How do sexual and gender minority people acquire the capability for suicide? Voices from survivors of near-fatal suicide attempts

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Abstract

Despite well-documented disparities by sexual and gender minority (SGM) status in suicide attempt and mortality rates, few studies have investigated the lived experiences that contribute to SGM people’s disproportionate risk of suicide. Having a history of at least one near-fatal (or medically serious) suicide attempt serves as a proxy for suicide mortality, but no known study has involved SGM people who have made such an attempt. Ideation-to-action theories of suicide posit that individuals acquire the capability for suicide through repeated exposure to painful and provocative events – namely, traumatic, threatening, and risky experiences – that can diminish the pain and fear of death. Yet whether identity-specific features of acquired capability for suicide contribute to SGM people’s disproportionate risk of suicide remains unknown. Drawing upon interviews with 22 SGM people who experienced a recent near-fatal suicide attempt, the current study sought to identify specific determinants of how SGM individuals acquire the capability to kill themselves, a potentially powerful, and modifiable, pathway to suicide. Results identified three SGM-specific contributors to the acquired capability for suicide: (1) identity invalidation during developmentally sensitive periods of childhood and adolescence that left participants feeling erased, invisible, and, in some cases, non-existent; (2) normalization of suicide within SGM social networks that increased acceptability and reduced the fear of suicide; and (3) structural stigma and SGM community trauma as habituating sources of pain that engendered feelings of exhaustion and positioned suicide as a reprieve from pervasive anti-SGM norms. This study demonstrates that dominant suicidology theories might need to be refined to account for the stigma-related determinants of SGM suicide. Further, this study reinforces the importance of qualitative methods...
for understanding the lived experience of suicide and calls for SGM-specific suicide prevention efforts to respond to stigma to support those SGM people who contemplate suicide.

1. Introduction

1.1. The epidemiology of sexual and gender minority suicide

Sexual and gender minority (SGM) people are at increased risk for suicidal thoughts and behavior compared to their heterosexual and cisgender peers. Population-level epidemiological studies indicate that sexual minorities (e.g., lesbian, gay, bisexual, queer, or same-gender-loving people) are more likely to think about suicide, make a plan to attempt suicide, and attempt suicide than heterosexuals (Haas et al., 2010; Plöderl et al., 2013). More recent population-based studies drawing upon mortality data also suggest that a disproportionate number of sexual minorities die by suicide than heterosexuals (Björkenstam et al., 2016; Cochran & Mays, 2015). These disparities extend to gender minorities (i.e., transgender, gender non-binary, genderqueer, or any person whose assigned sex at birth does not align with their current gender identity). Specifically, a preponderance of evidence from non-probability samples (Marshall et al., 2016; Wolford-Clevenger et al., 2017) and an emerging body of population-based studies (Boyer et al., 2021; Johns et al., 2019) demonstrates that gender minorities also experience sharply elevated rates of suicidal thoughts, behavior, and mortality.

In addition to establishing the magnitude of the suicide disparity affecting SGM people, epidemiological research has focused heavily on identifying SGM-specific correlates and risk factors of suicidal ideation and attempt (Haas et al., 2010; Tomicic et al., 2016; Virupaksha et al., 2016). Many studies assessing epidemiological risk factors for suicide among SGM samples have utilized a minority stress framework for sexual minorities (Brooks, 1981; Meyer, 2003) and, more recently, a gender minority stress framework for gender minorities (Tan et al., 2020; Testa et al., 2015). These minority stress frameworks posit that SGM people face unique stressors – including discrimination, anti-SGM attitudes, expectations of identity-based rejection, and the internalization of anti-SGM stigma – resulting from living in a cisheteronormative society. In turn, minority stressors contribute to poor mental health and suicide risk over-and-above the influence of general life stressors. There is substantial quantitative support for the association between minority stressors and suicidal thoughts and behaviors among SGM people (e.g., Meyer et al., 2015; Tebbe & Moradi, 2016). While these frameworks have advanced understanding of factors potentially contributing to elevated suicide risk among SGM individuals, substantially less work has sought to position SGM-relevant life experiences within dominant suicidology theories developed in general population samples. Further, most epidemiological studies assess ideation and behavior (e.g., lifetime suicide attempt) rather than more specifically examining suicide mortality.

1.2. Qualitative SGM suicidology

While epidemiological studies are critical to explicating the SGM disparity in suicidal ideation and attempt and delineating potentially intervenable risk factors, quantitative research can fall short in capturing the complexity of any given suicide. In Night
**Falls Fast: Understanding Suicide.** Kay Redfield Jamison reflects on the shortcomings of quantitative suicidology, noting, “psychological states, complex motives, and subtle biological differences are difficult enough to ascertain in the living; determining their existence, or the role they may play in those who die by suicide, is something else again” (Jamison, 2011, p.19). Qualitative research is particularly suited to moving beyond singular explanations or risk factors to facilitate deeper understanding of the lived experiences, motivations, and rationales of people who attempt suicide (Hjelmeland, 2016; Hjelmeland & Knizek, 2010). Yet such understanding is often unachievable in epidemiological studies by virtue of the fact that, “many of the relational, contextual, and historical factors which are relevant for understanding human suffering and suicidal despair are not easily amenable to categorization, measurement, or replication” (White, 2016, p.336). Only by qualitatively understanding suicide among SGM people can we begin to make meaning of why this group is disproportionately represented among those who die by suicide and, ultimately, lay the groundwork for timely and responsive suicide prevention efforts.

SGM qualitative suicidology is a nascent field, but its few existing studies profoundly advance understanding of what leads to a troubling number of SGM people ending their own lives. One of the earliest published qualitative studies focused on SGM suicide explored the lived experiences of suicide risk and resiliency through interviews with eight young gay men in New Zealand (Fenaughty & Harré, 2003). Authors developed the Seesaw Model of Bisexual and Gay Male Suicide which captured how the men described negotiating a “constantly fluctuating balance (p. 17)” between factors that tipped the proverbial seesaw towards suicide (e.g., social isolation, internalized homophobia, bullying) or towards resiliency (e.g., positive role models, belonging, self-esteem). A more recent advancement to SGM qualitative suicidology is Salway and Gesink’s (2018) effort to refute and expand upon the dominant narrative of gay suicide as being strictly tied to adolescent experiences such as homophobic bullying as was popularized by the It Gets Better campaign (Savage & Miller, 2011). Authors interviewed seven gay men in Canada who had attempted suicide between two and four times as adults and developed five suicide narratives spanning themes of pride, trauma-and-stress, legacy and permanence, anti-gay heterosexism, and feared erasure from the contemporary gay rights movement (Salway & Gesink, 2018). Most recently, qualitative researchers sought to understand the suicide histories of 85 transgender youth from the US and Canada (Hunt et al., 2020). Interviews identified four themes including belongingness, thwarted belongingness, embodiment, and self-preservation. Embodiment, particularly, documented a rich and complex physical-psychological interplay between gender dysphoria, body issues, and suicide whereby participants described feelings of dissociation from their bodies and subsequently attempted to physically reconnect with their bodies through the pain of self-harm and suicidal injury (Hunt et al., 2020). Taken together, these qualitative studies and a handful of others (e.g., Creighton et al., 2019; Ferlatte et al., 2019; Williams et al., 2018) emphasize the need to account for SGM-specific pathways of suicide in this population.

**1.3. Near-fatal attempts as an important, but rarely assessed, outcome**

At the same time that they provide an important advance beyond the documentation of epidemiological risk factors, these qualitative studies are limited by their use of broad
suicidality inclusion criteria. All studies to-date have defined inclusion by reporting any history of suicidal thoughts or reporting at least one suicide attempt regardless of seriousness. To our knowledge, no qualitative study with SGM samples has focused on individuals with a history of at least one near-fatal (or medically serious) suicide attempt despite such attempts offering “a valid proxy for completed suicides in research investigating the suicidal process and suicide prevention strategies” (Marzano et al., 2009, p.153). Quantitative studies have likewise rarely investigated death by suicide or medically serious suicide attempts, hampering clear understanding of pathways to lethal or near-lethal suicide attempts in this high-risk population (Haas et al., 2019). Yet by including SGM people who have experienced a recent near-fatal suicide attempt, researchers can better understand how they acquired the capability to kill themselves, a potentially powerful, and modifiable, pathway to suicide.

1.4. Acquired capability for suicide

Most people who think about suicide will never attempt or die by suicide (Nock et al., 2016); thus, understanding the transition from suicidal thoughts to action among those who attempt or die by suicide is critical to preventing suicide. In the past decade, ideation-to-action theories of suicide have documented important features of this transition (Klonsky et al., 2018). The Interpersonal-Psychological Theory of Suicide (Joiner, 2007; Van Orden et al., 2010) first proposed the notion that people who die by suicide (or who make a near-fatal suicide attempt) must overcome the evolutionarily adaptive fear and pain of death. This theory postulates that individuals acquire capability for suicide through repeated exposure to painful and provocative events – namely, traumatic, threatening, and risky experiences – that can habituate a person to the pain of death and diminish the fear of death (Van Orden et al., 2010). A recent review of quantitative studies assessing painful and provocative events found some – albeit mixed – evidence of an association between traumatic exposures (e.g., combat, childhood physical and sexual abuse, interpersonal violence) and acquired capability. This review found stronger evidence of an association between indirectly and directly self-damaging behaviors (e.g., engaging in non-suicidal self-injury, previous suicide attempts) and acquired capability (May & Victor, 2018). A more recent study found that for Black (but not White) adults, discrimination was associated with increased capability for suicide (Brooks et al., 2020), suggesting a potentially important route through which members of stigmatized groups may acquire the capability for suicide.

Few studies have investigated the acquired capability for suicide among SGM samples. One quantitative study with sexual minority adults found correlations among acquired capability, earlier awareness of one’s sexual orientation, and earlier coming out, suggesting that sexual minorities who came out earlier might have been exposed to more sexual orientation-related painful and provocative events (e.g., violence) thus contributing to their risk for suicide (Plöderl et al., 2014). Among transgender and gender non-conforming youth, higher acquired capability for suicide has been found to be quantitatively associated with a history of suicide attempt, but not suicidal ideation, demonstrating the potential utility of acquired capability in explaining suicidal behavior (but not ideation) among this population (Grossman et al., 2016). However, no known study has sought to understand how
SGM people may uniquely acquire the capability to die by suicide by studying their lived experiences.

That a disproportionate number of SGM people attempt or die by suicide indicates that features of acquired capability that are specific to participants’ experiences as SGM people may contribute to this population’s disproportionate risk. Yet quantitative studies assessing painful and provocative events contributing to the acquired capability for suicide overwhelmingly use the Painful and Provocative Events Scale (PPES; Bender et al., 2011), developed in a general population sample. The included events on this scale – and common conceptions of painful and provocative events in general – often do not consider the identity-relevant nuances of certain traumatic events that might be especially painful for members of stigmatized populations including SGM. For instance, many of the events listed on the PPES simply inquire about exposure to adventure-related activities (e.g., skydiving, rock climbing, playing a contact sport). A few of the events that do constitute potential triggers of acquired capability are known to be elevated among SGM people (e.g., experienced or witnessed physical/sexual abuse), yet there is no distinction on the PPES delineating whether or not someone experienced or witnessed abuse motivated by identity-specific bias. Further, there are no events on the PPES that inquire about exposure to discrimination despite clear and consistent evidence that discrimination is a precursor to suicide attempts among SGM people (Clements-Nolle et al., 2006; Layland et al., 2020) and is associated with acquired capability among minority adults (Brooks et al., 2020).

1.5. The current study

This study represents the first to draw upon the voices of SGM people who have experienced a near-fatal suicide attempt to better understand their lived experiences and conceptualize how they acquired the capability to kill themselves. Exploring the lived experiences – including the painful and provocative experiences – of SGM people who nearly died by suicide (rather than those who might have had thoughts of suicide or have made a less serious suicide attempt) can advance our understanding of how this disproportionately affected group may uniquely acquire the capability for suicide. Further, listening to how individuals who made a near-fatal suicide attempt understand, interpret, and make meaning of their own pathways to suicide is a critical methodology that has been rarely applied to SGM people (White, 2016).

2. Method

We interviewed 22 self-identified SGM adults aged 18 years or older who reported at least one near-fatal suicide attempt in the previous 18 months. The definition of ‘near-fatal’ involved a suicide attempt that could have resulted in death if not by chance (e.g., a roommate came home early) or medical intervention, or if the suicide attempt used a highly lethal method (Douglas et al., 2004; Marzano et al., 2009). We operationalized this construct as attempting suicide using: (1) a high-fatality method (e.g., firearm, hanging, drowning, jumping from height, stepping in front of a moving vehicle, crashing a moving vehicle); (2) overdose resulting in admission to a hospital’s intensive care unit; or (3) cutting or stabbing a vital body part (i.e., neck, abdomen).
Participants were recruited from across the United States using advertisements on social media platforms targeted to SGM people. Of note, advertisements did not mention the focus of the study on either SGM identity or near-fatal suicide attempt, but simply enquired, “Have you experienced suicidal thoughts or attempted suicide?” This recruitment strategy was used to avoid biasing selection into the study (i.e., by only recruiting individuals whose SGM identities were salient) or priming participants to tie their suicide histories to their SGM identities. No individuals refused participation after learning, during the consent procedure, of the study’s emphasis on the lived experiences of SGM people who attempted suicide. In total, 583 individuals began the study screener which obtained sociodemographic characteristics (e.g., age, sexual orientation) and suicide attempt histories (e.g., number of past-18-month suicide attempts, suicide attempt methods). Of these, 27 were determined to be eligible and 22 consented to participate in a one-on-one interview.

Interviews were conducted by the first author by phone between October and December 2020 and followed a semi-structured interview guide developed by the authorship team. Interviews were conducted by phone given previous research suggesting that participants in qualitative research on sensitive subjects often prefer phone interviews rather than face-to-face interviews due to convenience and the ability for participants to be open and honest despite the potential for emotional upset or fear of experiencing humiliation face-to-face (Heath et al., 2018). Interviews were, on average, 48 min in length, ranging from 31 to 67 min. The interviewer asked about the participant’s near-fatal suicide attempt, mental health and suicide attempt histories, perceptions of what led to their suicide attempt, and how being an SGM person affected their life. This study was approved by the Yale University Institutional Review Board (# 2000028648).

Interviews were confidentially transcribed by a transcription company and data were coded in Dedoose software (Dedoose Version 8.0.35, 2018) by the first and third authors with supervision from the second and fourth authors. Data analysis followed a flexible and reflexive thematic analytic framework with combined inductive and deductive approaches (Braun & Clarke, 2006, 2013, 2019, 2020). In adhering to a reflexive thematic analysis approach (Braun & Clarke, 2019, 2020), we acknowledge that our analysis is a reflection of the intersection of the data, the theoretical assumptions of the analysis, and our research team’s analytic skills, knowledges, and resources. Our research team was knowledgeable about suicidology theories, including theories of acquired capability for suicide, but we tended to prioritize participant voices in guiding the analysis. Indeed, given the study’s focus on advancing existing theory regarding SGM people’s suicide experiences, any patterns that emerged during analysis that did not clearly align with existing theory were highlighted. In relying as much as possible on the participants’ subjective meanings of their lived experiences, we engaged in qualitative research grounded in social constructivism (Creswell & Poth, 2013; Denzin & Lincoln, 2011). In practice, we utilized broad, open-ended questions to understand the lived realities of the participants within their own unique backgrounds and settings. Further, throughout the analytic process, we recognized that our positionality as researchers shaped our interpretation of participants’ lived experiences.

To conduct the analytic process, the first and third authors read and re-read all interviews, coded six of the same interviews to develop an initial codebook that included a combination of inductive codes (i.e., in vivo codes directly drawn from participants’ words [“feeling
like I’m nobody”]) and deductive codes (e.g., codes based on existing theoretical constructs such as components of the interpersonal theory of suicide (“thwarted belongingness”)), and then divided and coded the remaining interviews line-by-line. Dedoose software includes a “living codebook” that can be edited and expanded by multiple coders throughout the analytic process, thus allowing for real-time codebook refinement and application. After the first and third authors coded all interviews, the entire authorship team met over several meetings to identify, develop, and define themes. Aligned with reflexive thematic analysis (Braun & Clarke, 2019, 2020), this process was collaborative, “aiming to achieve richer interpretations of meaning, rather than attempting to achieve consensus of meaning (Byrne, 2021).” In a final analytic step, the preliminary themes were presented to a group of nine researchers engaged in SGM mental health research for feedback, which confirmed the data labels and organization.

3. Results

3.1. Sociodemographic background and suicide histories

Table 1 depicts sociodemographic characteristics. Participants were generally young (mean age = 24), over half reported a plurisexual sexual orientation (e.g., 59% bisexual), two-thirds were non-Hispanic white (63.6%), and half of the sample were cisgender women (50.0%) while nearly one-quarter (22.7%) were transgender men. Participants resided across 15 contiguous states. Most were working part-time (36.4%) or unemployed (27.3%) and reported an annual income of less than $10,000 (40.9%).

Past-18-month suicide attempt histories are presented in Table 2. Half of participants reported one suicide attempt in the past 18 months (50.0%), more than one-third (36.4%) reported two, and the remainder reported three or more. In total, participants reported eight distinct methods used in their near-fatal suicide attempts; the largest proportion (36.4%) reported overdose with admission to a hospital’s intensive care unit. On average, interviews took place about ten months since participants’ near-fatal suicide attempt.

During their interviews, most participants revealed that they had suffered from severe and persistent thoughts of suicide throughout their lives often starting in early-to-middle adolescence; the remainder reported chronic suicidal thoughts beginning either in childhood or in early adulthood. Many participants struggled with comorbid mental health problems, most commonly bipolar disorder and depression. Due in part to the severity of participants’ near-fatal suicide attempts in conjunction with their mental health histories, most participants had experienced at least one inpatient psychiatric hospitalization; several participants had been hospitalized multiple times. All but one participant had previously attempted suicide at least once in their lifetime before making a near-fatal suicide attempt.

Below we present three overarching themes that begin to document how SGM people might uniquely acquire the capability to make a fatal or near-fatal suicide attempt. The current study focuses on features of acquired capability that were specific to participants’ experiences as SGM people. These specific experiences were often layered on top of general painful and provocative experiences (e.g., had surgery, shot a gun, been in a car accident)
that have been studied in general population samples and are theorized to contribute to the acquired capability for suicide (Forrest et al., 2019).

3.2. Identity invalidation and erasure during developmentally sensitive periods

A key feature of acquired capability for suicide involves repeated and habituated exposure to physically and emotionally painful and fearsome experiences that “wear away at natural barriers to suicide (e.g. fear of death and pain avoidance), thereby increasing suicide capability” (May & Victor, 2018, p.1). For many participants, a taxing source of pain and fear was the prolonged and systematic invalidation, minimization, and erasure of their SGM identities by the people closest to them, almost always their parents, but sometimes other revered family or community members. Such chronic invalidation and erasure of their identities was not a singular event, but rather a chipping away at their identities over time. Ashlyn, a 24-year-old bisexual/pansexual transgender woman, recounted an early memory of her father criticizing SGM people. The tacit understanding that she could never reveal her emerging gender identity to her parents without severe backlash caused fear and mental anguish beginning in childhood:

My second or third earliest memory was my dad bashing on the LGBT community … At a very young age, even though I didn’t know – wanting to be a girl as part of that community – I didn’t even know that was a thing until I was a bit older. I did feel somewhat uncomfortable with telling my parents. I knew that it would be a problem … At a young age, it was a lot of trying to rationalize, like, what’s going on, and maybe – if I want to be a girl, maybe I could do something about that after my parents pass on [die] so I don’t have to embarrass them … It’s a lot of self-negative thoughts at a young age, which, I don’t exactly know what age, nine or ten, where I pushed those thoughts down and I just ignored them. I guess it didn’t really affect me in a conscious way for a while until puberty hit. I guess by that time there was just a lot of dysphoria and pain and uncomfort.

Many participants described invalidation by loved ones as especially painful during sensitive periods of development for SGM young people, including late childhood and early-to-middle adolescence when SGM youth often navigate typical developmental stressors alongside the complexities of an emerging minority identity (Russell & Fish, 2019). Like Ashlyn, many participants described chronic invalidation and erasure beginning in childhood before they even fully understood their own sexual or gender identities. Eddie, a 24-year-old gay cisgender man, recounted an early invalidating home environment steeped in his mother’s conservative religious expectations that caused him to fear explicit rejection from his mother along with the existential dread that he would be condemned to hell:

My mother was a conservative Christian, very strict, stuff like that. I grew up in a strict conservative Christian household where being gay is just the ultimate sin to her. That had to cause me to deny myself for a long time and deny what I felt inside and try to keep that secret and hidden from her … I was always struggling with religion as a kid. I prayed every night. I was always praying to God to, as some would say, “pray the gay away” inside me because I knew I was a homosexual, and I had, at the time, sincerely believed that was an unpardonable sin like my mother...
told me and that I was going to burn in hell and that it was a choice of my own, not
something that I was inside me. I was always taught it was a choice.

Ashlyn, Eddie, and many other participants, responded to chronic invalidation and attempted
erasure of their identities by denying their identity to themselves and others. Indeed, Ashlyn
recalled, “I convinced myself I wasn’t trans.” Such repression of one’s own identity –
especially during sensitive developmental periods – fostered severe identity confusion that
often culminated in feelings of detachment from the self. In turn, this detachment seemed to
contribute to an increased capability for suicide because those who experienced it felt that
they did not fully exist. Ashlyn described this phenomenon:

[I] definitely struggle with suicide because [hiding my identity] made me feel like I
don’t have an identity of sorts. I hid my identity for so long that by the time I was
able to actually be who I was, I feel like I’m nobody, like I don’t have an identity.

The chronic invalidation of participants’ identities, especially during sensitive developmental
periods in childhood and adolescence, engendered intense psychic pain (“Just a lot of
self-hatred and pain and sadness.” – Ashlyn) and fear (e.g., of being ‘outed,’ of being
abandoned, of recognizing you embody a hated identity). Together, these painful and
fearsome invalidating experiences contributed to the acquired capability for suicide because
participants felt that they were already erased, invisible, and, in some cases, non-existent.
Clara, a 29-year-old lesbian/questioning cisgender woman, described the culmination of
these thoughts and feelings the moment before she stepped in front of a car:

… it’s like I didn’t even matter or anything. Then, it’s like, then I feel like, well
I didn’t matter anyway so what does it matter? I don’t know. It’s like … you feel
destined to do it [suicide]. It’s an awful feeling.

3.3. Normalization of suicide within SGM social networks

Many participants were embedded within social networks of other young adult SGM people,
many of whom were also experiencing family rejection, socio-economic marginalization,
and mental health problems. The habituation to the pain and fear of death that is an
essential feature of the acquired capability for suicide was evidenced by participants’
descriptions of how, within their social networks, suicide was frequently normalized, joked
about, and perceived as an acceptable reaction to a painful and rejecting world. Especially
for participants who transitioned rapidly from thinking about suicide to acting upon their
suicidal urges, the normalization of suicide among friends seemed to facilitate this transition
for two reasons.

First, participants described how when they sought help from their friends before attempting
suicide, the seriousness of their suicidal urges was frequently overlooked or rebuffed due to
the pervasiveness of suicidality among their friends. Emma, a 20-year-old bisexual cisgender
woman, described mentioning her suicidal thoughts to her friends before her near-fatal
suicide attempt: “… in terms of talking to friends … I’ll talk to my friends about, ‘Oh,
I kind of feel like I want to die,’ and everyone just sits in the room and goes, ‘Same.’ I
think [my suicidality] got lost in the void.” Jay, a 26-year-old bisexual transgender man,
similarly recounted the normalization of suicide among his friends. When asked if he had communicated to his friends that he was thinking about killing himself, Jay explained:

In the past, I had. In that friend group, it was pretty normal to be like, “Yes, I’m extra suicidal today.” … It was almost just an accepted thing because everyone in my circles, was extremely poor and queer. Poor, queer people just have mental health problems, we turned it into a joke because there wasn’t anything we could do about it.

Second, several participants, like Jay, described that they and their friends joked about suicide as a way to cope with their mental health struggles. For the many participants who experienced severe and chronic suicidal thoughts, the boundary between humor and reality was often blurred and, for some, joking about suicide reduced their fear of making a suicide attempt. Nic, a 22-year-old queer transgender man, described this fine line:

Sometimes I’ll catch myself slipping. I feel like it’s easy for me to make a few too many jokes about, like, “I’ll die” and then almost trigger the suicidal thoughts, invite them back, so I have to be careful about the media that I consume, and the things that I say in my own internal monologue, just because I feel like my relationship to being alive is fragile. The suicidal thoughts are horrible. They eat me up inside. When I made the [near-fatal] attempt … I just wanted to get away from my own suicidal thoughts.

Rebecca, a 20-year-old asexual cisgender woman, explicitly described how joking about jumping off a bridge habituated her to using the bridge as the method in her near-fatal suicide attempt:

Last year, one of my friends and I started to joke of jumping off the bridge together. That’s where [the idea to jump off a bridge] came from … There was a hint of truth. I actually really wanted to do it and he didn’t. It was just a joke to him, but it wasn’t a joke to me. He knows now that it wasn’t a joke to me …

Like, Rebecca, Emma explained that only after making a near-fatal suicide attempt that left her intubated and in coma for nearly a week did her friends recognize that her jokes about suicide had been serious: “… I don’t think [my friends were] really surprised … I expressed suicidal ideation in the past. I think what drove it home for people was [the seriousness of the suicide attempt] like, ‘Oh, she was not kidding. No, not a joke.’”

### 3.4 Structural stigma and SGM community trauma as habituating sources of pain

Painful and provocative events that facilitate the acquired capability for suicide are often described as actual or potential injuries (e.g., assault, combat exposure, broken bone) or self-directed violence (e.g., self-injury) (Forrest et al., 2019). However, participants in the current study broadened this conception of painful and provocative experiences to include recurrent exposure to anti-SGM structural stigma (e.g., stigmatizing laws, policies, and societal norms (Hatzenbuehler, 2016)) as well as witnessing other SGM community members experience stigma-related trauma. This structural stigma and trauma served as a habituating source of pain and fear that contributed to their acquired capability for suicide.
Participants described structural stigma as a taxing source of emotional pain that chipped away at their threshold for suicide action. Cassie, a 22-year-old bisexual cisgender woman, described how the mental exhaustion caused by existing in a heteronormative society helped explain her near-fatal suicide attempt and the higher rates of suicide among SGM people overall:

I mean, I guess, what I’ve witnessed and what I’ve experienced it can be really difficult to not fit into a very heteronormative society. I’ve seen a lot of my friends who are part of the LGBTQ community being very demonized by their own families and their own friends … I can understand how mentally exhausting that can be. From, I guess, my own personal experience a lot of what drives someone to be super suicidal is like, “I’m exhausted from fighting.”  … I think I can apply that to being a member of the LGBTQ community in our very heteronormative society and just-, it’s exhausting for sure. That’s how I make that make sense for myself.

The negative mental toll of navigating stigmatizing social norms was reiterated by numerous participants, including Shae, a 21-year-old asexual/queer cisgender woman, who described that thinking about the pervasiveness of heteronormative social norms often preempted what she described as a “spiral” of negative thoughts and feelings that resulted in suicidality:

… in general, I think, just thinking about how heteronormative the world is kind of gets me down and makes me almost feel a little ashamed … I think a lot about how heteronormative relationships have existed and how they manifest today. I think a lot about people on the internet saying bad things about queer people. Also, people online saying things about what men and women should do [that is] traditionally appropriate. Also, thinking about media representation [of queer people] …

Many participants linked residing in geographic regions with particularly high structural stigma (e.g., southern US states (Lax & Phillips, 2009)) or being embedded within socially conservative communities as contributing to their feelings of otherness and emotional pain as well as instilling fear of rejection and violence. Riley, a 19-year-old bisexual/demisexual non-binary person, described how SGM people were treated in their hometown in Arkansas:

If they [anti-LGBTQ groups in the region] know someone is queer, especially if they have a pride flag on their house, they will set up burning torches in their yards and burn their flag … It’s the Bible Belt. You can’t go a mile without finding another church. You’re told in the same way that whenever you’re feeling bi-curious, or you’re like, “Oh maybe I’m not-, maybe this body isn’t quite like me,” you’re told, “It’s just a phase.” It’s a culture of, “You have to be like the rest of us because it makes us uncomfortable.”

The pain and fear caused by navigating structural stigma seemed to contribute to the acquired capability for suicide because participants wished for any escape from pervasive anti-SGM social norms. Indeed, for Cassie, Shae, Riley, and others, the strain of existing in a heteronormative society seemed to diminish the pain and fear associated with suicide and, instead, intensify feelings of fatigue that positioned suicide as a kind of reprieve. In support of this, many participants described the sharp relief that they felt in the moments prior to making a near-fatal suicide attempt. For example, Tina, a 28-year-old queer/bisexual/
pansexual cisgender woman, who described how her conservative community viewed SGM people as “shameful,” “deviant,” and “defective” recalled how she felt as she attempted suicide by crashing her car: “It was a sense of clarity, or just at peace, for once.”

In addition to the personal toll of structural stigma, many participants described how witnessing their fellow SGM community members experience stigma-related trauma served as a painful reminder of inequalities that disproportionately affect them and contributed to a deep sense of hopelessness. Nic described how witnessing violence enacted against his fellow transgender community members wore down his mental fortitude against suicide:

I don’t care about being alive that much. I think I still have a rocky relationship with being alive, but I don’t actively have suicidal thoughts anymore. I’m not planning anything, I don’t think about killing myself, but I don’t necessarily think I would be particularly upset if somebody else – like if I was murdered or something … it feels like the whole system’s got me down. It still sucks. Trans people, particularly trans women of color, still have the lowest life expectancy, the highest rates of incarceration. It just doesn’t feel like a great time to be alive and be, like, a poor trans person …

Clara, a lesbian/questioning cisgender woman, described how even though she understood that societal attitudes towards SGM people were improving over time, she still experienced the insidious stigma directed toward herself and her fellow SGM community members. This omni-present rejection served as a habituating source of pain that contributed to her acquired capability for suicide:

When I think of the pain that my fellow LGBT folks face. God, it’s no wonder, they try to – and they do succeed, a lot of them – at suicide. It’s really no wonder with the hatred that people spew at them. Even though everything is getting more accepting – and, yes, that’s good – there’s this underbelly of society and you can feel it. That it’s just this rejection of the other. It’s like we’re the aliens to them. We’re these othered people. It’s like this message that you don’t belong here. God, anybody dealing with that, especially for somebody who’s dealing with that on a day-to-day basis, of course they’re going to try [to kill themselves] …

4. Discussion

Through interviews with 22 SGM people who made a recent near-fatal suicide attempt, findings from this study provide important new theoretical insights into how SGM people who contemplate suicide might uniquely acquire the capability to kill themselves. This study extends current conceptions of painful and provocative experiences that contribute to the acquired capability for suicide (Forrest et al., 2019) to include identity-relevant factors highly salient to SGM’s suicidal thoughts and behaviors. The three themes we uncovered suggest extensions to current suicide theories and research methods to improve detection and prevention of suicide among this population with a substantially elevated burden of suicide. Notably, deeply ingrained socio-structural processes and organizations (e.g., political conservatism, religious beliefs, conservative cultural norms) as well as economic disenfranchisement and poverty often served as a backdrop to the three uncovered themes.
Across themes, SGM-relevant painful and provocative events that contributed to acquired capability were frequently produced by a quagmire of socio-structural conditions that disproportionately stigmatize and harm SGM people and reduce SGM people’s access to supportive resources.

First, we found that chronic identity rejection and invalidation, especially during childhood and adolescence, can severely harm healthy identity development, causing SGM young people to feel erased, invisible, or even non-existent, thereby contributing to their capability for suicide. While quantitative research has clearly demonstrated that family rejection of a child’s SGM identity is associated with increased risk for suicidal behavior (Klein & Golub, 2016; Ryan et al., 2009), this theme begins to untangle the deeper underlying mechanisms. Recently, Cardona et al. (2021) posited that chronic, traumatic invalidation that disrupts healthy emotional processing is the principal mechanism underlying SGM people’s disproportionate likelihood of experiencing mental and behavioral health problems. Authors described several domains of chronic, traumatic invalidation experienced by SGM people (e.g., dismissive, stigmatizing, blaming, systemic; see Table 1 in Cardona et al., 2021 for SGM-specific examples) that can produce deficits in adaptive emotional processing and cause emotional, interpersonal, and behavioral challenges. The current study’s first identified theme supports Cardona and colleagues’ conceptualization of chronic invalidation as a primary mechanism underlying severe, adverse mental health problems among SGM people. Here, we uncovered specific examples of lived experiences of identity-relevant traumatic invalidation that contributed to the acquired capability for suicide and commonly served as precursors to SGM people’s near-fatal suicide attempts.

Our first theme further suggests that chronic invalidation chips away at SGM people’s healthy identity development and can diminish their sense of self. Self-continuity theory, which has been posited as key to understanding why there is a sharp rise in suicidality during the adolescent years (Chandler, 1994; Chandler & Proulx, 2006), provides a useful heuristic for understanding the current theme. Self-continuity is defined as holding a persistent sense of one’s past, present, and future self. In the general population, it is theorized that the rapid developmental transitions present during adolescence can challenge a teen’s ability to link their past, present, and future selves, and that such an untethering from the self can corrode one’s defenses against suicidal desire (Chandler, 1994). For SGM young people, who face normative but challenging developmental transitions alongside deep and complex identity development trajectories and coming out processes (Russell & Fish, 2019), maintaining self-continuity might be especially difficult. Lived experiences in the current study illuminate how growing up in a chronically invalidating home environment can lay the groundwork for a loss of self-continuity during sensitive developmental periods (e.g., “I feel like I’m nobody”). Many participants recounted the horror and emotional pain they felt upon realizing that they held an identity that was openly castigated by their parents. Often, this emerging SGM identity neither aligned with their past self nor did it link to the self they imagined for their future. Aligned with recent quantitative research (Meyer et al., 2021), most participants recalled that their first suicide attempt was around the same time that they realized their SGM identity. For participants who experienced chronic identity invalidation and a resulting untethering from their self, the pain and fear of suicide was greatly diminished and, thus, their acquired capability for suicide enhanced. The only
known study investigating associations between SGM identity and self-continuity found that sexual minority young adults reported significantly lower self-continuity than heterosexuals (Martin-Storey et al., 2020). Findings reported here call for additional qualitative and quantitative research to understand associations between chronic parental invalidation and SGM people’s self-continuity as a pathway *en route* to acquiring the capability for suicide.

Second, we uncovered that the normalization of suicide among SGM young people’s social networks was also strongly related to acquired capability for suicide. Participants recounted that the normalization and acceptability of suicide among their friends reduced their perceptions of pain and fear associated with suicide. In one stark example, a participant who joked with a friend about jumping off a bridge for several months then did so. This theme is aligned with two recent quantitative studies showing that sexual minority youth and adults consider suicide to be more acceptable and view suicide more empathetically than heterosexuals (Blosnich et al., 2017; Canetto et al., 2020). The normalization of suicide within social networks may lead young sexual minorities to develop a “suicide script” in which they, “view suicidality as an inevitable response to life problems — a view that may become a self-fulfilling prophecy” (Canetto et al., 2020, p. 7). Findings from the current study support the notion that suicide scripts are an under-researched but crucial area of SGM suicide prevention. Additionally, some social network research with youth has documented the phenomenon of “suicide contagion” in which suicide has the potential to spread between individuals. One study found that adolescents with a friend who made a suicide attempt were themselves nearly twice as likely to report a suicide attempt one year later (Mueller & Abrutyn, 2015). Many participants in the current study described that suicide was ubiquitous among their friends and several mentioned knowing people who had attempted or died by suicide — particularly among SGM experiencing intersectional burdens, such as that of poverty. These findings suggest that it is important to conceptualize how peer influence can contribute to the acquired capability for suicide, especially in peer networks of young SGM in which many individuals might be struggling with mental distress and suicidality.

Finally, we documented that anti-SGM structural stigma (e.g., heteronormativity; Hatzenbuehler, 2016) and witnessing SGM community trauma are taxing sources of pain and fear. Pervasive exposure to anti-SGM social norms led to exhaustion and fatigue, thereby increasing participants’ acquired capability for suicide by wearing down their desire to be alive and concurrently decreasing their fear of suicide. This was especially pronounced among participants who lived in regions and/or communities with deeply ingrained anti-SGM societal norms. One queer, transgender participant residing in Florida, which ranks among the nation’s least accepting states due to religious refusal and anti-SGM laws (Human Rights Campaign Foundation, 2020), described feeling that anti-transgender oppression made being alive difficult. This participant expressed that although they no longer had suicidal intent they still thought about death by other means — including being murdered — as a welcome reprieve from anti-SGM stigma. This jarring reflection offers insight into the psychic toll of structural stigma and complements existing quantitative research showing that anti-SGM societal norms — and associated stigmatizing laws and policies — are linked with SGM people’s suicidal behavior (e.g., Rabasco & Andover, 2020; Raifman et al., 2017). For example, previous research drawing upon a gender minority stress framework has documented that fear of anti-transgender societal stigma is associated with
suicide risk among gender minority adults (Tebbe & Moradi, 2016). The current qualitative study dovetails with such previous quantitative research by broadening conceptualizations of painful and provocative experiences to include the consistent and pervasive presence of anti-SGM structural stigma. Indeed, participants’ accounts of their lived experiences in the current study delineate how pervasive societal norms can engender emotional pain, fear of violence or rejection, and, ultimately, a sense of exhaustion and hopelessness that can ultimately position death by suicide as an escape.

4.1. Research and intervention implications

These findings suggest three implications for research. First, research is warranted to investigate how dominant theories of suicide (e.g., ideation-to-action) might operate uniquely among stigmatized sub-populations including SGM. Theoretical tenets developed in general population samples should be probed, adapted, and updated to reflect relevant stigma-related contexts and minoritized lived experiences. Second, the acquired capability for suicide is important to advancing understanding of SGM suicidology, but popular psychometric scales measuring painful and provocative events overlook highly relevant identity-specific experiences that contribute to suicide capability among SGM. Relatedly, despite discrimination contributing uniquely to acquired capability for suicide among Black (versus White) adults (Brooks et al., 2020), discriminatory experiences are not captured by either of the field’s two main painful and provocative events scales (Bender et al., 2011; Forrest et al., 2019). Thus, studies assessing the acquired capability for suicide among SGM and other stigmatized populations could benefit from considering painful and fearsome identify-relevant experiences to aid detection and prevention of risk. The current study’s three themes lay the foundation for such future research. Last, this study provides rich evidence of the importance of drawing upon lived experiences to enhance understanding of suicide processes and buttresses recent calls for the field of suicidology to utilize qualitative methodologies to advance understanding of suicide (Hjelmeland, 2016; Hjelmeland & Knizek, 2010; White, 2016).

These findings also suggest several implications for intervention. First, interventions that support parents of SGM youth to validate, affirm, and foster healthy development of their child are needed, yet very few exist (Coulter et al., 2019). Attachment-Based Family Therapy (ABFT), an intensive three-to-four-month family-based treatment focused on improving trust and building safety in the parent-child relationship, is one of the few such existing interventions tailored for SGM youth and their families. ABFT was found to be associated with reductions in sexual minority adolescents’ suicidal ideation even among SGM youth with persistently rejecting parents (Diamond et al., 2012). This approach may also be applicable to transgender adolescents’ suicidal thoughts and behavior (Russom et al., 2021). While promising, only future testing of ABFT in a randomized-controlled trial can confirm its efficacy in reducing suicide among SGM young people who face chronic identity invalidation. In the meantime, pediatricians, primary care providers, and mental healthcare personnel including school-based clinicians and counselors should be prepared to identify, intervene, and protect SGM young people struggling with suicidal thoughts and behaviors and who may be facing parental rejection and identity invalidation (Ryan, 2013). Importantly, providers should be trained to recognize potential risk factors...
of acquired capability and associated suicidal behavior rather than suicidal ideation alone. Further, access to gender-affirming medical care for gender minority youth who desire such care is associated with reduced suicidality (Green et al., 2021). Thus, providing access and counseling related to gender-affirming clinical care represents a potentially important approach to suicide prevention. Second, findings suggest that SGM peer networks are a suitable venue for intervention including diffusing positive narratives of SGM peoples’ lived experiences to combat the normalization of suicide. Rather than reiterating “suicide scripts,” SGM-focused community organizations, media sources, social networks, and mental health services can offer positive narratives that elevate the resilience, joy, and thriving of SGM people (Riggle & Rostosky, 2011). Last, an all-hands-on-deck approach is required to dismantle anti-SGM laws and policies, root out anti-SGM institutions, and upend pervasive anti-SGM attitudes and norms that contribute to SGM people’s suicide risk. The influx of anti-SGM (particularly anti-transgender) legislation currently sweeping US states, particularly in the Southeastern US where structural stigma is high (Krishnakumar, 2021), demonstrates the importance of continued efforts of grassroots organizations, policymakers, public health experts, community leaders, and medical providers to advocate for protecting and valuing SGM lives. Supportive interventions are especially needed for SGM people living in environments that might be more prone to produce painful and provocative experiences, such as SGM individuals living in regions or communities where anti-SGM values are upheld (e.g., conservative religious communities) and among SGM people experiencing economic disenfranchisement.

4.2. Limitations

Despite its notable strength in assessing the lived experience of SGM people who nearly died by suicide, results must be interpreted in light of the study’s limitations. The non-random sample likely does not represent the experiences of all SGM people who made a recent near-fatal suicide attempt. For instance, there could be systematic differences in severity of suicide attempt between the current study’s participants and those who would or could not respond to a study advertisement about their suicide histories. Further, while our sample was relatively diverse regarding sexual orientation, gender identity, and geographic region, most participants were white and in their 20s which prohibited a fully intersectional analysis capturing how lived experiences of race, ethnicity, and culture may intersect with SGM identities to contribute to the acquired capability for suicide. Finally, our study recruitment occurred during the COVID-19 pandemic, and respondents shared a multitude of experiences related to the pandemic (e.g., job loss, lockdown and isolation, illness of self or family) that we do not discuss in the current paper in order to offer more generalizable depictions of suicide experiences among SGM. Such experiences and their relations to suicide should be explored in future work.

4.3. Conclusion

This study advances understanding of how SGM people who desire suicide might uniquely acquire the capability to kill themselves. By drawing upon lived experiences from SGM people who made a recent near-fatal suicide attempt, this study identified chronic identity invalidation, suicide acceptability among SGM peer networks, and anti-SGM social norms as potent factors contributing to SGM people’s capability to kill themselves. Future research
is needed to probe and update dominant theories of suicide to apply to SGM, to incorporate identity-relevant painful and provocative experiences into assessments, and to employ qualitative methods to bring to the fore lived experiences of suicide attempt survivors. Finally, this study suggests that interventions that support parents of SGM youth in affirming and validating their children, diffuse positive narratives of SGM thriving through SGM social networks, and continue to work to root out anti-SGM stigma can potentially prevent suicide among SGM people.

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### Table 1

Sample sociodemographic characteristics.

| Variable                        | n  | mean | %    | range |
|---------------------------------|----|------|------|-------|
| Age, y                          | 24.1 | 19–45 |
| **Sexual Orientation [select all that apply]** | | | | |
| Gay or Lesbian                  | 6  | 27.3%|
| Bisexual                        | 13 | 59.1%|
| Queer                           | 6  | 27.3%|
| Demisexual                      | 1  | 4.5% |
| Pansexual                       | 2  | 9.1% |
| Asexual                         | 2  | 9.1% |
| Uncertain, Not Sure             | 1  | 4.5% |
| **Gender Identity**             |    |      |      |       |
| Cisgender Woman                 | 11 | 50.0 |
| Cisgender Man                   | 3  | 13.6 |
| Transgender Man                 | 5  | 22.7 |
| Transgender Woman               | 1  | 4.5% |
| Non-Binary                      | 2  | 9.1% |
| **Race/Ethnicity**              |    |      |      |       |
| Non-Hispanic, White             | 14 | 63.6 |
| Black/African American          | 3  | 13.6 |
| Hispanic, Latinx                | 2  | 9.1% |
| Asian                           | 2  | 9.1% |
| Another Race/Ethnicity          | 1  | 4.5% |
| **State of Residence**          |    |      |      |       |
| Arkansas                        | 1  | 4.5% |
| California                      | 1  | 4.5% |
| Florida                         | 2  | 9.1% |
| Idaho                           | 1  | 4.5% |
| Illinois                        | 1  | 4.5% |
| Michigan                        | 3  | 13.6|
| Minnesota                       | 1  | 4.5% |
| New Jersey                      | 1  | 4.5% |
| New York                        | 3  | 13.6|
| North Dakota                    | 1  | 4.5% |
| Ohio                            | 1  | 4.5% |
| Oregon                          | 1  | 4.5% |
| Pennsylvania                    | 3  | 13.6|
| Utah                            | 1  | 4.5% |
| Vermont                         | 1  | 4.5% |
| **Employment Status**           |    |      |      |       |
| Full-time (40 h per week)       | 5  | 22.7%|
| Variable                                           | n | mean | % | range |
|----------------------------------------------------|---|------|---|-------|
| Part-time (fewer than 40 h per week)               | 8 | 36.4%|    |       |
| Unemployed                                         | 6 | 27.3%|    |       |
| Permanently or temporarily disabled and not working| 3 | 13.6%|    |       |
| **Annual Income**                                  |   |      |   |       |
| Less than $10,000                                  | 9 | 40.9%|    |       |
| $10,000 to $19,999                                 | 6 | 27.3%|    |       |
| $20,000 - $29,999                                  | 5 | 22.7%|    |       |
| $30,000 or more                                    | 2 | 9.1% |    |       |
Table 2

Sample suicide attempt history information.

| Variable                                      | n [mean]     | % [range]         |
|-----------------------------------------------|--------------|-------------------|
| Length of time between near-fatal suicide attempt and interview | 9 months, 18 days | [1 month, 13 days–19 months, 13 days]$^a$ |
| Number of suicide attempts in past 18 months  |              |                   |
| 1 time                                        | 11           | 50.0              |
| 2 times                                       | 8            | 36.4              |
| 3 or more times                               | 3            | 13.6              |
| Method used in near-fatal suicide attempt      |              |                   |
| Overdose (with admission to hospital’s intensive care unit) | 8            | 36.4              |
| Jumping from height                           | 3            | 13.6              |
| Stepping in front of a moving vehicle         | 3            | 13.6              |
| Hanging                                       | 2            | 9.1               |
| Crashing a moving vehicle                     | 2            | 9.1               |
| Cutting or stabbing (vital body part, e.g., neck, abdomen) | 2            | 9.1               |
| Firearm                                       | 1            | 4.5               |
| Drowning                                      | 1            | 4.5               |

$^a$Range includes time period greater than 18 months because interviews were scheduled up to two months after participants completed the study screener in which time since near-fatal suicide attempt was recorded.