| Perpetrators of sexual violence | Raising awareness and challenging sexual violence |

| | |
|---|---|
| Realising you are not alone in sexual violence experiences | Risk of invalidating, associated with shame |
| Service - their accessibility, visibility and promotion | Services - how they may be shaming |
| Services - how they work with and support minority identities | Services - uncertainty if safe to disclose identity or sexual violence |
| Services as accepting, safe open and reliable (secure base ideas) | Services making judgements or assumptions about us |
| Sexual violence as taboo and difficult to talk about | Shame avoidance or refusal |
| Societal attitudes towards LGBTQ+ young people | Stereotypes |
| Strategies used to protect against and following sexual violence | Supportive friendships are needed to deal with sexual violence. Friends can play the role of services. |
| The emotional, social and relational impacts of sexual violence | The geographical location |
| The impact of media representations | The legal system and their impact |
| The role of families in making sense of experiences and identities | We have educate others about our identities. More understanding is needed (society and services) |

**Appendix U: Coded Extract Example**



**Appendix V: Initial Thematic Map**

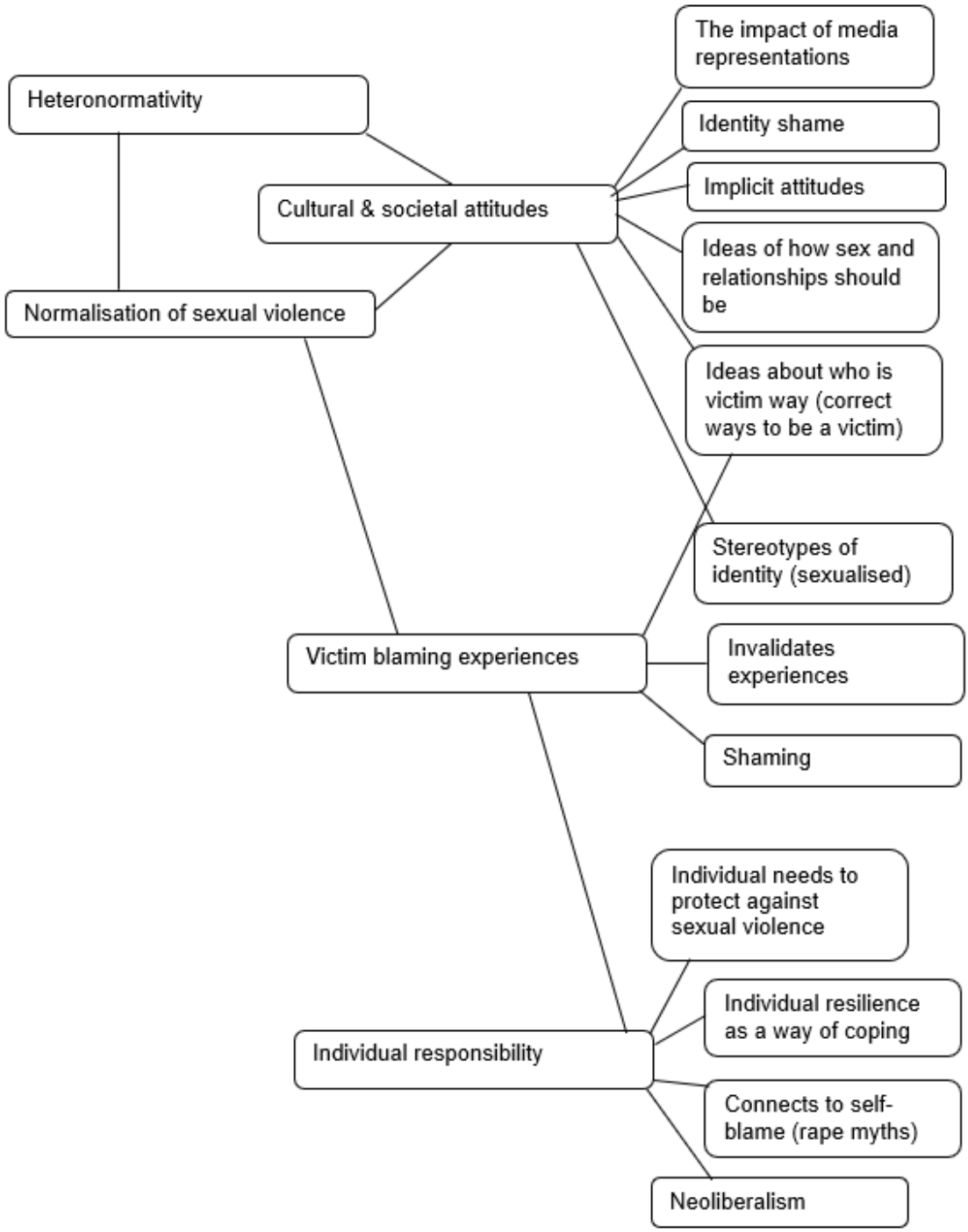



Figure 8: Initial thematic map one (page one)

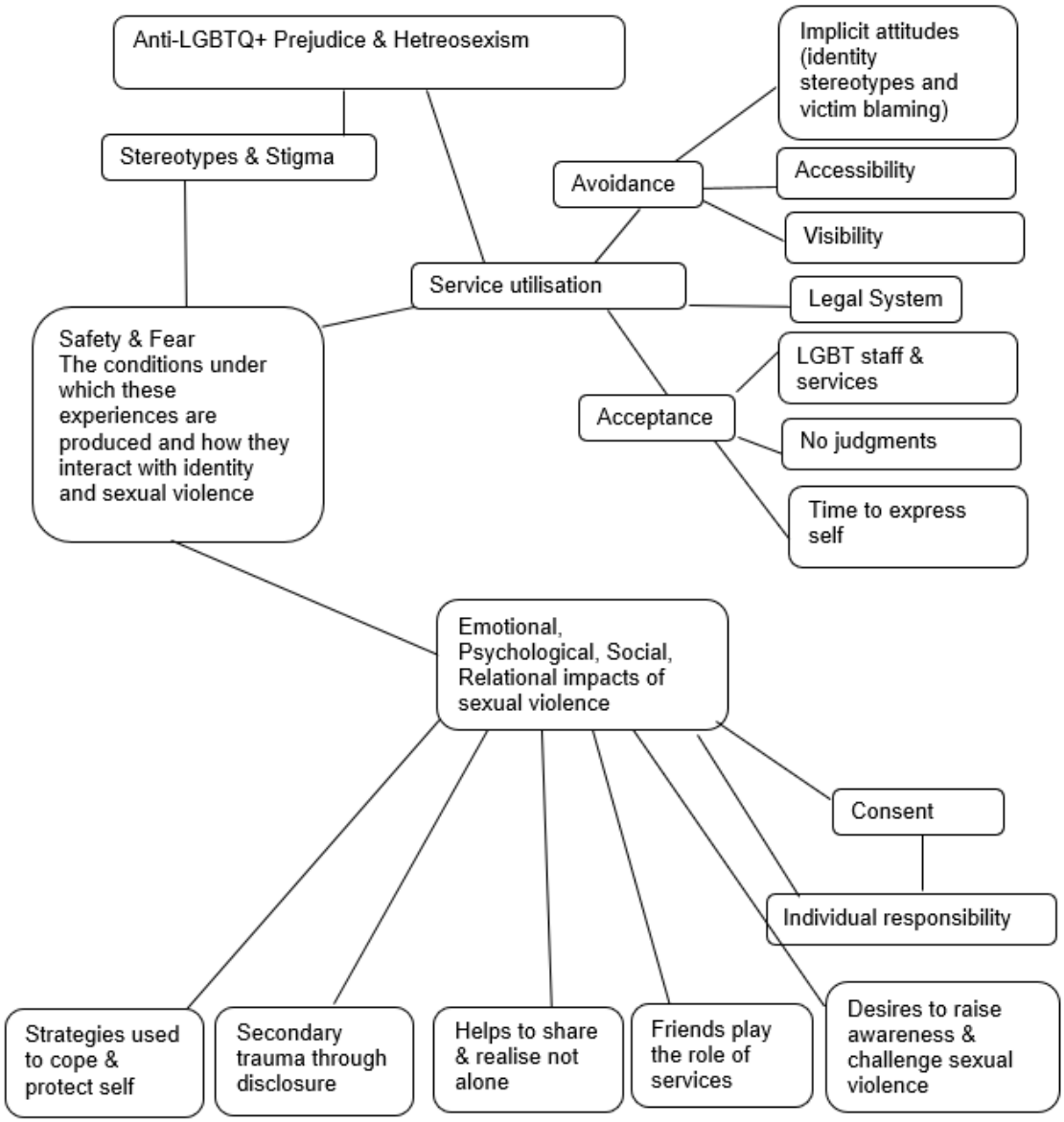



Figure 8: Initial thematic map one (page two)

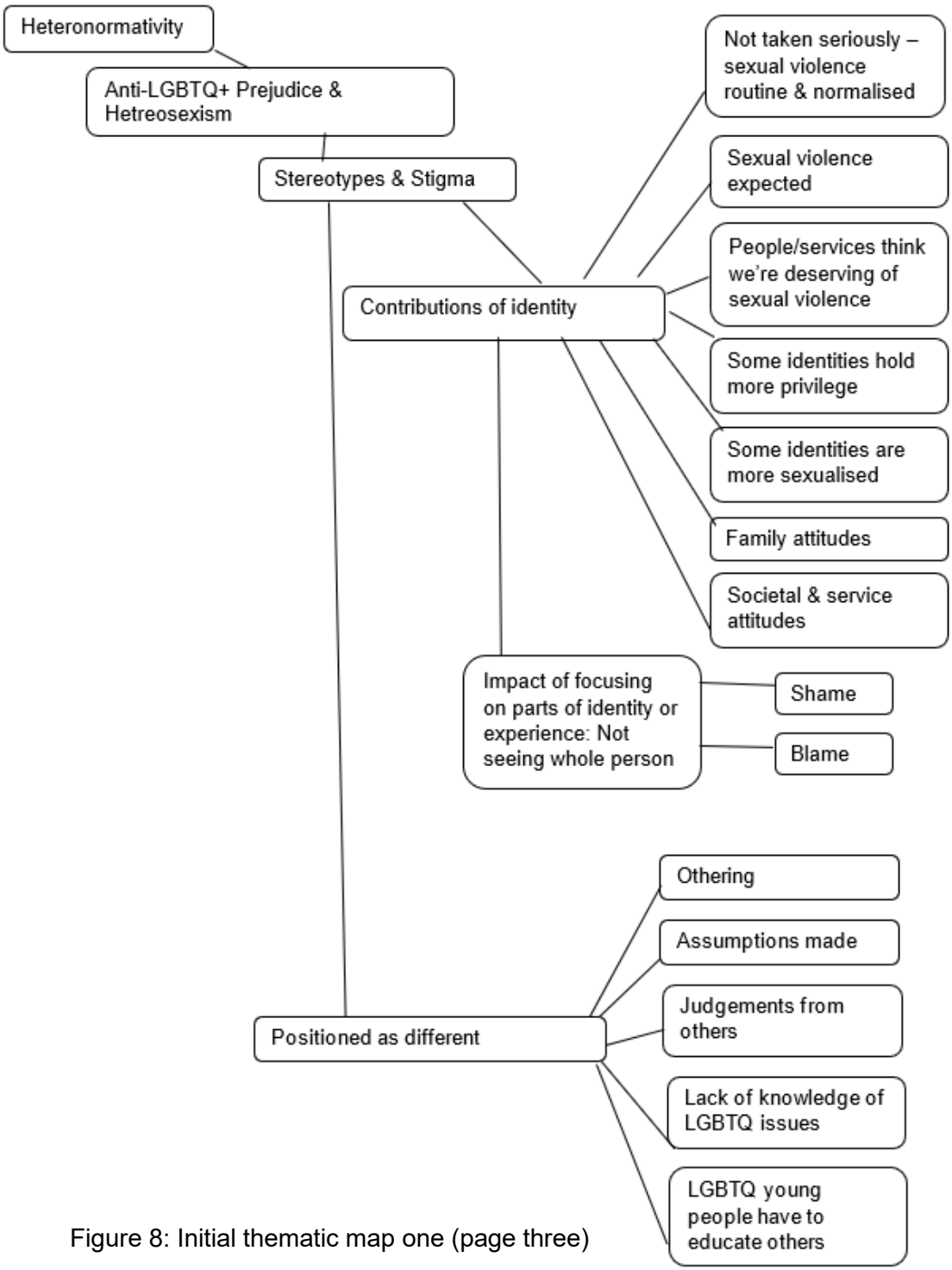



Figure 8: Initial thematic map one (page three)