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Exploring LGBT resilience and moving beyond a deficit-model: findings from a qualitative study in England

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ABSTRACT

The aim of this study is to critique and extend psychological approaches to resilience by examining retrospective accounts of LGBT people in England who had directly experienced or witnessed events that were salient as significantly negative or traumatic. Pre-screening telephone interviews identified ten individuals who matched inclusion criteria (mean age: 39 years; range 26–62 years) as part of a larger study. Interviews were semi-structured and informed by a literature review undertaken at the start of the study. We identified three themes of that extend the resilience literature for LGBTQ+ people: (1) *identifying and foregrounding inherent personal traits* – how non-contextual inborn qualities or attributes needed external effort to be recognised and operationalised; (2) *describing asymmetric sources of social support and acceptance* – the importance of positive environment is unequally available to LGBT people compared to heterosexuals, and uneven within the LGBT group; and (3) *blurring distinctions between resilience and coping* – experiential approaches to moving beyond distress. We suggest that narratives of resilience in the accounts of LGBT people can inform the development of resilience promotion models for minoritized individuals and support movement away from deficit-focused approaches to health policy.

Introduction

Early research focusing on the study of resilience, centred on young people deemed to be 'at risk' of delinquency and sought to understand those internal and external protective factors that guarded against negative social outcomes (see, Garcia-Dia et al., 2013; Garmezy, 1973; Werner & Smith, 1992). Further research leant towards social-ecological or biopsychosocial perspectives to better understand those internal and external factors that indicate personal resilience (Beasley et al., 2015; Greene et al., 2004; Stewart et al., 1997). Research continues to develop and debate the definition and applications of resilience in psychological research (Bartos & Langdridge, 2019; I. H. Meyer, 2015; Riggs & Treharne, 2017). Many have defined resilience with more or less focus on the capacity of the individual, with the defining characteristic of resilience being where individuals demonstrate, 'successful functioning in a context of high risk' (Fraser et al., 1999, p. 136) and 'one's ability to

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bounce back or recover from adversity' (Garcia-Dia et al., 2013, p. 267). Conversely, Masten's (2001) definition emphasises the interactions of internal and external constructs in, 'a class of *phenomena* characterized by good *outcomes* in spite of serious *threats* to adaptation or development' (p. 228, *our emphasis*). Ultimately, while some scholars have thought of resilience in terms of being an extra-ordinary, individualised process (e.g. Fraser et al., 1999), Masten (2001) has argued that it is not out of the ordinary at all, rather it is a demonstration of human adaptability in the face of threatening situations. Thus, observations of resilience have little in the way of uniformity in how resilience is expressed, and it is often described only in terms of outcome. While there are general psychometric instruments that purport to measure resilience objectively (see, Windle et al., 2011) resilience is highly contextual and 'universal' themes in the general resilience literature are highly dependent on context (Wilson & Wilson, 2019).

Much of the literature on the mental health of lesbian, gay, bisexual and trans (LGBT) people has focused on the increased risk we face due to the minority-related stress associated with stigma arising from societal prejudice and discrimination (Hatzenbuehler, 2009; I.H. Meyer, 2003; Kelleher, 2009; Livingston et al., 2019; McConnell et al., 2018; Mustanski et al., 2010). While researchers acknowledge the greater risk LGBT individuals face as a result of the prejudice and discrimination that exists in many societies, Colpitts and Gahagan (2016) have argued that deficit-focused health research only serves to reinforce negative perceptions of LGBTQ (here 'Q' can refer to 'queer' or 'questioning') health. There is a need, therefore, for researchers to make (what they describe as) a 'conceptual shift' towards health-promoting LGBTQ research, including the study of resilience, a gap that we aim to address with this study.

Over the years, researchers have identified a number of traits and characteristics that are associated with the successful navigation of adverse situations. Internal traits associated with resilience in the LGBT population include hope (Kwon & Hugelshofer, 2010), optimism (Bowleg et al., 2003; Kwon, 2013), the ability to accept one's own or others' emotions and process them insightfully (sometimes referred to as emotional literacy, Knight & Wilson, 2016; Kwon, 2013), open-ness and transparency (Kosciw et al., 2015; Lewis et al., 2005), personal hardiness (Smith & Gray, 2009), and lower levels of internalised homo/transphobia (Cortes et al., 2019; Shilo et al., 2015). External factors attributed to resilience among LGBT people focus primarily upon forms of social support. Here social support is used as an umbrella term that includes contextual aspects such as social network size (Fredriksen-Goldsen et al., 2013), family connectedness, other adult caring, and school safety (Eisenberg & Resnick, 2006), family support, friend support, and being in a steady relationship (Shilo et al., 2015). Social support also includes social connectedness (DiFluvio, 2011), community connectedness (Zimmerman et al., 2015), strong ties to the LGBT community (Gray et al., 2015; Shilo et al., 2015), and LGBT-friendly work environment (Rostad & Long, 2007). Missing from the LGBT-focused resilience literature to date, however, is the complexity of how these multiple, inter-secting individual and social contexts are experienced or available asymmetrically.

In terms of those strategies that promote resilience, actions such as seeking out like-minded individuals and/or communities, re-framing personal narratives, re-interpreting ideas and ideologies, collective meaning making and compartmentalisation are often reported (Bowleg et al., 2003; DiFluvio, 2011; Foster et al., 2015; Gray et al., 2015; Scourfield et al., 2008; Wexler et al., 2009). Again, this places the burden of resilience on individuals (cf. Riggs & Treharne, 2017), and fore-grounds the need for further detailed understanding of the idiographic lived experience.

While the rise of LGBT resilience studies indicates that a shift from a more risk-focused approach to a more strength-based approach has already begun (e.g. Russell, 2005), some researchers argue that the focus on individual-level determinants of health ignores those systemic factors that promote poor LGBT health (Bartos & Langdridge, 2019; Mulé et al., 2009). Indeed, Mulé et al. (2009) have also argued that most of the models that have been used to inform studies of LGBT health are not specific to this population; they have been devised for the general population and are underpinned by heteronormative frameworks where it is automatically assumed that the experiences of LGBT people are similar to those of their age-matched heterosexual or cisgender peers. As Colpitts and Gahagan

(2016) demonstrate in their review, some researchers have argued that resilience among LGBTQ populations must be understood and measured through LGBTQ-specific resilience models, acknowledging lived experiences of adversity endured by those navigating non-normative feelings and identities within heteronormative and cisnormative social systems.

The aim of the present study,[1] therefore, is to help illustrate some of the factors that have been theorised to buffer against poor mental health and promote resilience using data from LGBT people with lived experience of distress. This paper aims to answer the question: how are trauma and negative events defined and framed by LGBT people who fit current models of mental health resilience? How can this be informative to promote wellbeing for more people with LGBT lived experience of distress. We argue that closer examination of the experiences of LGBT people who have demonstrated resilience despite accounting narratives of negative or traumatic events whilst growing up provides opportunity to illustrate and direct positive mental health promotion interventions, identify where LGBT-specific resilience-promotion may be effectively targeted to reduce inequities, and further move away from deficit-focused approaches to health policy.

Methods

As noted above, these data form a subset of data for a larger, mixed-methods study. For this arm of the study, our objective was to explore experiences of resilience, which disrupted common deficit-based health literature, through semi-structured interviews with LGBT people (aged 18 years and older) who had reported lived experience of distress, and who did not report developing mental health issues later in life. A conversely defined sample was recruited to probe the experiences of 'risk' (see, Rivers et al., 2018).

Respondents to the larger survey (n = 2183) could opt-in to take part in either set of interviews. Respondents who opted-in (n = 565) were asked to comment on why they were interested to participate in an interview. Respondents considered to be at higher risk (e.g. suicide attempt or self-harm in the past 12 months; drinking alcohol more than once per week; include not currently experiencing mental health difficulties) were excluded from potential inclusion at follow-up interview.

Shortlisted individuals were contacted by telephone by a research assistant using a guide to affirm they met the selection criteria and would not be at risk from taking part in the interview stage (see, Nodin et al., 2015 for further information). For the purposes of the 'resilience' interviews, resilience was defined for the recruitment category as a person who had experience of lived distress but no current or prior mental health distress. Ethical approval for the larger study was obtained from the Ethics Committee of one of the participating university partners in April 2010. Approval for this specific study was obtained in December 2013.

Participants

Ten people who matched inclusion criteria for this arm of the study were recruited as a purposive sample. Given the diversity within the LGBT+ collective-moniker, this is acknowledged as a relatively small sample but fits within the costed resources and delivery time available within the larger study and the parallel data collection on 'risk'.

Provided with three gender categories, five identified as women, four as men and one selected to identify as 'other'. In terms of LGBT identities, four identified as lesbian, three as gay. Two selected 'other' and one participant described himself as a 'straight' crossdresser who identified with the trans community. All identified as a 'White' ethnicity and one participant reported having a disability. Ages ranged from 26 to 62 years (mean age: 39 years). All participants reported that they had experienced or witnessed significant negative or traumatic events earlier in their lives but did not report mental health issues at the time of their interviews (see, Table 1 for all details).

Table 1. Participant Information.

Participant	Age	Gender Identity	Sexual Orientation	Interview Modality	Negative Experiences
Carla	62	Female	Other	Telephone	Diagnosed with paranoid schizophrenia prior to transition from male-to-female
Catherine	43	Female	Lesbian	Telephone	Loss of father to suicide
Janet	25	Female	Lesbian	Face-to-face	Death of father; sexual abuse by step-father
John	50	Male	Gay	Face-to-face	Sexual abuse by teacher
Lawrence	41	Male	Straight	Telephone	Difficult transition into cross-dressing
Leon	54	Male	Gay	Telephone	Physical and emotional abuse by father
Owen	30	Male	Gay	Face-to-face	Severe bullying at school
Sarah	30	Female	Lesbian	Telephone	Parental divorce
Sophie	30	Other	Lesbian	Telephone	Sexual assault; forced to leave country
Vanessa	32	Female	Other	Face-to-face	Family dysfunction; sexual assault; parental divorce

With input from our community advisory panel, the recruitment criteria for resilience had first been defined as a person having experienced or witnessed events that were salient to them as negative or traumatic earlier in their lives but not going on to experience mental health issues. This proved to be self-limiting as a definition for recruitment. Trauma is defined by the American Psychiatric Association (APA) in their *Diagnostic and Statistical Manual of Mental Disorders* (5th edition; DSM-5), in terms of acute exposure to events that 'threaten death, serious injury, or sexual violence' and are experienced directly, witnessed or learned to have taken place (American Psychiatric Association, 2013, p. 271). People whose responses included obvious experiences of acute trauma were likely to have indicated mental health distress whilst volunteers who were assessed as at low-risk often provided accounts that did not fit the DSM-5 criteria of witnessing or experiencing acute trauma. During analysis, we revised our definition of resilience with lived experience of distress. This serves both to utilise and critique the limitations of how trauma has been defined when considering the experiences of some LGBT people in the context of understanding minority stresses (Katz-Wise & Hyde, 2012). Second, the expanded definition of responding to lived experience of distress creates space for emerging narratives of chronic distress that sometimes illustrate responses similar to those defined in the trauma literature (Ellis, 2020; I.H. Meyer, 2003).

Procedure

Recruitment for this arm of the study took place in England between February and April 2014 (see, Nodin et al., 2015 for details). Written consent was obtained from each participant prior to interview data collection. Interviews were semi-structured and used a guide informed by a literature review and the larger study's research questions. Initial questions focused on participants' perceptions of fitting into the specific profile of interest to the study. For example, *'We want to hear from people who believe they have good mental health even though they lived through difficult or traumatic situations in their past. How do you think you fit into this profile?'* Subsequent questions focused on participants' opinions of 'risk' and 'resilience' factors for specific mental health issues affecting LGBT people (e.g. *What would you say can cause problematic alcohol use in LGBT people?*) and responses to preliminary findings from a previous phase of the research (e.g. *responding to survey findings comparing suicidality between LGBT and heterosexual participants*).

We recruited and trained a small team of community volunteer research assistants to conduct and transcribe the interviews (see, Nodin et al., 2015). Six interviews were carried out by telephone, and the remaining were face-to-face due to the geographical location and preferences of participants. The different modalities of data collection used in this study did not impact upon the length of the

interviews or the depth of the data generated. Interviews were audio-recorded and transcribed verbatim by interviewers and reviewed by members of the research team who checked for transcription errors and any information that could compromise the anonymity of participants was removed. Participants' real names have not been used.

Analysis

Following transcription, interviews were analysed using thematic analysis, which allowed the flexibility to incorporate both theory-led and data-driven approaches, as well as move between more essentialist, semantic coding at initial stages and then later take on a more reflexively constructionist approach (Braun & Clarke, 2006) as we recognised tensions in how 'trauma' was co-constructed through the interviews and analysis (Edwards & Holland, 2013). Transcripts were first coded by CP-A and NN, in sequence using a semantic data-driven approach, identifying new codes based on the content of the interviews and guided by the research questions. After initial coding, the codes were examined, evaluated for similarity, and grouped together in a structure, with tentative names assigned to the code groups. Codes with few source references were moved, merged, renamed or deleted after close re-reading of the code content. The code sets were then further grouped into overarching themes. In the later stages of reviewing themes, we recognised tensions in how 'trauma' was co-constructed through interviews and analysis and so IR, AT, and EP provided additional coding to the data selected to illustrate themes.

Findings

In our interviews, participants discussed the promotion of resilience in association with three elements, which we have developed as our themes. The first theme, which we label *identifying and foregrounding inherent personal traits*, amplifies participants' own perceptions of being able to identify personal qualities or attributes that were available to them regardless of context or circumstance. The second theme illustrates how *asymmetric sources of social support and acceptance* highlighted the importance of the environment to our interviewees in their narratives of overcoming adversity. Here, our data evidence how this was described as unequally available to LGBTQ people in varying degrees. The third theme both extends and disrupts these two aspects of resilience and is informative for *expanding resilience and coping strategies* with details from lived experience of effort applied to personal traits and social support.

Participants demonstrated how the resilience and coping factors they discussed were interdependent. For example, the ability to 'talk things out', a coping strategy, is interrelated with having access to and maintaining a support network and, as one participant demonstrates, a degree of emotional literacy to reflect on what is happening at a psychological level.

Identifying and foregrounding inherent personal traits

Several participants perceived internal, individualised strengths, ascribed to physical or psychological traits that helped them to sustain good mental health while enduring distressing events. For example, Sarah indicated that personal qualities such as tolerance and optimism had helped her survive her parent's 'very messy divorce' during her teenage years:

I'm quite a tolerative [sic], optimistic person. And it's only been in the last few years I've realised that I think that maybe . . . I just didn't realise, I don't know if I realised it wasn't what everyone else was like. Y'know, you kind of . . . I think there is something here from the, you kind of get to know yourself a bit better and you realise actually yeah, other people handle things differently (Sarah, age 30)

Here, Sarah discusses attributing resilience to being 'tolerative' and optimistic and goes on to illustrate that she has recognised a lack of consensus across how people respond to similar situations.

Vanessa's account builds on this attribution to internal characteristics by contrasting her own situation with responses of 'clinical depression or mental illness' In her interview, Vanessa conveyed experiences of childhood sexual assault, family dysfunction, and her parents' divorce, but she attributed her resilience to luck and physical traits. 'I think I probably just got lucky with genes. I didn't have, didn't inherit, a pre-disposition to very [sic] clinical depression, or mental illness' (Vanessa, age 32).

Sophie also cited luck for an internal aspect of resilience, having intelligence. 'I guess I am kind of lucky that I am fairly intelligent' (Sophie, age 30). Having been forced to leave her home country as a child, she attributed her intellect to her ability to cope and adapt to a new and unfamiliar environment, describing her ability to meet the challenges of a new system of education and new topics of study and examination. More salient to our participants, from the responses in their interviews, was the significance of social support and acceptance.

Asymmetric sources of social support and acceptance

Separate from personal or intrinsic factors, participants also attributed social support and acceptance as crucial to their ability to withstand adverse experiences. Notably, social support was described as varied and asymmetric. Most participants placed a particular emphasis on the importance of family and/or friends. Importantly, the stories of social support were not consistent in the size of the social support network or whether it consisted of family, friends, or a combination of both. What was salient was the quality of the bonds that were described. For some participants, this meant that they could talk with those close to them about significant and sensitive topics. It also meant that participants felt emotionally close to, supported and understood by significant others – as well as being supportive themselves.

Leon grew up with a violent father who abused him and his immediate family members. He recalled that his siblings were his main source of support:

I think what's really helped us is the fact that we've all been there for each other, that's like it's five children in the family and we've all been there and we still generally by andlarge we get on with each other. So erm I think that's been a big, that sort of bondbetween us all helped us get through that situation (Leon, age 54).

Leon refers to mutual support amongst the five children and constructs their shared bond as essential for – and created by – getting through experiences of emotional and physical abuse.

Carla's account illustrates the impact of external social factors through both positive and negative examples, recalling how, earlier in her life, she was incorrectly diagnosed with schizophrenia and was hospitalised for several months:

I had the unwavering support of my mother, my biological mother. And I mentioned thatbecause it was clinically significant as well as morally excellent. And through theservices of her support, understanding and practical efforts on my behalf over that period,I pretty much recovered! (Carla, age 62)

Carla attributed the distress she faced to transphobia in her community, whereas she assigned resilience mostly to the emotional and practical support she received from her mother. Catherine lost her father at age 13 to suicide. Here, she discussed how having a 'tight' group of friends had helped her cope and recover:

Some of my resilience factors were that I had an extremely good peer support networkuhm at that time, so I grew up with a very tight friendship group who are still, uhm Iconsider to be my best, you know, some of my best friends. You know, thirty years onthey, so that for me is extremely important (Catherine, age 43).

Catherine's quote illustrated a longitudinal sense of connectedness with friends who have provided a consistency across distinct periods of grief and recovery over 30 years.

Vanessa's story illustrated that support was particularly salient when it was triangulated from multiple social nodes, such as family 'to support me' and friends 'to support me, so I've never felt alone in the world' (Vanessa, 32). For Vanessa, resilience came from not feeling 'alone in the world' but always feeling able to talk openly with others. Sarah added in detail to explain the importance of friendships in talking through issues

As an adult, when stuff goes wrong now when I'm struggling, having close friends, andI'm really close to my family, being able to talk things through and have a rant atsomebody and somebody giving you a glass of wine and pat you on the shoulder andunload on is often really helpful. I think if I, or if people don't have that kind of supportit's really difficult to cope with things (Sarah, age 30).

Like Catherine, Sarah's account illustrates a cumulative element of resilience, through the consistency of an available network. Sarah's description of what connection meant to her is textured with various states of talking, ranting, sharing companionship, reassurance, and unloading.

Blurring distinctions between resilience and coping

An environment where one can feel open and accepted is described as important for individuals belonging to groups that are sometimes misunderstood even within the LGBT population. Lawrence, who described himself as a heterosexual male crossdresser, recalled a trans-social group that he joined as an open and accepting space where he could be authentic and not worry about what others might think:

When you get to social evenings or when you are talking to trans friends when you're notcross dressed you can have these unguarded conversations. It can be as good as anevening where you get to dress up. That's an evening when you get to be yourself, that'sthe benefit of going to one of these social groups (Lawrence, age 41).

In this context, the *environment* Lawrence described included space to simply have 'unguarded conversations'. Participants described acceptance in larger social environments, including university, school, workplace, extended family or community as very important. Owen identified moving to his university environment as a key space for shaping resilience in his life, noting the experience of being accepted by peers at this new place as a positive step to emotionally move beyond the bullying that he experienced at his all-boys boarding school:

And so going to university, uh, which wasn't a kind of Oxbridge university, there was a huge range of people. And they, you know, they from the word go, I felt more open to discuss my sexuality, to be open with them and that had no problems at all. At all. Uh in fact I had positive words of encouragement from people: 'Oh it's amazing that- I think it's really great that you can do this'. Um so that really revolutionised my life (Owen, age 30).

Removing oneself from a difficult situation or from other people to be able to compose oneself was a strategy shared by some participants. Sophie described recognising when she needed to 'take some time out' to make a space for feeling through her emotions:

If I get sad, I umm, take some time out. I try to get away from people initially umm if Icry, I cry, I let myself cry. Umm and when I've dealt with most of it or part of it initiallythen I feel like I'm a bit stronger in myself and then I can go to someone else and say thisis what's upsetting me at the moment and at that point I'd started to work through thingsanyway and then other people help (Sophie, age 30)

Being aware of one's own emotions (personal emotional literacy) was an important aspect of being able to cope with negative experiences.

During the interviews, our participants shared some of the strategies that they believed contributed to their personal sense of resilience. In doing so they implicitly articulated an understanding of resilience as '[t]he capacity to remain flexible in our thoughts, feelings, and behaviours when faced by a life disruption, or extended periods of pressure, so that we emerge from difficulty stronger, wiser, and more able' (Pemberton, 2015, p. 2). Some participants said these strategies helped them to frame or understand their experiences, drawing meaning from them and situating them in a particular historical context. For example, some people talked about consulting mental health professionals in order to deal with emotional distresses often unidentified as related to much earlier experiences. They credited this step with providing a structure that allowed them to retain a sense of control. Janet recalled how discussing current problems with a counsellor also gave her space to address underlying issues associated with past childhood sexual abuse

> I think it definitely sort of helped me move past it [childhood sexual abuse]. Um, because I think sort of, talking through it and coming to terms with it, I feel like that sort of allowed me to be like, ok, now I can move on. Yeah, it definitely made a difference (Janet, age 26).

Echoing Owen's physical and emotional move to a safe space, Janet invoked movement and space and 'talking through it'. Owen also felt that psychotherapy as an adult helped him to overcome the bullying abuse he had experienced. Although he indicated that he functioned well on a day-to-day basis, he recalled how he had continued to experience distress arising from memories of school. After seeking help from a therapist, he was able to address that distress:

> It was only until I went to this recent psychotherapist, a couple of years back, whokind of could see it immediately, and then has kind of helped me that I've really kind ofgot on top of it. Um, and that was when I had the kind of biggest peak of feelingdistressed (Owen, age 30)

Janet described using the historical context as a way to compartmentalise (see, Gray et al., 2015) her recollections of the sexual abuse that was enacted on her in her teenage years as a place she is removed from:

> I've compartmentalised it quite effectively, um, so I sort of feel like it's, it's very much in the past, like it's something that has happened to me, but it's in the past, and it's all over and done with, and it's all sorted now, and so I feel like there's sort of … it's 'done'. (Janet, age 26).

Participants also spoke of making positive relational comparisons with similar situations or other people. Lawrence described how, even though he had experienced a great deal of transphobia in his life, he could frame his experiences as having less impact 'compared to other folks'

> Have I had anguish because I am who I am? Maybe a bit but if I look at people who go tothe social support group, people who get attacked, people who are still on anti-depressants you know, who still struggle to hold their marriages together, you know I getoff quite lightly compared to other folks, so yeah (Lawrence, age 41).

Whereas some of the accounts framed lived experiences as something that 'happened to' people, linguistically erasing the attacker, some participants also attributed responsibility to the people who had enacted their negative experiences refusing to accept shame or guilt for events over which they had little control. For example, John (age 50) was emphatic 'he [teacher] should have kept his hands off me' and Janet (age 26) stressed she was not responsible for the sexual abuse that was enacted on her 'it wasn't actually my fault'. This approach to coping was particularly salient where participants recounted incidents of rape, sexual assault or bullying. Taken together, there were a range of approaches, supports and contexts which participants drew on that, in one form or another, contributed to the expansion of their resilience strategies.

Discussion

While this qualitative study was part of a much larger mixed methods exploration of risk and resilience factors among LGBT people in England (Nodin et al., 2015), our specific focus on resilience among those who consider themselves as having lived through significant negative or traumatic events without reporting long-term and pervasive mental health issues is important for several reasons. First, it describes a much clearer illustration of those factors participants believed to be key in safeguarding mental health. Second, it identifies key others in the lives of LGBT people who play a part in promoting well-being. Third, it explains key coping strategies that can be introduced by mental health professionals to support recovery from early negative experiences. Finally, it points to forms of support that may be accessed by those who identify as LGBT to prevent or alleviate the development of mental health problems in later years.

The themes we have identified in our analysis fit – to a certain degree – with those factors proposed by Greene et al. (2004) in their analysis of the theoretical and professional conceptualisations of resilience. For example, they also identified three core factors. Firstly, comparable with our findings, they identified internal factors such as attitude, intelligence, problem-solving skills, a sense

of agency and what they described as 'a survival instinct' (p. 82) as key. In terms of external factors, they too argued that social support (whether it be from family members, teachers, peers or community members) has a significant role to play in challenging adversity. However, when it comes to coping strategies, our results substantially diverge from those of Greene and colleagues. While they found it was important for professionals to recognise the pain of those they were supporting and the need to mobilise community members to promote attachment and reintegration, they also talked about role-modelling and finding meaning in survival. In contrast, in our study, the skills we identified, in addition to talking, seemed more clearly linked to an ability to understand emotional states, navigate personal stories, compartmentalise negative thoughts (consigning them to the past) and recognise the role of others in exposing our participants to significant negative or traumatic situations. These differences are not unsurprising. Greene et al.'s data was primarily drawn from the perspectives of 18 professionals experienced in working with clients who had experienced trauma. More importantly, Greene et al. did not review or discuss studies relating to LGBT lives. Thus, while our findings indicate that some of the basic factors underpinning LGBT resilience are the same for heterosexual and cisgender people, there are also differences.

A key point of difference between studies of LGBT mental health and those conducted with heterosexual and cisgender populations relates to social support and acceptance within communities. As Kosciw et al. (2015) have pointed out, when young LGBT people decide to disclose their sexual orientation, they must consider whether family members, friends, community members and even community leaders will be accepting and support them. We know that for some young people support is not forthcoming, namely support is experienced asymmetrically across the 'LGBT' umbrella term. Rivers and Gordon (2010) pointed out that while gay and bisexual young men are less likely to assess the potential fallout from coming out for the first time, lesbian and bisexual young women are much more likely to be outed and subject to emotional conditionals where parents or significant others express negative emotions that elicit guilt, anger or sadness.

An additional point raised by Greene et al. (2004) in their conceptualisation of resilience relates to the importance of role-models. For many LGBT people, especially those who grew up before many of the legal and social changes that have resulted in a greater acceptance of LGBT identities, there was a distinct lack of role-models in society and thus little in the way of evidence of resilience (Rostosky et al., 2015). Therefore, the presence of many LGBT role models in Western society today (including England where our study took place) does not negate the fact that, for older members of our LGBT population, the experience of growing up was one of perceived isolation and self-reliance.

For the participants in our study, open and accepting environments were primarily LGBT-friendly environments. Developing ties to and active participation in communities that are LGBT-friendly has clear mental health benefits together with the ability to be open and authentic as Lawrence, one of our participants, pointed out (Kosciw et al., 2015; Lewis et al., 2005). Concomitant with social support, support from health professionals was also found to be a significant buffer against long-term mental health problems. This is comparable with Eisenberg and Resnick's (2006) finding that 'other adult caring' can have a significant impact upon the lives of LGBT youth. However, as Nodin et al. (2015) found in the larger study linked to this one, professionals who are not specifically trained to work with LGBT clients can have a negative impact on well-being among LGBT people.

Strengths and limitations

One of the strengths of this study and the model of LGBT resilience promotion we have proposed resides in its grounding in data collected from LGBT people who are themselves resilient. Our participants not only self-identified as resilient but also met criteria described by Masten (2001) in that they all had experienced or witnessed significant negative or traumatic events earlier in their lives; however, their outcomes in adulthood had been 'good enough'. For this study, 'good enough' was determined to be synonymous with not having poor mental health at the time of interview. A second strength lies in the fact that this is the

first qualitative study of LGBT people who self-identify as resilient, who understand their own resilience processes, and can provide an account of those factors they feel have contributed to their positive outcomes. Notwithstanding those strengths, we also acknowledge that our study has several limitations. This is a qualitative study based, to a certain extent, on self-description, and we recognise that there is a level of subjectivity with respect to the extent to which the histories recounted to us by participants were 'high-risk' or significantly negative. This limitation was partially addressed by using filtering and recruitment protocols which aimed at increasing the accuracy of the study's selection criteria. Linked to this first limitation, there was no way we could independently assess whether the outcomes described by participants were 'good enough' at the point of screening. Some participants did narrate stories of past mental illness; however, those stories also suggested a degree of recovery brought about by their ability to access inherent personal traits, seek social support and acceptance and utilise coping strategies effectively. Thus, we argue that the process of screening we employed taken together with the utilisation of self-defined negative experiences or events has ecological validity: our data reflect a diversity of personal negative experiences and challenges and, more importantly, provides insights into individual responses to those challenges.

As we have noted elsewhere, our data does, in part, reflect existing models of resilience found within heterosexual and cisgender populations (Greene et al., 2004). It does therefore seem to be the case that people across the sexual orientation and gender-identity spectra do share some common adaptation mechanisms that promote resilience. However, there are some notable variations and nuances which we hope will advance the field of LGBT health promotion and research. Finally, in addition to our sample being small (in part due to the screening criteria employed and the niche nature of the participant profile that was targeted) it was also drawn from one ethnic group. Ties to one's ethnic community can also shape access to social support (Bowleg et al., 2003; Gray et al., 2015), and caution should be exercised in generalising our findings to populations with intersectional experiences of stigma, trauma, and/or resilience. The small sample size of this arm of the study limited the ability to explore distinctions within diverse LGBT identities. These points evidence that further research could extend this work with more homogenously defined communities.

Implications and future directions

There are several summary points we wish to highlight that arise from this study. First, it is clear that familial and other support systems play a pivotal role in fostering resilience; hence, there remains a need for therapeutic, public, and educational interventions aimed at creating supportive and accepting environments for LGBT people. This should be a primary goal for intervention in this area, as opposed to tackling preventable mental health issues that impact upon LGBT people. Second, health/mental health professionals were identified as a key group who promoted resilience among participants. It remains imperative that efforts to sustain the availability of LGBT-friendly health services are prioritised (Bowling et al., 2019). It should be noted that PACE – the lead LGBT community mental health partner for this project closed soon after this study was completed. Third, further qualitative research into the experiences of resilience among LGBT people is warranted, paying particular attention to those environments and communities where LGBT people experience lesser acceptance (Hatzenbuehler et al., 2011). Further research is also needed into resilience among specific subgroups within the LGBT population not represented by this study. It is suggested that comparative studies be undertaken to better understand the individual characteristics of resilience that are community, culture or identity specific. Finally, we suggest that further research is needed to better understand how the different resilience factors identified in this study promote and/or depend on each other.

In conclusion, resilience remains a term that has many definitions. This study provides an insight into the ways in which a sample of LGBT people understands and describes their own resilience having experienced or witnessed significant negative or traumatic events earlier in their lives. It provides a model of LGBT resilience promotion that recognises individual as well as social and skills-based factors that explain participants' mental health or, more specifically, the absence of self-reported poor mental health.

Note

1. The current study represents one aspect of a larger five-year study (2010–2015) focusing on risk and resilience among LGBT people in England (see, Nodin et al., 2015; Rivers et al., 2018; Tyler et al., 2016). The project was developed by the London-based charity PACE (represented by NN & CP-A) in conjunction with academics from three universities (EP, AT & IR). It was funded by the Big Lottery Fund.

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