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## **Suicide prevention from the perspectives of gay, bisexual and two-spirit men**

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## *Abstract*

Although gay, bisexual, and two-spirit men (GBTSM) experience high rates of suicidality, there have been few empirical studies of prevention initiatives and policies that could address or reverse this major social problem. This article reports on a photovoice study of 29 GBTSM who had a history of suicidality or lost a fellow GBTSM to suicide. We focused our analysis on participants' perspectives on suicide prevention. Participants described four key considerations for GBTSM suicide prevention: 1) Recognizing and addressing enduring homophobia, biphobia, and mental illness stigma; 2) Provision of low-barrier, long-term, and GBTSM-affirming counseling; 3) De-isolation through peer support and community connection; and 4) Fostering creativity and cultural resilience. By engaging GBTSM affected by suicide through photographs that depict their experiences and points of view, in this study we offer concrete recommendations to reduce suicidality amongst GBTSM.

## INTRODUCTION

Suicide is among the 10 leading causes of death in Canada and the USA, and a major cause of premature mortality globally (World Health Organization [WHO], 2017, Public Health Agency of Canada [PHAC], 2016, Centers for Disease Control and Prevention [CDC], 2015). It is estimated that 5% of the population make a non-fatal suicide attempt at least once in their lifetime, with many more struggling with suicidal ideation (Nock, 2008). While suicide impacts everyone, some communities, including gay, bisexual and two-spirit<sup>1</sup> men (GBTSM), are overrepresented in the epidemic. Research from the last 30 years has consistently highlighted GBTSM as a high-risk group for suicidality (suicide ideation or attempts), largely due to homophobia, biphobia, and other social inequities affecting sexual minorities (Haas et al., 2010; Hottes, Bogaert, Rhodes, Brennan & Gensink, 2016; King et al, 2008).

Suicide is preventable, yet GBTSM have rarely been the focus of suicide prevention efforts (Haas, al. 2010) despite evidence that: 1) GBTSM are four times more likely to attempt suicide compared to heterosexual men (Hottes et al., 2016); 2) GBTSM report higher rates of suicidal ideation per year than heterosexual men report over an entire lifetime (Ferlatte, Dulai, Hottes, Trussler, and Marchand, 2015); 3) suicide deaths likely exceed HIV/AIDS-related deaths among GBTSM in the era of effective HIV treatment (Hottes, Ferlatte, Gensink, 2014); and 4) GBTSM may be more likely to have unmet mental health needs as compared with heterosexual men (Salway et al., in press; Tjepkema, 2008).

Based on the above research, targeted suicide prevention interventions are needed to reduce suicidality among GBTSM (Haas et al., 2010). Research on suicide has predominantly focused on general risk factors (Haas et al, 2010); yet, the magnitude of this disparity suggests a

need to look at GBTSM-specific factors that are amenable to prevention. Moreover, engagement of GBTSM in suicide research may result in more widespread community support for and uptake of targeted prevention initiatives, because the resulting recommendations will come from GBTSM themselves. We therefore launched a participatory photovoice project with GBTSM, who had a history of suicidality or lost a GBTSM friend, partner, or family member to suicide. We invited these participants to share their perspectives on GBTSM suicide in order to inform GBTSM-targeted programs and policies to prevent suicide in their communities.

## **METHODS**

Our study employed photovoice, a research method wherein participants express and share their viewpoints and experiences by taking and narrating photographs (Wang & Burris, 1997; Wang, 1999). Photovoice has been purposefully used to engage diverse communities to produce knowledge on an array of health-related issues including cancer (Rapport et al., 2017; Yi, Kim & An, 2015), smoking cessation (Olliffe, Bottorff, Kelly, & Halpin, 2008), stroke (Maratos, Huynh, Tan, Lui & Jarus, 2016), and medical treatment experiences (Werremeyer, Skoy & Kelly, 2017). In the specific context of mental health, photovoice has been described as an underutilized but promising methodology to advanced understanding of mental illness from the viewpoint of those with lived experience (Han & Olliffe, 2016).

We conducted our study in Vancouver, which is the third largest city in Canada. We recruited participants by distributing flyers at coffee shops, libraries, and community centers, inviting GBTSM who had a personal history of suicidality or had lost a fellow GBTSM (friend, partner, family member) to suicide. We also promoted the study online through social media sites including Craigslist, Facebook, Twitter, and newsletters produced by GBTSM community

health organizations. Potential participants were invited to contact the study lead by email or telephone to confirm their eligibility. Inclusion criteria were: 1) identifying as a gay, bisexual, or two-spirit man; 2) history of suicidality (defined as suicide ideation or attempt) or bereaved by the suicide of a GBTSM; 3) 19 years of age or older; 4) living in Canada; and 5) English-speaking.

A total of 29 men participated in the study including 21 who had previously experienced suicidality and eight who had lost a GBTSM to suicide. Among the 21 men with previous experiences of suicidality, all had experienced suicidal ideation, 15 had previously made suicide plans, and 11 reported at least one suicide attempt. Seven of these 21 men had not received professional mental health care. Among those who lost a GBTSM to suicide, five had lost a friend, two lost a partner, and one lost his father. (See supplemental file for a full description of the sample.)

Participation included two stages:

***Stage 1. Intake interview:*** After a telephone screening to confirm eligibility, participants met with a member of the research team to discuss the study objectives, the photovoice assignment, and the potential risks of participating in the study. Participants provided informed written consent and completed a short demographic questionnaire. We offered participants a digital camera to take photographs that illustrated their experiences and perspectives about suicidality or the loss of a GBTSM to suicide, with a focus on potential suicide prevention strategies. We asked participants to write a caption for each photograph that explained the meaning of the image. Participants could opt to keep the camera provided as an honorarium or use their own camera, in which case they received \$100 CAD - the equivalent value of the camera. We also

provided participants with a list of mental health resources in the event they felt distress during or after their participation in the study.

***Stage 2. Photovoice interview:*** After taking photographs, participants were individually interviewed by a member of our team and invited to describe their photographs and the meaning behind them. We used a semi-structured interview guide beginning with open-ended questions about the photographs including: “What does this photograph mean to you?”; “What is most important about this photograph?”; and “What was your inspiration for sharing this image?” (Oliffe & Bottorff, 2007). We then asked additional questions about the participants’ experiences with suicide, including experiences seeking help for suicidality or bereavement, and about their ideas for suicide prevention strategies targeted to GBTSM (the topic of this article).

After the photovoice interview, we reminded participants of the list of mental health services provided at the first meeting and provided them with a second honorarium of \$100 CAD to acknowledge their time and contribution to the research project. The interviews typically lasted 90 minutes. Interviews were digitally recorded and transcribed verbatim, and transcripts were checked for accuracy. We inserted the photographs into the corresponding participant narrative in the transcribed interview, so that photographs could be analyzed in the context of participants’ own words, and so that participants’ words could be supported and enriched by the photographs provided.

### *Analysis*

We analyzed the data following the steps for thematic analysis described by Braun and Clarke (2006). First, we read and re-read the transcripts to familiarize ourselves with the data, noting our impressions and initial ideas for codes. Second, we imported the transcripts in NVivo™ and

performed an initial round of coding to identify and organize data relevant to the question: “What are GBTSM’s perspectives about and suggestions for suicide prevention?” Third, after all the transcripts were coded, we adopted a semantic approach where we organized, collated, and summarized the data to identify patterns across the sample related to perspectives and suggestions for suicide prevention. When looking for patterns, we opted for an inductive approach rather than a theoretical one, which is aligned with the photovoice method, which aims to understand and reveal the viewpoints of community members (Wang, 1999). At this stage, we also met as a team to identify connections between codes and broad themes. Fourth, we checked for the representativeness of the themes by reviewing and discussing the coded extracts and the complete data set. Fifth, we met and corresponded electronically to review and refine the themes, a process that continued throughout the writing of the current article.

## **Ethics**

We were granted research ethics approval by the Behavioural Research Ethics Board of the University of British Columbia (#H13-02592). We purposefully included men with a history of suicidality but excluded those who were currently thinking about suicide. This exclusion was intended to minimize potential harm to participants, as actively suicidal GBTSM may have found it especially distressing to describe their experiences without immediate therapeutic support. Those who described current suicidality were referred to appropriate mental health services. University ethics affirmed the appropriateness and procedure of our study, including the honorarium provided to the participants.

## **RESULTS**



Participants described four key considerations for GBTSM suicide prevention: 1) Recognizing and addressing the enduring effects of homophobia, biphobia, and mental illness stigma; 2) Provision of low-barrier, long-term, and GBTSM-affirming counseling; 3) De-isolation through peer support and community connection; and 4) Fostering creativity and cultural resilience. The following section explicates each theme, providing evidence in the form of photographs and quotes from the participants. To protect the participants' confidentiality, we allocated a pseudonym to each participant.

### **1. Recognizing and addressing the enduring effects of homophobia, biphobia, and mental illness stigma**

Most participants described how GBTSM's suicide risks largely flowed from various dimensions of the GBTSM community experiences of marginality and a broader sense of interpersonal alienation in everyday life. Whilst there was acknowledgment of the many gains that had been made over the past three decades, both legally and at the societal level, there was a consensus that the deeper trauma of homophobia and biphobia – both past and present experiences – continued to reverberate in the lives of many GBTSM. For example, when asked why GBTSM are more prone to suicide, David, a two-spirit man in his forties who had previously experienced suicidality, answered:

*“Probably because of homophobia. From friends that I have lost and even from other friends and family that are gay that have thought about suicide, they just cannot tolerate the homophobia, the hatred from family, from friends, from society in general.”*

Similarly, Brett, a gay man in his forties who grieved the loss of a close gay friend to suicide, submitted **Photograph 1** of a painted rainbow sidewalk in Vancouver's gay village which he

titled “*False pride*”, in making the point that despite signs of increasing acceptance of GBTSM rights, at a deeper level, society had not yet accepted or included GBTSM:

*“There's a lot of people who are fearful. There are people in the world who still think being homosexual is contagious. We've got a long way to go, we do.”*



**Photograph 1. False Pride**

A majority of men believed that ultimately, homophobia, biphobia, and marginalization of GBTSM needed to be addressed as requisite to preventing suicide among GBTSM. In the Canadian context where GBTSM had gained equal human rights, many participants noted that reducing societal homophobia further required sustained public education and awareness interventions in the form of campaigns, school-based interventions, and community workshops to raise awareness and challenge homophobia, violence, and social isolation. For example, Erik, a gay man in his thirties who lost a friend to suicide thought that awareness and improving social connection was important:

*“Probably the best prevention strategies are talking about it [homosexuality] and creating community awareness ... and that's something that we need to focus on*

*more, or re-focus on, you know it's really, it's creating community and creating community that meets people where they're at."*

Implicit to Erik's and many men's narratives were the need for community-based actions toward destigmatizing homosexuality and bisexuality to remedy longstanding discrimination. Many participants, like Erik, suggested that GBTSM were deprived of a sense of belonging to a community where they could be free from judgement. In this context, participants expressed that building inclusive communities that not only tolerated but also fully accepted sexual diversity was key.

Some participants discussed schools as key sites that could foster attitude change towards GBTSM, both as a place to counter prejudices among the population in general, and to create a safe place for young GBTSM to come to terms with their sexuality. Many participants described that educating all young people about GBTSM, homophobia, and biphobia would help to mitigate the isolation experienced by many GBTSM, which participants in turn linked to suicidality. Bruce, a bisexual man in his twenties who lost a GBTSM friend in high school to suicide, cited the Pink Shirt Day and Day of Pink campaigns<sup>ii</sup> as effective anti-homophobia campaigns deployed in schools. He suggested that they should be scaled-up to reduce suicide rates:

*"This is actually something a friend of mine did... probably the only student ever in our senior high to be openly gay, and he started this thing called the pink shirt campaign where people supporting would wear a pink shirt and say that gay is okay ... so I think that was huge just because there was nothing like that."*

Participants also frequently discussed mental illness as another factor causing GBTSM with suicidality to feel marginalized. For example, Brett (who had lost a friend to suicide) talked

about the stigma his deceased friend had endured, related to his depression and suicidality:

*“people just don’t get it [mental illness]. I think a lot of the time people are uncomfortable”.*

Similarly, Elmer, a gay man in his sixties with a long history of depression and suicidality, suggested that, *“people are just afraid of the terms depression and mental illness. People are afraid that you might become violent”*. Mental illness stigma and the cultural discomfort with suicide was also seen by some participants as intertwined with homophobia. Elmer explained the recursive relationship perceived by many people:

*“People tend to put gay people as people with mental issues because being gay, the very fact that you tell people that you are gay, people think that you have a mental issue. Straight people are not gay because they don’t have mental issues. That is sort of an analogy that did not sit well with me then, and even now.”*

Elmer highlighted the intersecting and double stigma endured by many gay men, wherein homosexuality has historically been conflated with mental illness, leading to a legacy where suicidality was linked to homosexuality itself, rather than to the societal homophobia.

Participants outlined the steps required to address the stigma surrounding mental illness as mirrored by the ones for addressing homophobia. These included de-stigmatization education campaigns and interventions. Ross, a bisexual man in his forties who previously struggled with suicidality described:

*“Teaching people that there is no stigma, that mental health is no different than a sore foot or bad kidneys, that there are procedures, cures, or that you can alleviate the symptoms ... Teaching people that they can and should talk about it; that they can approach other people. It’s the shame; getting rid of the shame is a big part of it, and somehow communicating that to the populous, that you can.”*

Ross and other participants argued that suicide and mental illness continued to be seen as ‘otherness’ and shrouded in silence, which reinforced stigma and resulted in GBTSM who experienced mental illness being doubly shamed and isolated in relation to both sexuality and mental health. Some participants highlighted the need to help young people who may be going through particularly stressful life stages. Todd, a gay man in his twenties with a history of suicidality suggested:

*“I feel like there needs to be more education at a younger age, more discussions around mental health and normalizing it for people. I feel some of the hardest times are during adolescence. If they are not given the tools at that point, you know they probably [are] never going to get them. Starting young is good.”*

In summary, the participants accounted for the need to address the societal environments that induce suicidality among GBTSM, which included societal stigma (being a GBTSM) and cultural taboos (mental illness). Participants readily identified this double stigma, and many asserted the need for effective policies and approaches to make society safer for and more accepting of GBTSM, same-sex relationships, and mental illness.

## **2. Provision of low-barrier, long-term, and GBTSM-affirming counseling**

Participants frequently discussed the provision of mental health counselling as a way of preventing suicide among GBTSM. Many men drew on experiences of accessing counselling to describe the benefits. For example, Aaron, a gay man in his thirties who suffered from depression most of his life, described counselling as the single most useful thing that improved his mood and helped him effectively manage his suicidality. He described his experience of seeing a counsellor:

*“I talked to the counsellor for an hour and I was like ‘My god’. I felt like a weight had lifted off my chest just from being able to express myself to somebody who could listen.”*

Aaron, and many other men, experienced counseling as a safe space to talk about what they were feeling – and to be heard – which was liberating. The security of engaging in personal conversations confidentially with an empathetic professional affirmed that the men’s feelings and experiences mattered.

However, many participants highlighted the challenges for GBTSM accessing professional mental health services, particularly counselling. For example, Brett, contributed **Photograph 2** of a local hospital that he titled: “*Do no harm*”, detailing the loss of a close friend to suicide who was struggling to access effective services:

*“I think we have an institutional failure for people with mental illness and drug addiction. I think that as long as we keep throwing pills at situations instead of real solutions, we’re going to have suicide and we’re going to have people with mental illness who are homeless and who aren’t being treated properly. I think what a lot of people with mental illness need is support and human touch.”*



**Photograph 2. Do no harm**

Brett's and other participants' narratives affirmed the need for talk therapy and counselling to reach the issues underpinning GBTSM men's suicidality. Moreover, participants implicated the lack of low-barrier mental health services, rather than men's reticence for help-seeking, in preventable outcomes like suicide. Participants also highlighted the financial cost associated with talk-therapy as a specific barrier. Even though counseling was described as "life-saving", many men noted that most GBTSM could not afford it, and participants argued that responsive counselling services should be made available as part of the Canadian public health care system and sufficient to meet the demand. For example, Leo, a gay man in his thirties who lost a friend

to suicide, pointed out that if his friend had received effective professional help, he would still be alive today:

*“I think free counselling/psychology would be helpful. It has to be there when people need it. They can’t be put on a waitlist for half a year to a year.”*

Aaron also made the point that counselling services needed to be longer term for GBTSMM with deeper issues, as *“short-term counseling does not work for depression”*. Todd, who had been sexually abused as a child and had a long history of mental illness and suicidality, confirmed cost as a significant barrier to effectively treating his long-term mental health problems:

*“I found it hard to find resources that could be with somebody for long-term counselling and therapy. There’s a lot of short-term help, but as somebody who has experienced pretty big trauma in life, it takes longer counselling that I don’t have the financial backing and resources for.”*

Another barrier often discussed by participants was the perceived ‘fit’ between clients and mental health care providers. Many participants turned to their family doctor to help them access counselling, but they infrequently got the referral they needed. For example, Thomas, a bisexual man in his twenties explained, *“I would tell my doctor ‘I’m at a real low and I’d like some help. Could you refer me to someone?’ And I wouldn’t get a referral, but I would get some pills.”* Similarly, Bobby, a gay man in his thirties, reflected on his own experiences with health providers and accessing mental health care: *“too many were pill pushers. Just pills, pills, pills. There’s isn’t a lot of really good help.”* These accounts provide evidence not only of the lack of mental health resources



but also the need for better primary health care provider training in shared treatment decision-making for mental illness.

Most participants also argued for GBTSM-specific services. The men were highly attuned to being judged on the basis of their sexual orientation, and GBTSM-affirming providers was described as a key aspect of effective mental health care. For example, Ivan, a gay man in his forties with a history of suicidality, described the significance of a therapeutic relationship in which he did not experience a sense of shame or judgment:

*“She is completely non-judgmental so I can tell her anything. She’s pretty accepting about everything. I think being able to talk to her about, you know, just her knowing that I’m gay and it’s a non-issue and I can talk about my relationship.”*

The therapeutic relationship with the care provider was paramount to participants’ sense of effective care, and many participants contrasted good and bad experiences, often stating that they had had to reach out for professional help multiple times to find the right help for them. Reflecting on their own experiences, participants suggested that other GBTSM who are struggling with depression or suicide should be persistent in finding the right therapeutic alliance with mental health care providers.

Some men reported an additional benefit if their counsellor was a GBTSM, reinforcing the notion that a shared sexual orientation could aid therapeutic alliances by reducing worry about encountering providers with GBTSM-stigmatizing attitudes. For example, Jamie, a gay man in his fifties who had a negative experience with a counsellor when he was struggling with suicidality, recounted how having a GBTSM counsellor would have helped him disclose and discuss more about his experiences, *“if my therapist could have been gay or lesbian even, to talk*

*to me about it, I think that would have made a huge difference*". Some participants recommended that mental health services be integrated in GBTSM organizations, as many GBTSM were comfortable in these spaces and knew they were GBTSM affirming.

In summary, participants highlighted the difficulties in finding low-barrier, long-term and GBTSM-affirming mental health services. They believed that services should be targeted to GBTSM, involving providers who were explicitly open to, and/or aligned with GBTSM communities. They also expressed a preference for talk therapies –rather than a sole reliance on medications (i.e. anti-depressant) - and emphasized the need for free services, especially those who were dealing with chronic mental illness issues.

### **3. De-isolation through peer support and community connection**

Participants described isolation and lack of social connection as important drivers of suicidality among GBTSM. As such, they described the potential of bolstering social support networks and peer-based interventions in the community in order to prevent GBTSM suicide. Recognizing that broad and supportive social networks may not be available to many GBTSM, the participants described the importance of formalized interventions in the GBTSM community to help de-isolate individuals at risk of suicidality. For example, Clint, a gay man in his twenties with a history of suicidality, provided **Photograph 3**, titled, *"We stand side by side"*, suggesting that, for him, the support of friends was more effective than professional counseling because of the deeper connection he felt:

*"What I really needed was someone I can emotionally depend on or trust. So I think friends and family is better than a counselor"*.



**Photograph 3. We stand side by side.**

Similarly, Todd, who previously struggled with suicidality, described how exchanging stories with others who had experienced depression and suicidality helped him:

*“I find one of the most useful things that I've done too, is like, talking with other people who have had similar experiences to me. ... It just feels like validating hearing somebody else talk about things. You're like, 'I get that, too.'”*

These participants' accounts evince the comfort in seeing and hearing from others who have lived through similar difficulties, but also the importance of sharing what worked and did not work to cope with suicidality. Moreover, as mental illness was still highly stigmatized, empathetic peers with similar experiences were perceived as more trusted and more likely to understand than others. This did not discount the need for professional services, but instead highlighted the added benefits of peer connectedness to men's healing.

Other participants emphasized the value of more formal, or structured, peer support interventions. Peer support groups were described as providing the opportunity to speak about

personal struggles and interact with others, without the power differential that typically existed in one-on-one formal counseling with professional health care providers. The benefits of support groups were articulated by Anthony, a gay man in his fifties who had a history of suicidality:

*“A support group where you could go and just sort of feel relaxed. I’ll listen and talk a little bit but I think they always say the more you try and talk about it the better you get your feelings out.”*

Participation in support groups yielded therapeutic interventions for some men, as Jamie explained:

*“I’m actually in a group now that I highly recommend. It’s a 12-week group. And that, maybe because of the group dynamic, and learning; we were given tools. Maybe that was what was missing with the counselor, was talk therapy.”*

In addition to peer support, several participants discussed how being connected to the GBTSM community helped them manage their suicidality. Participation in specific interest groups helped to increase social connectedness, as well as build knowledge. For example, Shawn, a gay man in his fifties with a history of suicidality, described the positive impact of being in a gay performing arts group:

*“This represents what really has been a support group, this group that I [perform] with, and have [performed] with for 32 years. I know a lot of them quite well... it’s something that I take a lot of pleasure in singing and I just always get to [perform] and get the oxygen flowing and stuff like that. It’s supportive in many ways. It’s supportive in the fact that it’s a family. I’ve known some of them for 30 years in there. That represents a rock at the moment.”*

Long-term participation in interest groups helped to create social connectedness, and stimulate a sense of personal growth for Shawn and many other men. Notably, many of the group activities that participants mentioned were specifically organized for GBTSM. These activities provided participants with joy, reduction in suicidality, and social connectedness as well as a sense of belonging and feeling safe.

Of note, another way participants connected to the community was through volunteering. For example, Ivan, a gay man in his forties who had experienced suicidality, volunteered at two community organizations for GBTSM. Other participants found meaning in commitments outside of the GBTSM community, volunteering at a local theatre or with a choir. By volunteering, participants connected to others within a community that was meaningful to them. There was a sense of purpose and benevolence that participants experienced by giving back to community and helping others. This also reduced men's time alone and perhaps distracted them from their own challenges. For Ivan, volunteering served as a positive alternative to work while on long-term disability;

*“...feeling like I'm helping people, having satisfaction from helping people. I volunteer but it's not enough. I'm looking for further volunteer work right now to add more meaning to my life and give me more to do.”*

As a community-based intervention, encouraging volunteerism among GBTSM may be a potentially fruitful approach to suicide prevention. Additionally, recommending that community organizations increase utilization of volunteers (more positions and/or shifts) could help connect more GBTSM and in turn reduce social isolation and therefore reduce the risk of suicide.

#### 4. Fostering creativity and cultural resilience

Due to the persistence and intersection of homophobia, biphobia, and mental illness stigma, it was common for participants to describe their lives, and the lives of other GBTSM, as “hard”, “challenging”, or “tough”. Nonetheless, participants described both community and individual strategies to combat suicidality. In the context where many GBTSM had negative experiences with finding appropriate support within the health care system, participants demonstrated perseverance, creativity, and resilience in the face of adversity.

Men’s commitments to self-managing their suicidality and practicing self-care were crucial, though for many men, doing so conflicted with traditional masculine norms. Todd noted, “*there are not a lot of things that are socially acceptable for men as far as self-care*”. Added to this were challenges embedded in struggling with depression and suicidality. Todd continued:

*“When you are struggling with mental health, it can be difficult to do the basic things such as getting your haircut or showering or taking a little bit extra time to pamper yourself and do things that make you feel good.”*

Nonetheless, many participants described how the GBTSM community was generally very supportive of self-care and of different expressions of masculinity and gender. Illustrating this, Todd submitted **Photograph 4** of his foot with painted toenails captioned, “*Those huge, little moments of self-care and wonder*”. He then related an experience of self-care he recently shared with other GBTSM:

*“I had a bunch of friends over to celebrate the idea of a softer, beautiful masculinity and to encourage men to maybe try some self-care type activities that they hadn't tried before like painting their nails or having a facial or whatever. I*

*had a bunch of my guy friends over. We all just like hung out and drank wine and read Cosmo and painted each other's nails and did make up and glitter beards and all that kind of stuff.”*



**Photograph 4. Those huge, little moments of self-care and wonder.**

Todd's and other participants' narratives made theGBTSM community's way of challenging traditional notions of masculinity visible. When these efforts were done in groups, they also affirmed that such actions are accepted and therapeutic amongGBTSM.

Many participants also developed more individualistic strategies such as reflection, meditation, mindfulness, and yoga. These strategies provided healthy alternatives to negative coping mechanisms that helped men manage their suicidality. Ivan elaborated on the importance of yoga for managing his mental well-being:

*“I do yoga three to four times a week and it is not an option not to do it. Like I’ve fallen off the wagon a couple of times and that’s when I start to notice that my mood will dip or I won’t be feeling the same. And then I’m like ‘shit, I haven’t been doing yoga. That’s what it is’. And I can do it once and I feel better.”*

For Indigenous participants, an important part of coping with the triple oppression they faced as Indigenous sexual minorities who experienced suicidality was connecting to and practicing aspects of their Indigenous cultures. For example, David, a two-spirit man in his forties who previously attempted suicide, explained, *“so basically finding my traditions ended those realms of committing suicide and all those thoughts that I’m not worthy of being here. It was like a rebirthing”*. Similarly, Anthony, an Indigenous gay man in his fifties with a history of suicidality, explained how smudging – a traditional practice of cleansing the body and spirit by burning sage – took *“away [his] thoughts of suicide”*.

Many participants found art to be effective in managing their suicidality. For example, when Jonathan, a gay man in his thirties, was asked what he would recommend to other GBTSM, he answered, *“Write things. Draw. Paint. Do something. Anything that you can find to express what you are feeling or what’s causing your thoughts of suicide”*. Jonathan’s statement illustrates the therapeutic value of creative expression for some individuals. Jonathan also described how performing as a drag queen improved his mental health by allowing him to better express himself: *“My drag is my way of dealing with my things”*. These GBTSM’s accounts include a diverse range of activities that contributed to their resilience. These activities could be emancipating, freeing and affording respite for dealing with challenges accompanying suicidality. These men’s reliance upon familiar activities is also notable.



Overall, the participants showed resilience and creativity in dealing with the challenges they faced, including suicidality. Despite a history of homophobic violence, bullying, and harassment, most men spoke of their sexuality and of the GBTSM community as sources of pride and assets. For example, when Drew, a gay man in his sixties with a history of suicidality, was asked if being gay was a disadvantage and a factor in his suicidality, he answered, *“No, I think it’s given me a perspective on life and an enrichment, and I’ve never wanted to not be gay.”* More so, many described how their sexuality had allowed them to explore their artistic sides and how the GBTSM community provided a non-judgmental environment for developing self-care practices that might be thought of as incongruent with masculinity by some. The descriptions of these GBTSM’s ongoing efforts to improve their well-being suggested that promoting resilience among GBTSM should be part of an effective suicide prevention strategy.

## **DISCUSSION**

By privileging lived-experience and creative expression through the medium of photography, our photovoice study highlighted insights from GBTSM who are closest to the suicide epidemic. These insights should be used to guide suicide prevention initiatives for GBTSM. This study is significant, as to our knowledge, this was the first study to describe the perspectives of GBTSM affected by suicide on the most promising remedies to reverse this inequity. The participants proposed four considerations for GBTSM suicide prevention that address different risk factors identified by GBTSM themselves based on their own experiences. The considerations call for interventions at different levels (societal, health care system, community, and individual) and include description by GBTSM of specific interventions (**Table 1**).

Below, we examine and explore each of the four prevention considerations advanced by GBTSM. First, echoing the findings of other research pointing to homophobic discrimination and violence as causes of suicidality among GBTSM (D'Augelli et al., 2001; Diaz et al., 2001; Ferlatte et al., 2005; Irwin et al., 2014; McLauren, 2016; Paget et al., 2016; Plöderl et al., 2014), the participants described how homophobia, biphobia and homonegativity continue to reverberate in the lives of GBTSM as a particular kind of collective and individual trauma, especially with respect to the potential for personal isolation and social disconnection. The need to understand the importance of the “de-isolation” for at-risk GBTSM could better inform suicide prevention work in the future. As highlighted in the photography of this study (e.g., with allusions to “false pride”), despite enormous gains in gay rights over previous decades (e.g. Weeks, 2007), and the triumph of the ‘coming out’ narrative as a key trope in western culture (e.g. Ridge and Ziebland, 2012), homophobia, biphobia and homonegativity are still prominent normative forces underpinning GBTSM’s everyday lives. The participants of this study pointed to the school system as a key environment where marginalization occurs and thus an important site of intervention. Recent studies of school systems have shown that policies and interventions can reduce sexual stigma, improve sense of belonging, and reduce suicidality rates (Seawyc, Kinishi, Rose & Hommma, 2014). The challenge is to scale-up these interventions as well as to adapt them to other spheres of society where GBTSM continue to experience stigma, such as sport and recreation (O’Brien, Shovelton, & Latner, 2013; Anderson, 2002), and workplaces (Embrick, Walther & Wickens, 2007). These interventions may best be led by GBTSM as volunteers, to ensure salience of the programs, and to involve individuals wanting to give back to their communities.

Second, several studies report that GBTSM have unmet mental health need (Grella et al., 2009; Koh & Ross, 2006; McCann & Sharek, 2014; Meyer, Teylan, & Schwartz, 2015; Tjepkema, 2008). The study participants described some struggle with the cost associated with mental health care as well as the format and character of services received, particularly talk-therapy. Cost has been previously reported as an important barrier to mental health services among GBTSM (Smalley, Warren, & Barefoot, 2015), but is not unique to this population (Mesidor, Gidugu, Rogers, Kash-MacDonald, & Boardman, 2011). In that sense, the participants strongly advocated for an expansion of mental health services coverage within the publicly funded Canadian health care system. More so, the study participants described that “brief” approaches to counseling, which are common low-cost options within public health care systems, failed to engage them in predicting similar outcomes for other men experiencing suicidality and trauma. Finally, it is clear that GBTSM’s mental health services and providers need specialized training (Lee, Oliffe, Kelly & Ferlatte, 2017) and while GBTSM or GBTSM-affirming providers might be preferred, competencies for treating GBTSM should be mandatory. As such, the results of this study highlight the need for professional educational and training programs for mental health professionals – including physicians, psychologists, social workers, and psychiatrists – to include comprehensive and empirically-based education about GBTSM’s mental health needs (Rutherford, McIntyre, Daley & Ross, 2012).

Third, the participants highlighted the important role for GBTSM and GBTSM’s community organizations in suicide prevention through fostering support, connections, and belonging. The importance of sharing stories and hearing from others who have struggled with suicidality was evident, as were the value of support groups for those bereaved by suicide or those experiencing suicidality in discussing suicide openly and regaining hope for the future

(Bartone, Bartone, Violanti & Gileno, 2017; Sandford, Cerel & Frey, 2016). Similar benefits may follow from support groups for GBTSM who struggle with suicide. In the context where suicide remains highly stigmatized (Oliffe et al., 2016; Carpiniello & Pinna, 2017), support groups may offer important opportunities for GBTSM to openly discuss their feelings and experiences.

Finally, GBTSM in our study demonstrated creative ways to be resilient. Resilience has been described as an “untapped resource” (Herrick et al., 2011) in the design of interventions targeted to promote wellness among GBTSM, but often analyses have lacked a sense of what resilience is and how it can be fostered. Our results suggest that it may be useful for those interested in developing interventions, and for mental health providers, to consider the specific protective factors and wellness-promoting behaviors that GBTSM can adopt. To foster resilience among GBTSM, however, policies, communities, and health and social services need to match GBTSM’s efforts (Luthar & Cicchetti, 2000). This will help create a resilience-promoting environment that nurtures GBTSM’s assets and makes it possible for their efforts to result in positive and healthy outcomes, including reduced suicidality.

### **Strengths and Limitations**

The main strength of our study is its design. By employing photovoice, this study provided an important space for GBTSM to illustrate and voice their perspectives and preferences for suicide prevention. Because participants decided what was photographed and discussed, it positioned GBTSM as experts and limited the influence of the interviewers over what was covered during the interviews (Oliffe & Bottorff, 2007; Wang, 1999). Also, this methodology allowed GBTSM to express opinions on traumatic experiences and taboo topics without relying on words alone

(Wang, 1999). Indeed, many participants noted during their interviews that they had never or rarely discussed their suicidality, but found photography a powerful tool to share their stories. Finally, photovoice helped capture the experiences of individuals holistically, illuminating community challenges and strengths. At the same time, our study was limited by drawing on previous experiences of suicidality, therefore potentially limiting what was remembered and shared by some men. Future work might explore the accounts of GBTSM experiencing current suicidality to distill unique insights and inform tailored prevention programs.

## **CONCLUSIONS**

An increasing body of empirical research has pointed to significantly elevated risk of suicide among GBTSM, yet it is unclear what type of interventions will address this. Our study revealed that photovoice is a powerful tool for community members to discuss a much-silenced topic and to share their perspectives about potential solutions. Indeed, participants described four considerations for prevention as well as diverse personnel and resources that need to be mobilized in order to reduce suicidality among GBTSM. These included policy makers, health care professionals, and community members. We have shared the participants' photographs in exhibits, online galleries, community forums, and presentations to message these stakeholders in authentic and powerful ways to lobby thoughtful consideration of, and ideally commitment to, developing targeted GBTSM suicide prevention efforts.

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**Table 1. Considerations for suicide prevention among gay, bisexual and two-spirit men (GBTSM)**

<b>CONSIDERATION</b>	<b>LEVEL</b>	<b>SUICIDE RISK FACTORS</b>	<b>INTERVENTIONS</b>
1. Recognizing and addressing the enduring effects of homophobia, biphobia, and mental illness stigma	Societal	Homophobia and biphobia	Public education and awareness education
			Anti-homophobia/biphobia school-based interventions
		Mental illness and suicide stigma	De-stigmatization education campaigns and interventions
2. Provision of low-barrier, long-term, and GBTSM-affirming counseling	Health care System	Financial cost associated with counselling	Extend health coverage for talk-therapy and long-term counselling
		Conflict with health care professionals about treatment options	Training for health care providers in shared treatment decision-making for mental illness
		Lack of GBTSM-affirming mental health services	Integration of mental health services within GBTSM organizations
3. De-isolation through peer support and community connection	Community	Isolation and lack of social connection	Peer support group for GBTSM experiencing suicidality
			Building connections through GBTSM sport, cultural, and advocacy groups
			Encouraging volunteerism among GBTSM with suicidality
4. Fostering creativity and cultural resilience	Individual	Lack of support for self-management of suicidality	Support self-care and resilience among GBTSM

<sup>i</sup> Two-spirit is an organizing term used by some Indigenous people in North America to describe their interrelated sexual, gender and/or spiritual identities and reclaim gender roles that were used in several Indigenous traditions before European colonization. In many cases it refers to a person who has both a masculine and feminine spirit. (Wilson, 1996)

<sup>ii</sup> Pink Shirt Day and Day of Pink are both movements that culminate on a day when everyone is invited to participate by wearing pink. Pink Shirt Day focuses its efforts to raise awareness of and reduce bullying in schools, while Day of Pink celebrates diversity and raises awareness to stop homophobia, transphobia and all forms of bullying among youth.