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Exploring and understanding young LGBT+ people's suicidal thoughts and attempts in Scotland

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Abstract

Background: Suicide is the second leading cause of death amongst young people aged 15-29. Amongst this young population it is estimated that lesbian, gay, bi and trans (LGBT+) young people are more likely than their cisgender (non-trans), heterosexual peers to think about and attempt suicide. In the UK there has been a paucity of research on this topic, and despite Scotland having higher suicide rates than England & Wales, UK-based research seeking to understand LGBT+ youth suicide is yet to include Scotland. Furthermore, existing research has focussed on the prevalence of suicidal thoughts and attempts amongst LGBT+ young people, demonstrating the disproportionate burden of suicide amongst this population. However, in doing so it has paid less attention to why this disparity exists. This research seeks to address these limitations in our understanding.

Aims: I used a multi-disciplinary approach to better understand how young LGBT+ people make sense of their experiences of suicidal distress, questioning what they identified as the pertinent contributory and protective factors, as well as their ideas for future LGBT+ youth suicide prevention.

Methods: To explore these questions in-depth, I undertook qualitative, semi-structured, conversational interviews with a community sample of 24 LGBT+ young people aged 16-24 with lived experience of suicidal distress from across Scotland. The interviews were then analysed using reflexive thematic analysis.

Findings: Participants identified a range of LGBT+ specific and youth-specific factors that interacted, contributing to and protecting against suicide. Adverse childhood experiences, bullying and social isolation, a cis-heteronormative community climate, concerns and challenges coming out, and difficulties in education were seen as contributory factors, to which suicide was often conceptualised as a response. For many underlying this were feelings of entrapment, defeat, burdensomeness, and a lack of belonging, and it was in response to this that participants in this study began to experience suicidal distress. Staying safe from suicide therefore often relied on dismantling these feelings, both through accessing support and gaining a sense of social connection. Relatedly, suggestions for reducing LGBT+ youth suicide in the future centred upon improving mental health support and challenging queerphobic stigma.

Conclusion: The cumulative weight of both LGBT+ specific and youth specific contributory factors meant that many participants in this study articulated a lack of spaces in which they could safely exist. This appeared to be exacerbated by an ontological rejection of participants as LGBT+ people by those around them, which could often feel irresolvable. Consequently, future suicide prevention needs to focus both on individual psychological support for LGBT+ young people who think about suicide, as well as social interventions that tackle queerphobia at its roots.

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Author's Declaration

I declare that I am the sole author of this thesis, except where the contribution of others has been acknowledged. The work in this thesis has not been submitted in any form for another degree or professional qualification at the University of Glasgow or any other institution.

Hazel Louise Marzetti, December 2020.

Glossary

Ace	Ace is used as short for asexual and/or aromantic.
Aromantic	Aromantic is a term used to describe a lack of romantic attraction, although a sexual attraction may be present (Holleb, 2019).
Asexual	Asexual is a term used to describe a lack of sexual desire/attraction (AVEN, 2017).
Biromantic	Biromantic is a term used to describe someone romantically, although not necessarily sexually, attracted to people of more than one gender.
Cisnormativity	Cisnormativity describes normative standards that position being cis as not only the ‘normal’, but also the desirable way for a person to be (Bauer *et al.*, 2009; Ansara and Hegarty, 2012, 2014).
Cisgender or ‘cis’	The term ‘cis’ or ‘cisgender’ is used to describe someone who’s gender identity corresponds with their sex assigned at birth.
Cisgenderism	Cisgenderism describes the positioning of being cis as not only the ‘normal’, but also the desirable way for a person to be; this has also be referred to with the term cisnormativity (Bauer *et al.*, 2009; Ansara and Hegarty, 2012, 2014).
Come out, coming out, being out or ‘out’	Used to describe the process of realising one’s LGBT+ identity (‘coming out to one’s self’) or disclosing one’s LGBT+ identity to another person.
Demiboi	‘Demiboi’ is a term used to describe someone who sees their gender as partially, but not entirely a boy (Holleb, 2019).
Demisexual	‘Demisexual’ is a term used to refer to someone who only experiences sexual attraction once they have an established emotional connection with a person.
Heteronormativity	Heteronormativity describes the positioning of being heterosexual not only as the ‘normal’, but also the desirable way for a person to be (Rich, 1980; Ahmed, 2006).
LGB	Acronym used to include lesbian, gay and bi people.
LGBT	Acronym used to include lesbian, gay, bi and trans people.
LGBT+	Acronym used throughout this thesis to include lesbian, gay, bi and trans people, as well as anyone who defines their sexual, romantic or gender identity outwith the

	confines of simultaneous cisgender, heteroromantic, heterosexuality.
LGBTI	Acronym used to include lesbian, gay, bi, trans, and intersex people.
LGBTQ	Acronym used to include lesbian, gay, bi, trans, and queer people.
Non-binary	Non-binary people are those who define their gender identity as in some way outside of the binary gender constructs man and woman or experience no gender identity (Scottish Trans Alliance, 2016; Richards, Bouman and Barker, 2017; Holleb, 2019).
Queer	Queer is a reclaimed slur, used to describe one's identity whilst resisting definitions and boundaries; it is deliberately ambiguous (Barker and Scheele, 2016; Holleb, 2019).
Queerphobic	I use the term 'queerphobic' throughout this thesis as a catch-all term to describe any and all discrimination, harassment and victimisation levied against a person because of their real or perceived LGBT+ identity.
Pansexual	'Pansexual' is a term used to refer to someone who is attracted to people of multiple or all gender, or to people regardless of gender (Holleb, 2019).
Self-harm	'Self-harm will be used to describe the practice of intentionally injuring one's self, including but not limited to cutting, poisoning, scratching, burning, and hitting (Chandler, Myers and Platt, 2011; Daley, 2015)
Suicide attempt	'Suicide attempt' is used to denote a non-fatal act performed where there is some evidence of the intent to end one's life.
Suicidal distress	'Suicidal distress' is used to denote the feelings and emotions experienced at times when a person is thinking about or attempting suicide.
Suicidal thoughts	'Suicidal thoughts' are used to denote thoughts about taking actions to end one's life.
Stealth	Stealth is a term used to describe a trans person who passes as cis and chooses not to come out within a particular context as trans (Holleb, 2019).

Transgender or trans	The term ‘transgender’ or ‘trans’ is used to describe someone whose gender identity is not the same as their sex assigned at birth.

Chapter 1 Introduction

1.1 Introduction

This doctoral research project seeks to better understand lesbian, gay, bi, and trans (LGBT+)[1] young people's suicidal thoughts and attempts in Scotland using a qualitative methodology. To introduce this study, I will give a brief overview of the historic, legal, social, and medical context of both suicide and LGBT+ people in Scotland. I will pay particular attention to how context has shaped the language used to describe both; however, due to the specialist language used throughout, a glossary is provided at the start of this thesis. Next, I will move on to discuss existing knowledge around the prevalence of suicidal thoughts and attempts amongst LGBT+ young people, where possible comparing them to their cisgender[2], heterosexual peers. I will end the chapter by discussing the knowledge gaps present at the time of writing and how my research seeks to address them, and by providing a thesis roadmap.

1.2 Background

Suicide is a major public health concern (World Health Organisation, 2014), thought to be the outcome of a complex interplay of biological, psychological, and social factors (O'Connor and Pirkis, 2016; Franklin *et al.*, 2017; O'Connor and Kirtley, 2018). Worldwide, around 800,000 people die by suicide annually and an estimated 20 times more survive suicide attempts (World Health Organisation, 2014). Young people aged 15-29 are thought to be at particular risk; suicide is the second leading cause of death in this age group, second only to road-traffic accidents (World Health Organisation, 2014). In 2019 suicide was the leading cause of death amongst people aged 5-19 and the second leading cause of death amongst people aged 20-34 in Scotland (National Records of Scotland, 2019). Over the past five decades, Scotland has had a higher rate of deaths by suicide when compared to England & Wales, contributed to by the

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[1] Many variations of the lesbian, gay, bi and trans (LGBT) acronym are used across different research outputs and organisations. In this thesis I will reflect the language used by organisations and individuals. Additionally, definitions are provided in the glossary and a discussion of LGBT+ language will be provided in section 1.4.1.

[2] I use the terms cisgender or cis in this thesis to denote any individual that is not trans, thus anyone who's gender identity corresponds with their sex assigned at birth.

increased rate of suicide amongst men aged 15-44 in Scotland (Mok *et al.*, 2012, 2013; Dougall *et al.*, 2017). In the Scottish Highlands and Glasgow, which have experienced particularly high rates of suicide, it is argued that this is in part a consequence of the depletion of industrial and agricultural jobs resulting from the neo-liberalism of the 1980s, the beef-farming crisis of the ‘80s and ‘90s, and the associated socio-economic deprivation (Levin and Leyland, 2005; Exeter and Boyle, 2007; Dougall *et al.*, 2017; Parkinson *et al.*, 2017).

The contemporary impact of the economic uncertainty and austerity measures of the last decade on young people’s suicide in Scotland is yet to be established. In 2013, a nationally representative study of 3,508 18-34-year-olds in Scotland found that 20% had thought about suicide and 11.3% had attempted suicide over their life course (O’Connor *et al.*, 2018). Some groups of young people, such as LGBT+ young people, are considered at higher risk than others. Lesbian, gay, bi, trans, and intersex (LGBTI) people have been identified as a group at heightened risk of suicide (World Health Organisation, 2014; Scottish Government, 2018b), and this is also the case in the youth population (Marshal *et al.*, 2011; Miranda-Mendizábal *et al.*, 2017; di Giacomo *et al.*, 2018). However, despite the disparities between Scotland and England & Wales (Mok *et al.*, 2012, 2013; Dougall *et al.*, 2017), there has been little investigation of the suicide experiences of LGBT+ young people in Scotland; this is a gap my research seeks to address.

1.3 Context

Both LGBT+ people and people who have experienced mental health problems, in particular those who experience suicidal thoughts or attempts, have at times in the UK been stigmatised (Neeleman, 1996; Government Equalities Office, 2018), criminalised through the justice system (Davidson and Davis, 2006; Mishara and Weisstub, 2016), and pathologised in medical settings (Drescher, 2010; Rimke, 2016; Davy and Toze, 2018). It is essential that this historical context is appreciated when trying to understand its contemporary effects. Key dates are shown in a timeline in Figure 1.

A BRIEF TIMELINE
LGBT+ HISTORY AND SUICIDE IN BRITAIN

1533
King Henry VIII implements anti-sodomy law (between men and women, men and men, men and beasts).

1885
Criminal Law Amendment Act extended criminality from sodomy to any sexual contact between men.

1921
Three MPs and fail to extend the Criminal Law Amendment Act 1885 to include women. Failed due to a concern that it might draw attention to the possibility of lesbian activity.

1951
First trans woman in Britain recorded to have undergone gender-affirming surgery.

1954
Wolfenden Committee established to consider the criminalisation of homosexuality.

1957
The Wolfenden Committee publish the Wolfenden report recommending the decriminalisation of homosexuality.

1958
Homosexual Law Reform society formed to campaign for implementation of the Wollfenden report.

1961
The Suicide Act decriminalised sucicide in England and Wales.

1966
The first trans support group, the Beaumonth Society established.

1967
Decriminalisation of homosexuality through the Sexual Offences Act 1967 provided the men are (i) over 21; (ii) consenting; and (iii) in private.

1968
Homosexuality added to the American Psychological Association's (APA) Diagnostic and Statistical Manual.

1969
Stonewall Riots against police brutality happen in New York.

1969
The Scottish Minorities Group have their first meeting in Edinburgh.

1970
First Pride happen in New York.

1970
Gay Liberation Front have their first meeting at the London School of Economics.

1972
First UK Pride happens in London.

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1973
APA removes homosexuality from the DSM, but replaces it with Sexual Orientation Disturbance which was the mental illness of finding your sexual orientation distressing.

1980
Criminal Justice (Scotland) Act decriminalises homosexuality in Scotland provided the men are (i) over 21; (ii) consenting; and (iii) in private.

1980
Sexual Orinetation Disturbance is displaced by Ego Dystonic Homosexuality and Gender Identity Disorder is added to in the DSM-III.

1982
The Homosexual Offences (Northern Ireland) Order 1982 decriminalises homosexuality in Northern Ireland

1987
Ego Dytonic Homosexuality is removed from the DSM-IIIR and is not replaced.

1988
Section 28 or Clause 28 banned the promotion of homosexuality in Public Sector organisations and the promotion of homosexuality as acceptable in schools.

1990
The World Health Organisation removes homosexuality from the International Classification of Diseases.

1994
Age of consent is reduced from 21 to 18 for sex between consenting men.

1999
The UK Government published two white papers 'Saving Lives: Our Healthier Nation' and 'National Services Framework for Mental Health' both prioritised suicide prevention through target setting.

2000
Clause 28 was abolished in Scotland.

2001
Age of consent reduced from 18 to 16 for men who have sex with men.

2002
Scottish Executive publish their first suicide prevention strategy entitled 'Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland'.

2002
Department for Health published the first National Suicide Prevention Strategy for England

2002
Equal adoption rights for same-sex couples

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2003
Employment Equality. Employers were no longer allowed to discriminate against their employees because of their LGBT+ idenitty.

2003
Section 28 abolished in England and Wales.

2004
Clivil Partnership Act introduced across all four nations of the UK.

2004
Gender Recognition Act introduced, allowing full legal recongition of trans people's gender.

2006
The Department of Health, Social Service and Public Strategy introduced 'Protect Life: Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011'.

2008
Human Embryo and Fertilisation Act allows same-sex parents to be legally recognised.

2009
Welsh Assembly Government introduce 'Talk to Me: The National Action Plan to Prevent Suicide and Self Harm in Wales 2009-2014'.

2010
The Equality Act brings together and builds upon existing legislation to protect people with a range of charactierstics both in employment and the provision of services. LGB people are protected under the sexual orientation section of the act, whilst trans people are protected under the gender reassignment section.

2013
Marriage (same-sex couples) Act legalises marriage between same-sex couples in England and Wales.

2014
Marriage and Civil Partnership Bill (Scotland) legalises same-sex marriage in Scotland.

2017
Alan Turing Law pardons those men prosecuted under the Sexual Offences Act in England and Wales.

2018
The Historic Sexual Offences (Pardons and Disregards) Act was passed , disregarding the historic criminal convictions for same-sex sexual activities between adult consenting men. in Scotland.

2018-PRESENT
Consultation and deliberation of the reforms to the Gender Recognition Act across England, Scotland and Wales.

2020
Legalisation of same-sex marriage in Northern-Ireland

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Figure 1 Selected Timeline of LGBT+ and suicide history in the UK

1.3.1 Criminalisation and legislation of suicide

In England & Wales, suicide was a criminal offence until 1961, when it was officially recognised that people who attempted suicide were in need of support rather than criminalisation (Neeleman, 1996; Mishara and Weisstub, 2016), but in Scotland suicide was never a crime (Kreitman, 1972). This does not mean it was without social or religious sanction however: for example, those who died by suicide were sometimes refused a church burial (Neeleman, 1996; Carpiniello and Pinna, 2017). Today, suicide can have material consequences for those left behind, with exemptions applied to life insurance pay-outs for those who die by suicide (Neeleman, 1996; Mishara and Weisstub, 2016; Carpiniello and Pinna, 2017). The material and social consequences of having a family member die by suicide are thought to have impacted on how suicide is officially recorded. Until recently, coroners in England were asked only to record suicide as a cause of death when suicidal intent was proven beyond reasonable doubt. However, in 2019, the Court of Appeal confirmed that instead, the civil standard of proof should be applied. Therefore, suicide could be concluded if, on the balance of probabilities, it was the most likely cause of death (Mackley, 2019). As a result, it has long been thought that deaths by suicide have been under-recorded (Kreitman, 1972; Neeleman, 1996; Jaworski, 2016), but it is hoped that with these legal changes gaining a more accurate picture of deaths by suicide may be more possible. Significant progress, in part due to efforts to reduce stigma, has been made throughout the late 20th and early 21st centuries, with all nations of the UK now having suicide prevention strategies and action plans (Mackley, 2019).

1.3.2 Pathologising suicide

It is well-established that there are high rates of mental illness, in particular, depression, amongst people who die by suicide (World Health Organisation, 2014). However, in recent times, the portrayal of an almost linear progression from mental illness to suicidal thoughts, attempts, and finally, death by suicide has been questioned (Phillips, 2010; Corrigan *et al.*, 2017; Hjelmeland and Knizek, 2017; Sheehan, Dubke and Corrigan, 2017). Researchers have asked whether pathologising suicide as the outcome of mental illness alone can somewhat mask the role of social and cultural factors in the development of suicidal behaviours (Button, 2016; Rimke, 2016; Mills, 2018; Chandler, 2019). Although suicide research is a multi-disciplinary field, it has been heavily dominated by psychology and psychiatry (Chandler, 2019). Consequently, criticism has been levelled that the majority of research in the field has taken a 'psychocentric' approach, focussing on individual risk factors for suicide, without sufficient acknowledgement of contributory social factors, such as structural inequalities (Button, 2016; Rimke, 2016). It has been suggested that to more fully understand suicidal thoughts and attempts, researchers need to combine psychologically focussed approaches, which seek to identify individual psychopathology, with more sociologically focussed approaches, that centre on social factors and inequalities in understanding suicide (Abrutyn and Mueller, 2014; Button, 2016; Mills, 2018; Chandler, 2019). In doing so, it is argued, that suicide research will be able to re-locate individuals experiencing suicidal distress within their socio-political context and explore multiple understandings of suicide as both a social and psychological phenomena (Button, 2016; Mills, 2018).

1.3.3 Suicide stigma

Mental health stigma can have a direct deleterious effect on mental health, as well as material consequences such as unemployment, loss of housing, reduced help-seeking behaviours, social avoidance, and negative impacts on physical health (Corrigan and Watson, 2002a, 2002b; Yap, Reavley and Jorm, 2013). It is proposed that stigma is born out of stereotypes and that when a society endorses such stereotypes, they can invoke negative emotional reactions and prejudiced behaviours, enacting stigma (Mayer *et al.*, 2020). Stigma usually begins as a cultural phenomenon known as social stigma; however, over time, individuals may go through a process of internalising stigma, termed 'self-stigma' (Sheehan et al., 2020). There are a plethora of stereotypes applied to people who experience mental health problems; for example, that they are 'weak', 'crazy', or 'incompetent' (Oexle *et al.*, 2019). However, it has been suggested that there are additional stereotypes applied to people who attempt suicide that can have a worsening effect on both their own and their loved ones' mental health (Oexle *et al.*, 2019).

People who attempt suicide have, at times, been labelled ‘sinful’, ‘dangerous’, ‘selfish’, ‘contagious’, and ‘attention-seeking’ (Oexle *et al.*, 2019; Mayer *et al.*, 2020; Sheehan *et al.*, 2020). Such labels have, in part, been attributed to some cultural and religious views on suicide, as discussed in section 1.3.1 (Carpiniello and Pinna, 2017). Whilst suicide stigma can have similar effects to mental health stigma, it has been hypothesised that these can be intensified due to the additional stigma-stress faced by those with a history of suicide attempts. This may be particularly the case for those who have visible scarring from a suicide attempt (Sheehan, Dubke and Corrigan, 2017), a stigma experience often shared with people who have self-harmed (Lewis, 2016; Hasking and Boyes, 2018). Furthermore, although stigma is seen as being a *response to* suicide behaviours, it has been argued that it might also increase people’s risk of re-attempting suicide due to increasing the likelihood that someone will experience known contributory factors for suicide such as feelings of hopelessness, unemployment, and social isolation (Carpiniello and Pinna, 2017; Sheehan *et al.*, 2020).

1.3.4 Legal reform of LGBT+ Rights

Both the criminalisation of suicide and of homosexuality were influenced by views held in some Christian denominations, translating acts considered sinful in the Bible into those that were illegal in law (Drescher, 2010). In the UK, same-sex sexual activity between men was first criminalised in 1533 under anti-sodomy laws (King, 2003). This was extended to include all same-sex sexual activities between men in the Criminal Law Amendment Act (1885). Same-sex sexual activities between men remained illegal until 1967 in England & Wales (Jowett, 2017), and until 1980 in Scotland (Davidson and Davis, 2006). As a result, the social and political organisation of LGBT+ people prior to legalisation was challenging, yet necessary, to pressure for law reform (Davidson and Davis, 2006; Cook, 2007). Due to a number of high-profile prosecutions post World War II, such as Alan Turing and Lord Montagu, the Wolfenden Committee was established in 1954 to examine whether homosexuality should remain criminalised in the UK. Their subsequent 1957 Wolfenden Report recommended the decriminalisation of homosexuality (Suffee, 2016; Jowett, 2017). However, it took another ten years and significant campaigning from the Homosexual Law Reform Society (established in 1958) before decriminalisation was achieved in England & Wales (National Archives, no date).

Shortly after the decriminalisation of homosexuality in England & Wales in 1967, the 1969 Stonewall riots protesting police brutality against LGBT+ communities broke out in New York. This was a pivotal moment for LGBT+ activism worldwide: the Stonewall Riots are said to have inspired the first ever Pride march, also in New York in 1970 (Stonewall, 2017), and was closely followed by the first Pride march in Britain, which took place in London in 1972 (Houlbrook, 2006; Cook, 2007; Stonewall, 2017). It was around this time that LGBT+ activism in the UK began to expand. In 1969, the Scottish Minorities Group (SMG) held their first meeting in Edinburgh, and in 1970, the Gay Liberation Front held their first meeting at the London School of Economics. The groups subsequently campaigned for decriminalisation of homosexuality in Scotland, equalisation of the age of consent, abolition of Section/Clause 28, and greater support during the HIV/AIDS epidemic (Davidson and Davis, 2006; Cook, 2007). Decriminalisation of homosexuality was achieved in Scotland in 1980 (Davidson and Davis, 2006).

For clarity, it is perhaps worth noting that same-sex sexual activity between women was never illegal in any part of the UK. In 1921, three MPs proposed that the Criminal Law Amendment Act (1885) should be extended to include same-sex sexual activities between women, but this was not taken on due to fears that in legislating, Parliament might draw attention to same-sex sexual activities as an option for women (British Library, no date). Similarly, in the UK it was also not illegal to be trans. In fact, in the early 20th century there are several records of people assigned female at birth living as men and marrying, seemingly without scandal or difficulty, and often wholly unnoticed (Burns, 2018). It was not until Corbett vs Corbett in 1970, in which Mr Corbett sought to divorce his wife of seven years Mrs Corbett due to her trans identity, that both marriage and gender recognition for trans people was brought into legal focus (Sharpe, 2002). After this landmark case, trans people were denied legal gender recognition until the introduction of the Gender Recognition Act in 2004 (Sharpe, 2009), which at the time of writing this thesis, was under review (Dunne, 2019).

In the intervening 40 years since the decriminalisation of homosexuality in Scotland, there has been a huge amount of progress made in the advancement of LGBT+ people’s rights such as the Equality Act (2010), Marriage and Civil Partnership Bill (Scotland) in 2014, and Historic Sexual Offences (Pardons and

Disregards) Act 2018. As a result, in 2015 the UK topped the International Lesbian and Gay Association for Europe (ILGA) LGBTI index and was declared as having the best legal provisions for LGBTI people in Europe (ILGA-Europe, 2015). Furthermore, although ILGA does not rank countries of the UK individually, the Scottish Government conducted its own analysis of Scotland's compliance with ILGA's criteria in 2016. They suggested that, if rankings had been calculated for Scotland as an independent country, it would have fulfilled 90% of the criteria and would therefore have been the most inclusive country in Europe for LGBTI people (Scottish Government, 2017).

However, despite the general spirit of progress between 1980 and 2020, Section/Clause 28 stands as a piece of legislation that had a hugely negative impact on LGBT+ people across the UK and, to some extent, continues to do so through its long-lasting legacy. Section 28 was legislation enacted by Margaret Thatcher's Conservative government in 1988. It banned the 'promotion' of homosexuality by local authorities, precluding the mention of homosexuality as acceptable in schools (Rahman, 2004). This not only meant that teachers were unable to include LGBT+ content in the curriculum, but it also meant that generations of young people had limited sex education, and many teachers felt unable to challenge homophobic bullying when they witnessed it (Greenland and Nunney, 2008). Furthermore, although this legislation was repealed in 2000 in Scotland and in 2003 in England & Wales, its legacy means that, for many, the inclusion of LGBT+ content remains contentious (Lee, 2019).This has been specifically addressed in Scotland recently through new recommendations of an LGBTI inclusive curriculum to be implemented across all Scottish public schools (Scottish Government LGBTI Inclusive Education Working Group, 2018).

1.3.5 Pathologisation of LGBT+ people

At the same time as the rapid legislative changes, there were also several changes to the treatment and classification of LGBT+ people in medicine that were undoubtedly influenced by the changing socio-political climate (Drescher, 2015). The relationship between the disciplines of psychiatry, psychology, medicine, and LGBT+ people has been fraught. The first edition of the Diagnostic and Statistical Manual (DSM), saw the classification of homosexuality as a mental illness by the American Psychological Association (APA) (Baughey-Gill, 2011). For some, the movement to classify homosexuality as an illness to be treated, rather than a crime to be punished was welcomed (Drescher, 2010, 2015). As with the legal frameworks governing same-sex sexual activity, the pathologisation of gay people was gendered. Gay men were given aversion treatment (most typically electric shock), psychoanalytic therapy, and oestrogen treatment to lower libido, amongst a range of other experimental approaches (Smith, King and Bartlett, 2004). The psychiatric treatment of women for same-sex attraction however was far more piecemeal, dependent on the clinician in charge of care and the hospital's ethos (Carr and Spandler, 2019).

The 'diagnosis' of LGBT+ identities was shaped by medical concerns underpinned by cultural and moral values, with Drescher (2010) suggesting that the pathologisation of LGBT+ people was a process of turning sin into illness. In 1973 therefore, the APA declared that 'homosexuality' was not a mental disorder and should not be in the DSM. This decision is likely to have been influenced by the changing social and political climate (King, 2003; Drescher, 2010). However, the removal was not without controversy. Furthermore, although homosexuality *per se* was declassified as a mental disorder in the DSM-II, it was replaced by the diagnosis 'Sexual Orientation Disturbance'. This diagnosis referred to the mental disorder of someone finding their own homosexuality distressing. It is to this diagnosis that the practice of so-called 'conversion therapy' is attributed; the idea being that a person should be supported to change their orientation if they find it distressing, failing to account for the role of social context and stigma in this distress (Drescher, 2015). In the DSM-III, this was then renamed 'Ego Dystonic Homosexuality', but, after significant opposition, this was removed from the DSM-IIIR in 1987. It was not until 1990 that the World Health Organisation removed homosexuality from the International Classification of Diseases (ICD-10).

Whilst homosexuality has now been formally depathologised in both the ICD and the DSM, the same cannot be said of trans people. Gender Identity Disorder was first included in the DSM in 1980, although it had been talked about within research literature from at least the 1960s (Ansara and Hegarty, 2012) and was included within the ICD-10 in 1992 (Drescher, 2010). In the DSM-5 there were efforts from an APA working group to depathologise trans people's identities by re-classifying the previous ‘Gender Identity Disorder’ to ‘Gender Dysphoria’ in the hope of reducing stigma and pathologisation levied on trans people (Davy and Toze, 2018). As with homosexuality, some trans people welcomed a diagnosis, particularly in the US, where a diagnosis is usually required for trans-affirming medical treatment (Drescher, 2010).

1.4 Terminology

Given the stigma, pathologisation and criminalisation faced by LGBT+ people and people who experience suicidal thoughts or attempts, terminology can become a tool through which stigma is communicated. Both of these groups have been subject to stigmatising language. For example, the (now somewhat reclaimed) slur ‘queer’ used against LGBT+ people (Barker and Scheele, 2016) or the fairly commonplace phrase ‘committed suicide’ used to describe those who die by suicide, harking back to a time where suicide was a criminal offence (Nielsen, Padmanathan and Knipe, 2016). It was therefore crucial in this study that I tried to be sensitive and reflexive in my choice of language.

1.4.1 LGBT+ Terminology

Terminology used in, by and about LGBT+ communities has changed over time. This can create research challenges when finding relevant research and ensuring that this research is referring to the same population (Eliason, 2014). However, it is also hugely important for ensuring that researchers respect and accurately reflect the identities of the people that we work with (Bergman and Barker, 2017). This can be particularly important to young people, who, it has been argued, use a more expansive range of terminology to describe their identities (Frohard-Dourlent *et al.*, 2017; Nic Giolla Easpaig and Fox, 2017).

Over the last two decades, the UK has seen an increase in activism to gain recognition of non-binary[3] people (Scottish Trans Alliance, 2016; Bergman and Barker, 2017), some of whom will feel that they fit into a broader trans community and some of whom will not (Scottish Trans Alliance, 2016; Frohard-

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[3] Non-binary people are those who define their gender identity as in some way outside of the binary gender constructs ‘man’ and ‘woman’ or experience no gender identity (Scottish Trans Alliance, 2016).

Dourlent *et al.*, 2017). It has been said that western perspectives on sexual and romantic attraction are defined in a gender-centric manner, meaning that terms used to describe sexual or romantic identities communicate information about an individual's gender and the gender of their partners, which are often predicated upon a binary view of gender (Weeks, 1996; Cover, 2012; Better and Simula, 2015). Therefore, perhaps partly in recognition of gender fluidity and non-binary people (Callis, 2014), and partly to recognise the fluidity of sexual and romantic orientations, terminology used to describe sexual and romantic orientation has also developed (Oswalt, Evans and Drott, 2016). For example, in work examining the experiences of Australian LGBT+ youth using health services, Nic Giolla Espaig and Fox (2017) surveyed 101 young people and found that alongside more widely recognised terms such as lesbian, gay, and bi, their respondents were also using terms such as 'queer'[4], 'pansexual'[5], and 'demisexual'[6] amongst others to describe their sexual and romantic orientations.

To incorporate the expansion in terminology used by individuals to describe their sexual orientation or gender identity, some organisations have expanded the LGBT acronym they use (Ghaziani, 2011; Eliason, 2014; Oswalt, Evans and Drott, 2016; Smoyak, 2016). Variations I have seen across community spaces have included: LGBTI, to explicitly include intersex people; LGBTQ+, to explicitly include queer people and recognise that an openness to others who consider that they belong within the organisation; LGBTQIAP, to explicitly include queer, intersex, asexual and pansexual people. In my research, I used LGBT+ to indicate the inclusion of all people who construct their sexual or romantic orientation or gender identity outside cisnormativity[7] or heteronormativity[8]. Throughout this thesis, however, I have reflected the language used by the participants, organisations, or researchers to whom I refer. This means there are a variety of

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[4] Queer is a reclaimed slur, used to describe one's identity whilst resisting definitions and boundaries; it is deliberately ambiguous (Barker and Scheele, 2016; Holleb, 2019)

[5] 'Pansexual' is a term used to refer to someone who is attracted to people of multiple or all gender, or to people regardless of gender (Holleb, 2019).

[6] 'Demisexual' is a term used to refer to someone who only experiences sexual attraction once they have an established emotional connection with a person (Holleb, 2019).

[7] Cisnormativity describes normative standards that position being cis as not only the 'normal', but also the desirable way for a person to be (Bauer *et al.*, 2009; Ansara and Hegarty, 2012, 2014).

[8] Heteronormativity describes the positioning of being heterosexual not only as the 'normal' but also the desirable way for a person to be (Rich, 1980; Ahmed, 2006).

acronyms used, which is particularly relevant in the discussion of research literature, where more medicalised language, such as ‘gender variant’ and ‘sexual minority’ is used. Where specialist terminology is used, it is both clarified in footnotes and listed in the glossary provided at the start of this thesis.

1.4.2 Suicide and self-harm terminology

Terminology used across suicide and self-harm varies by academic discipline, research setting, and geographical location, amongst a range of other influences (Silverman, 2016). As a result, there is not an agreed, consistent terminology used to describe suicidal behaviours (Van Orden *et al.*, 2010). Previously, the term ‘suicidality’ was used often without precise clarity of definition (Silverman, 2016). Now, there are a range of terms used to try and facilitate shared understanding, such as: suicidal ideations, thoughts, feelings, intent, and behaviours; suicide plans, and attempts; deliberate self-harm; and non-suicidal self-injury. However, concerns have been raised that, as a consequence of inconsistent terminology, it can be difficult to communicate findings and compare research across studies (Silverman, 2006, 2016).

Some have argued that the messiness in suicide terminology reflects the material difficulties of neatly categorising thoughts and actions (Andover *et al.*, 2012; Marsh, 2016). This is particularly the case with the distinction between self-harm and suicidal behaviours, where the intent of an action can change from moment to moment (McDermott and Roen, 2016; Silverman, 2016). For the purpose of my doctoral research, it is essential that I am clear about my use of language, whilst avoiding any phrases that could be potentially stigmatising (Nielsen, Padmanathan and Knipe, 2016). I will use the term ‘suicide attempt’ to mean a non-fatal act performed where there is some evidence of the intent to end one’s life; ‘suicidal thoughts’ to be thoughts about taking actions to end one’s life (Silverman *et al.*, 2007; Andover *et al.*, 2012; Robinson *et al.*, 2018); and ‘suicidal distress’ to describe the feelings and emotions underpinning these. Furthermore, the term ‘self-harm’ will be used to describe the practice of intentionally injuring one’s self, including but not limited to cutting, poisoning, scratching, burning, and hitting (Chandler, Myers and Platt, 2011; Daley, 2015).

1.5 LGBT+ Youth Suicide

1.5.1 Prevalence of LGBT+ young people’s suicidal thoughts and attempts

The last three decades has seen a rapid expansion of research demonstrating the existence of a disparity in the experience of suicidal thoughts and attempts between LGBT+ and cisgender, heterosexual young people. To synthesise this, Marshal et al (2011) conducted a meta-analysis of 19 studies examining the prevalence of suicidal thoughts amongst ‘sexual minority’ young people across North America. They found that sexual minority youths were 1.96 times more likely than heterosexual youths to have thought about suicide and 2.2 times more likely to have planned a suicide attempt (however, no confidence intervals nor significance was reported).

Building on this in a later review, di Giacomo et al (2018) conducted a meta-analysis of 24 articles reporting on 25 studies examining the prevalence of suicide attempts amongst LGBT young people aged 12-20, deemed to be of ‘high-quality’ (although it was unclear what criteria were used). They reported that LGBT young people were 3.5 times more likely than heterosexual people to have made a suicide attempt (CI, 2.98-4.12; $p < .001$). The data were then disaggregated and analysed separately. They found trans people 5.87 times more likely (CI, 3.51-9.82; no significance reported), bisexual people 3.69 times more likely (CI, 2.96 – 4.61, $p < 0.001$), and lesbian and gay people 3.71 times more likely than heterosexual people to have made a suicide attempt (CI, 3.15- 4.37, $p < 0.001$). However, they noted that there was significant evidence of between-study heterogeneity which they attributed largely to varied sample sizes, different study age groups, and data collection over a 25-year time-span (1990-2015) that saw huge socio-political change for LGBT people (as discussed in section 1.3). Furthermore, this meta-analysis included data from ten countries (Iceland, United States, Ireland, Canada, Switzerland, Norway, New Zealand, China, Taiwan, and Korea) and thus may have also been impacted by the variety of geographical and social contexts.

Although an important endeavour, there appeared to be a problem with the analysis of trans adolescents’ data in di Giacomo et al’s (2018) review, that was unacknowledged by the authors. The researchers highlighted that the inclusion of trans young people alongside lesbian, gay, and bisexual young people was a novel element of their meta-analysis. However, in both the amalgamated analysis of LGBT people and the individual analysis of trans people, the researchers reported that they had compared these groups with heterosexual young people. Doing so suggests mistakenly classifying trans identity as a sexual orientation, rather than a gender identity, failing to account for trans, heterosexual people and cisgender, LGB[9] people, which may have seriously affected the validity of the meta-analysis' findings. This said, this meta-analysis highlights two gaps in the existing research on LGBT+ youth suicide: a lack of data specific to trans young people, and on the suicidal thoughts and attempts of LGBT+ youth people in the UK. I will address each in turn.

1.5.2 Prevalence of trans young people's suicidal thoughts and attempts

In 2020, Surace et al. published the first meta-analysis of studies seeking to understand the suicidal thoughts and attempts of trans young people aged 25 or under. They included ten studies that sought to compare non-suicidal self-injury, suicidal thoughts, and suicide attempts amongst trans young people, which were predominantly from the US and UK. Although due to the lack of a control group included in the original studies, data could not be directly compared to cisgender peers, the authors instead compared to estimates for the general population. They found that 28% of 2,249 trans participants had thought about suicide (6 studies) and compared this to estimates suggesting around 25% of children and young people in mental health services and 11% in the community will have thought about suicide. Additionally, 15% of 1,039 trans participants included had attempted suicide (5 studies), which they compared to 3.6% of children and young people in mental health services and 0.8% in non-clinical populations.

These findings from Surace et al (2020) appear to indicate that trans young people experienced higher rates of suicidal thoughts and attempts than the general population. The authors explain this with appeal to minority stress

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[9] LGB: lesbian, gay and bi.

theory (which will be discussed in detail in Chapter Two), arguing that both peer and familial stigma may have contributed to the high rates of suicidal thoughts and attempts amongst this population alongside a high level of psychiatric morbidity. The lack of cisgender comparison within the studies included, and limited amount of data available for this population, is a clear challenge to understanding trans young people's suicide behaviour. The studies included in this meta-analysis were appraised using the Joanna Briggs Institute (JBI) Critical Appraisal checklist for Prevalence Studies. Using this, only two studies were considered high quality, with the remaining eight evaluated as having some limitations around the representativeness of the sample, the suicide outcomes recorded, or the appropriateness of statistical analysis undertaken.

Furthermore, the authors stated that they only included studies in which participants had a diagnosis of gender dysphoria (or equivalent) and therefore excluded studies in which participants self-reported trans identity. However, self-reported measures of suicidal thoughts and attempts were included, as were researchers' inferences of suicidal thoughts and attempts from clinical charts. Consequently, this meta-analysis would only represent the experiences of trans people who were already in touch with a gender specialist and therefore only those young people who desired, and were able to access, medical transitions, which is a subset of trans youths as a whole. The requirement of a clinical diagnosis of gender dysphoria (or equivalent) may have impacted upon the data reported. McDermott and Roen's (2016) qualitative work suggests trans young people experience a delicate balance whilst navigating mental health and gender identity services. Participants in their work felt that in order to access gender-affirming medical interventions they had to demonstrate they were distressed enough to warrant treatment, whilst being stable enough to consent to them (McDermott and Roen, 2016). It is unclear therefore how the requirement for clinical diagnosis may have affected these findings, but it suggests that more work in this area is needed to fully understand what appears to be an increased likelihood that trans young people will experience suicidal thoughts and attempts when compared to young people in the general population.

1.5.3 Prevalence of LGBT+ young people's suicidal thoughts and behaviours in the UK

A second key gap in the review papers is the limited amount of UK-based data. As discussed in section 1.3, even within the UK there are a number of national variations in protections and provisions for LGBT+ people and people with lived experience of suicidal thoughts and attempts. Therefore, although it may be possible to translate findings across international contexts this cannot be guaranteed. In di Giacomo et al's (2018) review, no UK-based studies were included, whilst in Surace et al's (2020), five out of the ten studies included data from the UK (although with lower quality as no cisgender comparison was available). Additionally, I identified two further studies that may provide insight into experiences of suicidal thoughts and attempts in England, as to date there were no peer-reviewed, published studies seeking to understand the experiences of young people living in Scotland (Metro and University of Greenwich, 2016; Oginni *et al.*, 2018; Rimes *et al.*, 2018, 2019). The Youth Chances study examined the experiences of 6,514 LGBTQ young people (aged 16-25) living in England (Metro and University of Greenwich, 2016), including 3,275 LGB and 677 'gender minority'[10] young people who answered questions on suicidal thoughts and attempts (Rimes *et al.*, 2018, 2019). However, although this study provides the largest data source on LGBTQ young people living in the UK, it recruited using LGBT community and online spaces as well as snowball sampling and the researchers were unable to conduct a direct comparison with cisgender, heterosexual peers.

The Avon Longitudinal Study of Parents and Children (ALSPAC) offers an opportunity for direct comparison of 'sexual minority' and heterosexual young people's suicidal thoughts. ALSPAC is a birth cohort study of women who were pregnant in the Avon area between April 1991 and December 1992 (15,247), and the children resulting from these pregnancies (15,458). ALSPAC asked participants to rate their sexual orientation at the age of 15: 2,551 (88.4%) identified as 100% heterosexual, 270 (9.4%) as mostly heterosexual, 47 (1.6%) as bisexual, 10 (0.3%) as mostly homosexual, and 8 (0.3%) as 100% homosexual. They recoded everyone who did not classify themselves as 100% heterosexual

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[10] Term used by authors to describe trans, including non-binary, people.

into a ‘sexual minority’ category in which they sought to represent LGB people and compare them with people who recorded their sexual orientation as 100% heterosexual. In their analysis, they found that ‘sexual minority’ young people were 2.96 times more likely than heterosexual young people to report past-year self-harm or suicidal ideations[11] at age 16 (CI, 2.43-3.60; $p < 0.001$) and 2.98 times more likely at age 20 (CI, 2.43-3.64; $p < 0.001$) (Oginni *et al.*, 2018).

Whilst ALSPAC provides us the first opportunity to directly compare ‘sexual minority’ and heterosexual young people in the UK, there are a few key limitations that must be noted. Firstly, ALSPAC is specific to the Avon area of England and thus findings may not be translatable to other contexts. Secondly, as the researchers combined self-harm and suicidal ideation measures, it is not possible to understand suicidal thoughts as distinct from self-harm, which we cannot presume are linked (this will be further discussed in Chapter Two). Finally, the combined ‘sexual minority’ measure was primarily comprised of people who reported they had a ‘mostly heterosexual’ orientation (270 people), compared to only 65 who reported that they were bisexual, mostly homosexual, or 100% homosexual. I therefore question whether the majority of people considered ‘sexual minority’ by the researchers would consider themselves to be LGB. Consequently, whilst it may statistically have created a larger category for comparison, I query whether in doing this the researchers may have compromised the validity of the category created. There was no representation of trans young people in this secondary analysis of the ALSPAC data.

In order to address the knowledge gap on trans young people’s suicidal thoughts and attempts, therefore, I will return to the Youth Chances dataset. Rimes et al (2019) conducted a secondary analysis of the suicide experiences of trans young people reported in the Youth Chances Study, providing the first UK-based analysis of trans youth suicide broken down by gender identity. 677 participants were categorised as being ‘gender minority youths’: 105 participants were trans women; 210 were trans men; 93 were non-binary people who were assigned male at birth; and 269 were non-binary people who were assigned female at birth. Respondents were asked about suicidal ideations, suicide attempts, and future risk of suicide to compare prevalence between groups of trans youth.

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[11] Self-harm and suicidal ideation were analysed as a single, combined measure.

Their analysis suggests that all trans people had high rates of suicidal ideations: across gender categories, between 64 and 76% of respondents had suicidal thoughts in the past year, with no significant between-group differences. However, there were differences in the distributions of suicide attempts, with non-binary people assigned male at birth significantly less likely to report having made a previous suicide attempt and future risk of suicide. The differences in reported suicide attempts between trans men and women were not significant. People who were assigned female at birth rated themselves the most likely to have a future risk of suicide. However, further work is needed to understand the influence of gender on the suicide experiences of trans people.

1.6 Aims of this study

Taken together, the evidence suggests that LGBT+ young people face a disproportionate burden of suicidal thoughts and attempts when compared to their cisgender, heterosexual peers. However, the question remains: why is this the case? It is this gap in existing research that I will focus on. Furthermore, although there is very limited research exploring LGBT+ youth suicide in England & Wales, there is even less so in Scotland. I therefore chose to explicitly and specifically focus this research on Scotland. As discussed throughout this chapter, Scotland has differences in legal provisions and social attitudes when compared to other nations of the UK. Despite this, however, existing research on LGBT+ young people’s suicidal thoughts and attempts in the UK has not included Scotland. As a result, our understanding of any potential differences in experiences between the nations of the UK resulting from the differences in legal provisions and social attitudes is impoverished.

To try and understand the intricacies of contributory and protective factors affecting suicidal thoughts and attempts in depth and detail, I used a qualitative methodology. This enabled me to explore with participants, from the perspectives of their lived experiences, what they felt contributed to their suicidal thoughts or attempts, what helped to keep them safe, and how they made sense of this within the broader context of their lives. I was also interested to explore their thoughts on what would help reduce LGBT+ youth suicide in the future. My research therefore sought to answer the following four questions:

1. How do young LGBT+ people in Scotland make sense of their suicidal thoughts and attempts?

2. What do young LGBT+ people in Scotland identify as the contributory factors to their suicidal thoughts and attempts?

3. What do young LGBT+ people in Scotland identify as the pertinent factors that have protected them from suicide?

4. What do LGBT+ young people believe could help reduce young LGBT+ people's suicidal thoughts and attempts in Scotland in the future?

1.7 Map of the thesis

In the following chapter, I will provide a review of the existing research literature, in order to situate my contribution to the field. My methods chapter outlines my epistemological and theoretical standpoint, my choice of a qualitative methodology, my decision-making process on my choice of methods, and how I worked to attempt to safeguard my own and my participants' wellbeing. Chapters Four to Six present the analytic findings of my study. In Chapter Four, I address research question one, exploring how participants understood their experiences of suicidal thoughts and attempts and how this was made sense of within the broader context of their life stories. In Chapter Five, I seek to answer research question two, focussing on the contributory factors to suicidal distress identified by participants, exploring both LGBT+ specific and more general factors. In Chapter Six, I address research questions three and four, exploring the factors participants identified as protecting them from suicide, as well as their ideas for future suicide prevention measures that could be taken. In Chapter Seven, to close this thesis, I will draw conclusions from my research, discussing the novel contribution it makes, presenting its strengths and weaknesses whilst reflecting on methodological implications, and considering recommendations for policy, practice, and future research.

Chapter 2 Literature Review

2.1 Introduction

This literature review provides a background to my doctoral research project. As discussed in the previous chapter, whilst there is a growing literature demonstrating that LGBT+ young people are more likely than their cisgender, heterosexual peers to think about and attempt suicide (Marshal *et al.*, 2011; Connolly *et al.*, 2016; Miranda-Mendizábal *et al.*, 2017; di Giacomo *et al.*, 2018), there is less research exploring why this is the case or how to prevent it (Savin-Williams, 2001; McDermott and Roen, 2016; Hatchel, Merrin and Espelage, 2019). To date, queerphobic[12] stigma, discrimination and harassment have primarily been used to explain the disproportionate burden of suicidal thoughts and attempts faced by LGBT+ young people. However, recently researchers have asked whether an unquestioning acceptance of queerphobia as explaining this disparity means that youth specific and general population factors increasing suicide risk have been overlooked, resulting in an impoverished understanding of LGBT+ youth suicide (McDermott and Roen, 2016; Bryan and Mayock, 2017). To avoid this common shortfall, and construct a more rounded contextual understanding of LGBT+ youth suicide in which my research could be situated, this literature review aims to provide a broad overview. To begin, I will outline key theories in the development of suicidology, I will then move onto consider youth-specific contributory factors to suicidal distress, and finish with an examination of research literature seeking to understand LGBT+ youth suicide.

2.2 Search strategy

This literature review aims to bring together three separate research literatures focussing on theories of suicide behaviours, youth suicide, and LGBT+ youth suicide. In doing so, I was keen to bring psychological and sociological works into dialogue with one another. Historically, suicide research has been dominated by the 'psy' disciplines (psychology and psychiatry), in which biological, psychological, quantitative approaches have been favoured (Hjelmeland and Knizek, 2010, 2016). Consequently, much of the research in the three areas

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[12] I use queerphobic as a catch-all term to describe any and all discrimination, harassment and victimisation levied against a person because of their real or perceived LGBT+ identity.

explored in this literature review have been dominated by what has been termed ‘psychocentric’ approaches (Rimke, 2016). In critiques of psychocentrism in suicide research, it has been argued that through a process of pathological individualisation, suicide is reduced, essentialised and decontextualized (Marsh, 2013; Rimke, 2016). Through this process, suicide is produced as the tragic outcome of mental illness without paying sufficient attention to broader socio-economic, political and structural factors contributing to the development of suicidal distress (Button, 2016; Mills, 2018). In contrast to mainstream suicide research’s approaches, LGBT+ youth suicide research has tended to focus on stigma, discrimination and harassment to explain suicide. In doing so however, it has been argued that this has been to the exclusion of many factors thought to impact on suicide risk in the wider population (Cover, 2012; Bryan and Mayock, 2017), which will be discussed in detail in section 2.5.4.

The division between psychological and sociological approaches to suicide research has been problematized. Chandler (2019) argues that in order to advance suicide research and construct better understandings, we must take a more interdisciplinary approach, bridging unhelpful disciplinary borders and facilitating dialogue. The majority of research informing this doctoral project is psychological, as this has been the primary method of inquiry used. However, responding to the call for more interdisciplinary ways of undertaking suicide research, I was keen to also draw upon sociological approaches, queerphobia and cis-heteronormativity (which will be covered in detail in section 2.5), creating dialogue. In doing so, I aimed to consider individual actions, interpersonal interactions and wider societal structures and attitudes in my exploration of suicidal distress. To do so, I constructed this literature review (and more broadly this project) as a conversation between psychological and sociological approaches to suicidal distress, considering the ways in which dialogue between the disciplines could enhance understandings.

Given the depth of research literature exploring general population, youth specific and LGBT+ youth specific factors influencing suicidal thoughts and attempts, this review must be understood as selective. To begin searching, I identified core papers that I used to build a picture of key search terms. Following on from this I worked with the specialist librarian in the University of

Glasgow's College of Medical, Veterinary, and Life Sciences to construct a search strategy combining youth, suicide and LGBT+ terminology and locate databases within which to search. Subsequently, articles were screened and I used hand searching and reference tracing from the articles that were most useful.

It must be noted that I decided specifically to search for research literature focussing on suicidal thoughts, plans, attempts, and deaths by suicide, and excluded self-harm and self-injury. There is a complex relationship between suicide and self-harm. Although self-harm is often considered a risk factor for suicide, as it is prevalent amongst those who think about, attempt and die by suicide (Gordon *et al.*, 2010; Whitlock *et al.*, 2013; Franklin *et al.*, 2017), it has also been explored as a technique for managing negative emotions and a tool for self-soothing (Chandler and Simopoulou, 2020). Therefore, I did not wish to pre-empt a connection between them, recognising that for many people self-harm has no relationship to suicidal thoughts or attempts. Secondly, due to the size of the two combined literatures it would not have been possible to review and synthesise the literature in sufficient depth.

2.3 Theories of suicide

The study of suicide dates back to Durkheim (1897/1952), however despite the long history of the field, it has been argued that broadly suicidology has been under-theorised (O'Connor and Pirkis, 2016; O'Connor and Kirtley, 2018). Thomas Joiner's Interpersonal Theory of Suicide (IPTS) (Joiner, 2007; Van Orden *et al.*, 2010) is an established approach proposing three key constructs in the modelling of suicide behaviours - thwarted belongingness, perceived burdensomeness and the acquired capability for suicide. IPTS proposes that should an individual feel socially isolated, lonely and that they lack mutually caring relationships, they may begin to view themselves as a burden on those they have close relationships with, for example friends, families or partners. For those thoughts to become active they argue the individual may lose hope that these two states, the lack of belonging and perceiving one's self to be a burden, can improve. Once suicidal thoughts are active, they propose that progression toward a suicide attempt is affected by a familiarity with thoughts about suicide, sufficient to allow the individual to imagine and plan a suicide attempt, and a reduced fear of death.

Whilst the IPTS focuses on the individual and their interpersonal relationships, the Integrated Motivational-Volitional (IMV) model builds on this, taking a broader approach that accounts for biological, psychological and social factors, to explain the development of suicide behaviours (O'Connor and Kirtley, 2018). The IMV model models the transitions between the pre-motivational, motivational and volitional stages in the development of self-harm and suicidal behaviour, shown in Figure 2.

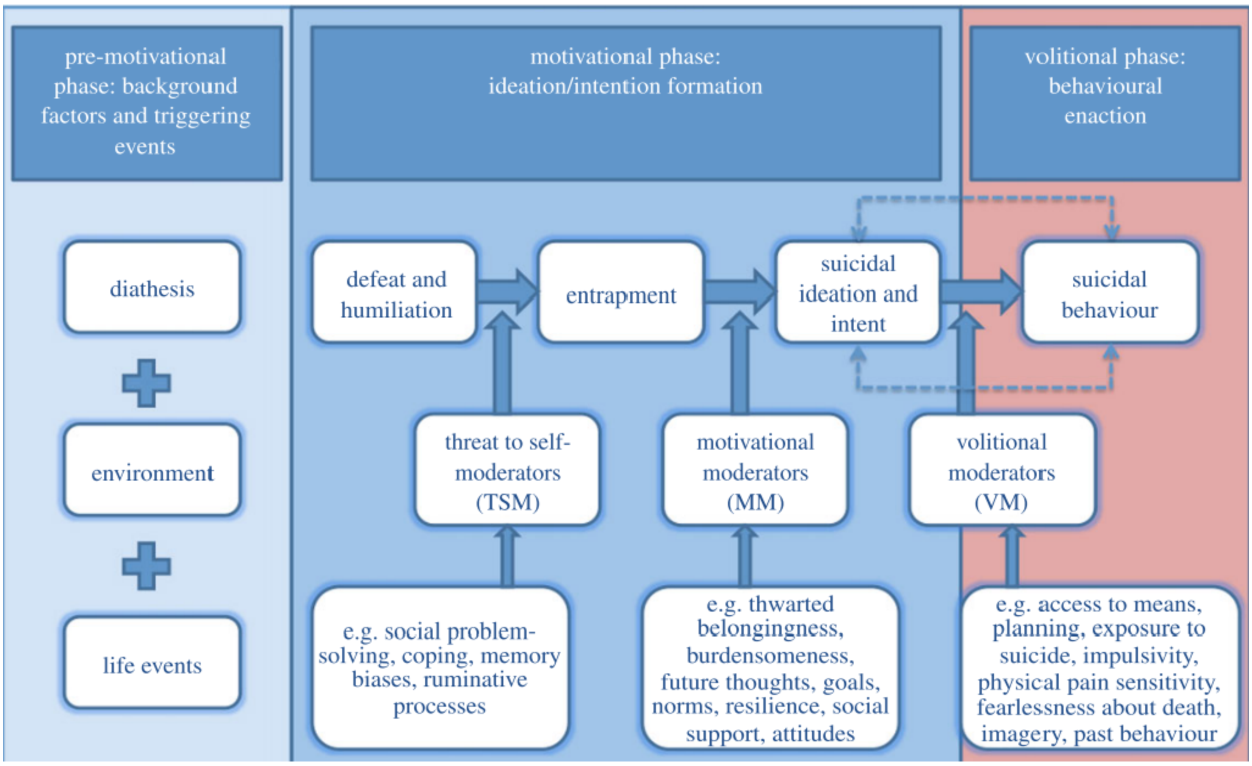

Figure 2 The Integrated Motivational-Volitional Model of Suicide Behaviours (O'Connor & Kirtley, 2018)

IMV incorporates an individual's background into the development of self-harm and suicide through the pre-motivational stage, which is comprised of biological and genetic diathesis, environmental factors (in my population of interest this could be living in a queerphobic home or experiencing adverse childhood experiences) and life events (for example, failing an important exam or experiencing abuse).

Whereas the IPTS positions thwarted belonging and perceived burdensomeness as the key constructs in the development of suicidal intent, the IMV model cites defeat, humiliation and entrapment as the proximal predictors of suicide. They argue that although many individuals feel defeat and humiliation, this will not necessarily lead to a feeling of entrapment. Instead, O'Connor and Kirtley (2018) propose that this development of feelings of entrapment depends on a range of 'threat-to-self' moderators such as social problem-solving skills, memory biases, and rumination. Consequently, they suggest that where a person is not able to overcome feelings of humiliation and defeat, they may indeed begin to feel trapped (either internally within their own minds, or externally within their circumstances) and suicide may be considered a possible way to change this.

However, despite this, the development of suicidal thoughts within the context of defeat, humiliation and entrapment, are not positioned as inevitable. Instead, IMV proposes that the emergence of suicidal thinking is dependent on the presence of motivational moderators, such as thwarted belonging and burdensomeness (as identified in Joiner's model), social support, and ability for future thinking and goal setting. The transition point thereafter between suicidal thoughts and attempting suicide is influenced by a group of factors called volitional moderators. One such volitional moderator is Joiner's acquired capability, which is the term used to describe an individual overcoming what is thought to be an evolutionary instinct of fearing suicide both because of a fear of death and a fear of pain. However, O'Connor and Kirtley (2018) build on this, also introducing social factors such as the exposure to the suicide of someone else, personal characteristics such as impulsivity, suicide planning and the ability to imagine one's own death, and pragmatic factors such as access to lethal means, each moderating the pathway between thinking about and attempting suicide.

The Interpersonal Theory of Suicide and the Integrated Motivational-Volitional model provide big-picture frameworks to help conceptualise multiple stages in the development of suicidal thoughts and attempts. Whilst IPTS focuses on interpersonal relationships, IMV allows more scope to examine the influence of social and structural factors influencing suicide, that, as discussed in Chapter One, have thus far appeared under-valued in suicidology (Button, 2016; Rimke, 2016; Hjelmeland and Knizek, 2017; Mills, 2018). However, given the breadth of terms such as defeat; humiliation; entrapment; thwarted belonging; perceived burdensomeness; and acquired capability for suicide; it is necessary to consider the specific ways in which they might manifest themselves amongst my population of interest. This is the case for youth and LGBT+ youth suicide studies; each of which I will look at in turn.

2.4 Understanding Youth Suicide

Due to the size of the literature in this area it is impossible to go into extensive depth (Evans, Hawton and Rodham, 2004; Cash and Bridge, 2009). However, I will give a brief overview of the key topics pertinent to my thesis. The transition from youth into adulthood can be a particularly challenging time, with high levels of change and choices to be made about the future (Thompson and Swartout, 2018). Changes in hormones mean that heightened emotions are to be expected during this time, although this is dependent on the social and developmental context (Blakemore, Burnett and Dahl, 2010; Casey, Duhoux and Cohen, 2010; Ahmed, Bittencourt-Hewitt and Sebastian, 2015). During this time, young people develop skills of affective control which enable them to effectively regulate their emotions into adulthood (Blakemore and Robbins, 2012; Schweizer, Gotlib and Blakemore, 2020). Conversely, young people who experience excessive negative ruminations, habitually supress emotions, and struggle to reappraise difficult emotional events, down-regulating their negative effects, are found to experience higher levels of mental health problems (Schweizer, Gotlib and Blakemore, 2020). As negative emotions are one of the most commonly examined factors in the exploration of pathways to suicide behaviours (Zhang *et al.*, 2017), and suicidal thoughts during adolescence are considered a significant predictor of mental illness in adulthood (Cash and Bridge, 2009), it appears a time of life that requires careful attention.

Youth and adult populations share some personal and social suicide risk factors, such as gender (Smalley, Scourfield and Greenland, 2005), ethnicity (Miller and Eckert, 2009; Cha *et al.*, 2018), lower socio-economic status (Miller and Eckert, 2009; Hawton, Saunders and O’Connor, 2012), pre-existing mental illness (Gould and Kramer, 2001; Cash and Bridge, 2009), and having previously attempted suicide (Gould and Kramer, 2001). Whilst the heterogeneity of experiences mean that suicide risk is hard to predict (Nock, 2008), it is proposed that there are factors specific to the youth population (see Table 1) (Hawton, Saunders and O’Connor, 2012; Bilsen, 2018). In a review paper, Hawton, Saunders and

O’Connor (2012) cite difficulties or concerns about educational achievement, family history of suicidal behaviour, parental separation, divorce, or death, and social contagion as factors that may be particularly pertinent to young people.

Table 1 Factors contributing to youth suicidal behaviours edited from Hawton, Saunders and O'Connor (2012).

Contributory factors for suicidal thoughts and attempts amongst young people	
• Sex or gender	• Mental health conditions
• Low socioeconomic status	• Ethnicity
• Defeat and humiliation	• Previous suicide attempt
• Restricted educational achievement	• Social isolation and thwarted belonging
• Entrapment	• Perceived burdensomeness
• Parental death	• Drug or alcohol misuse
• Adverse childhood experiences	• Negative emotions
• Bullying	• Family history of suicide behaviour
• Hopelessness	
• Social contagion	• Acquired capability for suicide

2.4.1 Abuse and Adverse Childhood Experiences

The traumatic effect of experiencing childhood abuse on suicidal thoughts and attempts has long been acknowledged. In a systematic review of the literature, Miller et al (2013) found longitudinal and cross-sectional studies in both community and clinical settings demonstrated that physical abuse, sexual abuse, emotional abuse, and neglect were all significantly associated with an increased risk of suicidal thoughts and suicide attempts (although evidence for emotional abuse and neglect was more limited). Additionally, they argued that sexual abuse seemed to have the largest detrimental effect, and this was particularly the case when emotional abuse was co-present. These results were echoed in a later systematic review by Serafini et al (2015) looking at the relationship between adverse life events and suicide behaviours. They found that whilst all forms of childhood abuse increased the likelihood of thinking about or attempting suicide, this was particularly the case for those who had experienced childhood sexual abuse, with a strong and significant effect observed between sexual abuse and suicide attempts. Both the IPTS and IMV models of suicide suggest that a decreased sensitivity to pain is a key factor in developing the capability or volition for suicide, with both also citing abuse as a way that a person might become more habituated, and thus less sensitive, to pain (Van Orden *et al.*, 2010; O'Connor and Kirtley, 2018). This may explain the mechanism through which young people with histories of sexual abuse become more likely to think about or attempt suicide.

Adverse Childhood Events (ACEs) are recognised as playing a significant role in predicting suicide behaviours (Dube *et al.*, 2001; Fuller-Thomson *et al.*, 2016; Merrick *et al.*, 2017). In particular, it has been noted that whilst individual ACEs will significantly impact suicide behaviours, there appears to be a dose-response, meaning that the more ACEs experienced, the more likely an individual is to experience suicidal thoughts or attempt suicide, and often the greater the likelihood in engaging in more lethal suicide behaviours (Dube *et al.*, 2001; Merrick *et al.*, 2017). It has also been argued that low-lethality of a young person's suicide attempt cannot be assumed to indicate a lack of intent to die, as young people often struggle to assess the lethality of methods (Bridge, Goldstein and Brent, 2006). The Scottish Government identify ten ACEs which increase the risk of long-term adversity: abuse (sexual, verbal, or physical); neglect (emotional or physical); parental separation; living in a household where an adult has spent time in prison; living with adults who have mental health problems; living in a household where there is domestic violence; and living with adults who have drug or alcohol problems. However, in addition to this, they recognise there may be other adverse experiences, outwith the specified ACEs, that have a detrimental effect on health risk behaviours and health outcomes, such as bereavement, bullying, and living in deprivation, (Scottish Government, 2018a).

Although not specific to young people, the long-term impact of experiencing ACEs on both physical and mental health (Kalmakis and Chandler, 2015), make them worth considering in a little depth. In a study of over 8,000 people investigating eight ACEs[13], Dube et al (2001) found that people who had experienced any single ACE were between 2 and 5 times more likely to attempt suicide than someone who had not, and their risk increased by 60% for each additional ACE experienced. Adults who had experienced seven or eight ACEs were 30 times more likely to have attempted suicide than those who had not (CI= 15.3-57.9; $p<0.002$), whilst a child or adolescent who had experienced seven or eight ACEs was 51 times more likely to have attempted suicide than those who had not (CI=17-151.4; $p<0.002$).

Whilst ACEs clearly have a hugely detrimental impact on young people's mental health, an implicit aim of this study is to investigate the ways in which they might affect LGBT+ young people specifically. There is some research to suggest that LGBT+ young people report higher rates of ACEs than their cisgender, heterosexual peers (Schneeberger et al., 2014; Blosnich and Andersen, 2015; Zou and Andersen, 2015; Clements-Nolle et al., 2018; Schnarrs et al., 2019). Although it is not clear why this is the case, one suggestion by Clements-Nolle et al (2018) has questioned whether this may be explained by a higher prevalence of gender non-conformity amongst LGBT+ adolescents, as gender non-conformity in childhood has also been found to be associated with higher instances of childhood abuse and neglect. Given the role of ACEs in increasing risk of suicidal thoughts and attempts amongst young people, a heightened incidence of ACEs amongst this population may provide some insight into the disproportionate burden of poor mental health and suicidal distress faced (Schneeberger et al., 2014; Blosnich and Andersen, 2015; Clements-Nolle et al., 2018; Schnarrs et al., 2019).

Although experiencing ACEs may be unrelated to young people's experiences of queerphobia in childhood and adolescence, it is also possible that the abuse reported is queerphobic, encompassing familial non-acceptance and negative reactions to a young person's LGBT+ identity (Schnarrs et al., 2019). It has been found that the support of close networks (such as friends, families and partners) can have a protective effect on mental health (Poteat et al., 2009, 2011; Ryan

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[13] Abuse (sexual, physical, emotional); witnessing domestic violence against their mother; household substance use; household mental illness; parental separation or divorce; and having a member of their household incarcerated

et al., 2010; Olson et al., 2015; Snapp et al., 2015; Luong, Rew and Banner, 2018), whilst rejection or non-acceptance can have a deleterious impact, particularly if parents are the perpetrators (Bouris et al., 2010; Skerrett et al., 2017). Due to the variability in measures used across research in this area (Ream, 2019), a meta-analysis of the evidence has not been possible. However, Bouris et al's (2010) narrative review suggests there is modest evidence that supportive parents could have protective roles, and negative parental reactions to coming out could be positively associated with suicide attempts.

Although it is difficult to gain insight into the lives of those who have died by suicide, one way of trying to do so is by using a psychological autopsy approach. Psychological autopsies involve interviewing those closest to an individual who has died by suicide to try and understand the factors influencing a death (Beskow, Runeson and Åsgård, 1990; Houston, Hawton and Shepperd, 2001). In one such study of ten LGBT youths who died by suicide in Australia, parental non-acceptance, and in particular paternal non-acceptance, was a dominant feature in the narratives about young people's suicidal behaviours (Skerrett et al., 2017). However, given the small scale of such psychological autopsies and the difficulties in using close networks to assess the deceased individual's mental state, findings must be treated with caution (Hjelmeland, 2016).

2.4.2 Bullying

Bullying is not generally included as an adverse childhood experience, although the Scottish Government acknowledges that it can have similar long-term detrimental effects (Scottish Government, 2018a). However, bullying is thought to have a negative impact on the wellbeing of both victims and perpetrators, which can increase the likelihood of a young person thinking about, attempting and dying by suicide (Hinduja and Patchin, 2010; Bauman, Toomey and Walker, 2013; Holt *et al.*, 2015; Rodway *et al.*, 2016; Shain, 2016). This is especially important within this research as LGBT+ young people are considered significantly more likely to experience bullying and peer victimisation than their cisgender, heterosexual peers, particularly whilst in education (Fedewa and Ahn, 2011; Toomey and Russell, 2016; Myers *et al.*, 2020).

In a systematic review of 165 studies, Moore et al (2017) analysed the consequences of bullying on its victims; one such consequence they included was impact on mental health, where they discussed the effects of being a victim of bullying on both suicidal ideations and suicide attempts. They found that young people who had sometimes been bullied were 1.53 times more likely to think about suicide than those who had not been bullied (CI:1.28-1.82; p>.01), whilst those who were frequently bullied were 2.59 times more likely to think about suicide (CI:2.06-3.25; p<.01). Reflecting this inter-group difference, those who had sometimes been bullied were 2.19 times more likely to have attempted suicide (CI:1.71-2.8; not significant at p<.48), and those who were frequently bullied were 3.77 times more likely to have reported a suicide attempt (CI:2.55-5.58; p<.01), suggesting a potential dose-response as is found with ACEs.

LGBT+ youths are consistently identified as at higher risk of experiencing peer victimisation and bullying within educational environments than their cisgender, heterosexual peers (Fedewa and Ahn, 2011; Toomey and Russell, 2016; Myers *et al.*, 2020). Meta-analyses, primarily from the US, of peer victimisation has suggested that trans young people (Myers *et al.*, 2020), young gay and bi men (Toomey and Russell, 2016), and sexual minority youths aged under 17 (Fedewa and Ahn, 2011) may be most strongly affected by peer victimisation, whilst those who are questioning their gender identity or sexual orientation report being less affected, perhaps due to being less likely to be 'out'[14] (Myers *et al.*, 2020). Due to the high rates of bullying found in this population (Fedewa and Ahn, 2011; Toomey and Russell, 2016; Myers *et al.*, 2020) and the established relationship between bullying and suicidal thoughts and attempts (Moore *et al.*, 2017), bullying and peer victimisation have been widely examined as contributory factors for suicidal thoughts and attempts in this population (Almeida *et al.*, 2009; LeVasseur, Kelvin and Grosskopf, 2013; Mustanski and Liu, 2013; Ybarra *et al.*, 2015; Hatchel, Merrin and Espelage, 2019).

Although some work suggests that LGBT+ youths who have been bullied are at an increased likelihood of thinking about and attempting suicide (Almeida *et al.*,

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[14] 'Out' is a colloquial term used to describe someone either coming to terms with their own LGBT+ identity (being 'out' to one's self) or having disclosed their LGBT+ identity to another person (being 'out' to others).

2009; LeVasseur, Kelvin and Grosskopf, 2013; Mustanski and Liu, 2013; Ybarra *et al.*, 2015), a meta-analysis from Hatchel, Polanin and Espelage's (2019) unsettles this. In their systematic review, they found a moderate effect size between generalised peer victimisation and suicide behaviours amongst LGBTQ youth, but a smaller effect size for what they termed 'bias-based victimisation' (aiming to capture victimisation that was queerphobically specific). The authors remarked that they were not sure how to make sense of this given existing research on the topic. They suggested that it was possible their findings were influenced by questions in the original research regarding bias-based victimisation being excessively abstract and broad. As a result, they may not have been the most suitable or appropriate questions for youths, and consequently may have failed to accurately capture respondents' experiences. There is perhaps therefore a need for more youth appropriate measures to be used in this area in order to develop a more nuanced and detailed understanding.

2.4.3 Mental health problems

A range of mental health problems, including mood disorders, personality disorders and psychosis, are consistently found to be significant predictors of suicidal thoughts and attempts across both youth and adult populations (Bridge, Goldstein and Brent, 2006; Muehlenkamp and Gutierrez, 2007; Miller and Eckert, 2009; Shain, 2016). Particular attention has been paid to the role of depression and self-harm as risk factors for suicidal thoughts and attempts. It is argued that the majority of young people who think about, attempt, and die by suicide will have had a mental illness (Miller and Eckert, 2009; Nock, Mattew *et al.*, 2013). Indeed, it has been estimated that up to 90% of adolescents who die by suicide in North America meet the diagnostic criteria for mental illness (Shain, 2016). A nationally-representative sample of youths in the US (10,148 adolescents aged 13–17) found that 89% of youths who had suicidal ideations and 96% of youths who had attempted suicide met the diagnostic criteria for at least one mental illness (Nock *et al.*, 2013). However, it is essential to note that many young people experiencing depression or self-harm will not become suicidal.

There are thought to be a range of affective factors influencing the development of suicidal thoughts and attempts such as hopelessness, worthlessness, low self-esteem, negative self-referential thinking, rumination, emotional suppression and neuroticism (Cha *et al.*, 2018). Although some research conceptualises an almost linear progression from mental illness to self-harm, followed by suicidal thoughts and ending in a suicide attempt, Joiner *et al.* have found that previous suicide attempts are the strongest and most direct predictor of future suicide attempts and that this relationship holds when an enormous raft of risk factors are taken into account (2005). Amongst the LGBT+ youth population, there are thought to be high rates of mental health problems, including depression (Marshal *et al.*, 2011), which may contribute to increased risk of suicidal thoughts and attempts.

2.5 Understanding LGBT+ Youth Suicide

Whether a central construct, or mentioned in passing, the impact of stigma, discrimination and harassment is a somewhat omnipresent explanation for the disproportionate burden of suicide amongst LGBT+ young people (McDermott and Roen, 2016; Bryan and Mayock, 2017; Wilson and Cariola, 2019). As discussed in Chapter One, the latter 20th and 21st centuries have seen rapid legal and social changes in the protections and provisions for LGBT+ people. As a result, it is hoped that over time, experiences of queerphobia will reduce, and thus there might be an improvement in the mental health of LGBT+ people (Savin-Williams, 1994; Irish *et al.*, 2018). However, at the time of writing, it did not appear that disparities in suicidal thoughts and attempts between LGBT+ and cisgender, heterosexual people were equalising (Mustanski and Espelage, 2020). Therefore, to date, queerphobia remains one of most widespread explanations for why LGBT+ young people are more likely than cisgender, heterosexual youths to think about and attempt suicide (McDermott and Roen, 2016). This has also been theorised using stigma theory (Goffman, 1963; Link and Phelan, 2014), and was specifically tailored for LGBT+ people by Meyer in the 1990s, termed ‘minority stress’ (Meyer, 1995); each of which I will briefly explore.

2.5.1 Stigma theory

> ‘We apply the term stigma when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold.’ (Link and Phelan 2001)

Since Erving Goffman's seminal 1963 work *Stigma: notes on the management of spoiled identity*, interest in stigma, the ways it is operationalised, and its effects, has rapidly grown. For Goffman, stigma was a process through which an individual or group of individuals was denied full social acceptance because of a particular characteristic or social identity. Although people have a huge number of personal characteristics and social identities, the majority of which are wholly unremarkable, some carry particular weight within the social hierarchy (Link and Phelan, 2001). Some people's stigmatised identities may be somewhat invisible, for example those with a mental health problem or a trans person who is living 'stealth'[15], and therefore an individual may choose whether, when, and how to disclose to others (Goffman, 1963). However, for others their stigmatised identity may be quickly identified by others: for example, a butch lesbian may not get a choice about coming out, her sexual orientation may be immediately assumed (Ahmed, 2006). Similarly, a person with visible scarring may be immediately identifiable as having had a history of self-harm or suicide (Sheehan, Dubke and Corrigan, 2017).

Whether through a process of recognition or disclosure, it is argued that once someone has been identified as a member of a stigmatised group, they may then be viewed by others in connection with negative stereotypes societally held about people who belong to that stigmatised group. This may then establish a sense of 'us' and 'them', and can result in the assessment of an individual as of less worth in the social hierarchy, in what has been termed 'status loss' (Link and Phelan, 2001). This process of discrimination can be enacted through direct individual acts, for example using queerphobic slurs or making statements about LGBT+ people that are explicitly negative. However, within 'civil spaces' it is far less likely that stigma will be direct (Goffman, 1963), as people are usually acutely aware that overtly discriminating can itself face social sanction (Link and Phelan, 2014). Instead, the discrimination can be more subtle.

Link and Phelan (2014) conceptualise two key ways that discrimination is enacted: structural discrimination and interactional discrimination. They propose structural discrimination as a process through which institutions can be

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[15] Stealth is a term used to describe a trans person who passes as cis and chooses not to come out within a particular context as trans (Holleb, 2019).

designed to cater for the dominant class of people and may, through their organisation, exclude people who do not ‘fit’. One such example in my population of interest is the exclusion of same-sex couples from the institution of marriage which persisted until relatively recently, or the exclusion of trans people from legal gender recognition (a process which is still on-going). Interactional discrimination, on the other hand, is a process through which a person from the dominant class interacts differently with someone who they are stigmatising. This is not always to treat them badly or awkwardly, but could also be to treat them exceptionally kindly without clear reason. The key is that the person from the dominant class signals to the other individual that they know they are *different*.

There are two key clarifications about stigma theory necessary before moving onto minority stress theory. Firstly, it must be acknowledged that anyone with any position in the social hierarchy can treat another badly. The crucial part of the bad treatment, giving these acts stigma-power, is their enactment within the context of an imbalanced power structure. It is the power of one group over another within a social hierarchy that means these stigmatising thoughts and actions have the power to negatively affect the material circumstances of others’ lives. The use of stigma-power is argued to benefit those at the top of the social hierarchy. It may allow them to exploit the labours of those within a stigmatised group; change the behaviours of those stigmatised to maintain the social order that benefits those more powerful; or sustain a socially sanctioned distance between those at the top of the social hierarchy and those lower down it (Phelan, Link and Dovidio, 2008; Link and Phelan, 2014).

Secondly, it has been queried whether the concepts of stigma and prejudice have been used in such similar ways across the research literature that they may have become somewhat redundant as individual concepts (Phelan, Link and Dovidio, 2008; Hatzenbuehler and Pachankis, 2016). This prompted Phelan, Link and Dovidio (2008) to explore whether they had now merged into a single construct. They concluded that although there was quite a lot of overlap in the way that these constructs were used in research, they were still to some extent distinct. The key differences noted were not necessarily in the concepts operationalised, but in their foci: prejudice research tended to focus on the perpetrators of prejudice whereas stigma research tended to focus on those that had experienced stigma (Phelan, Link and Dovidio, 2008; Stuber, Meyer and Link, 2008). Additionally, prejudice research often focussed on ethnicity whereas stigma research was more likely to focus on illness, disability, LGBT+ identity, and particular behaviours e.g. substance use.

From the inception of stigma research, the impact of homophobic stigma on gay people has been of interest (Goffman, 1963). Although it is hoped that over time queerphobic stigma will reduce (Savin-Williams, 1994; Irish *et al.*, 2018), at the time of writing, experiences of interpersonal stigma (with families, peers, and at school) are internationally cited as the primary explanation for the disproportionate burden of suicidal distress on LGBT+ youths (Mustanski and Espelage, 2020). In addition to this, as discussed in Chapter One, the UK has also stigmatised people with mental health problems, those who self-harm, and people who have a history of suicidal thoughts or attempts (Sheehan, Dubke and Corrigan, 2017; Oexle *et al.*, 2019; Robinson *et al.*, 2019). Consequently, it has been argued that LGBT+ young people may experience intersecting queerphobic and mental health stigma (McDermott, 2015; McDermott and Roen, 2016).

McDermott and Roen (2016) have argued that the potential intersection of mental health and queerphobic stigma amongst LGBT+ young people may be further compounded by societal narratives on ‘normal’ maturation and youth. They argue that the containment of emotions, gender conformity and heterosexuality can all be viewed as the product of a normative maturation process. By extension, they therefore suggest that a young LGBT+ person who experiences suicidal thoughts can be viewed, either by themselves or by others, as failing against these three normative standards. In response to this, they propose that LGBT+ young people can begin to feel shame not singularly as an internalised, individual psychological state, nor as entirely externalised as social judgement, but moreover interpersonally, in the interaction between the individual and society. In turn, it is suggested this may impact on how LGBT+ young people with lived experience of suicidal thoughts and attempts view themselves, are viewed by others, and how they feel able to interact with the world around them.

There are a range of explanations offered for how stigma may increase suicide risk (Hatzenbuehler, 2009). In research looking at the reinforcing nature of suicide stigma, it has been argued that people with lived experience of suicidal thoughts or attempts are stigmatised because of their experience of suicide and that in experiencing this stigma, people are at greater risk of experiencing social isolation and hopelessness (Carpiniello and Pinna, 2017; Sheehan *et al.*, 2020). Similarly, it has been suggested that as a result of experiencing queerphobic stigma, LGBT+ people can experience negative ruminations, hopelessness, social isolation and an increased likelihood of mental health conditions such as depression (Hatzenbuehler, 2009). These explanations appeal to established theories of the development of suicide behaviours (as discussed in section 2.3). However, McDermott and Roen (2016) were keen to resist medicalising views of suicide, instead viewing self-harm and suicide as embodied responses to society's positioning of LGBT+ youths as shamed subjects. The concept of suicide as a response to shame has also been drawn upon in Rob Cover's (2012) work. Cover argues that queer sadness has become one of the many stereotypes associated with LGBT+ youths, and that consequently sadness and suicide have, through repetition, been established as responses to queerphobic shame. However, despite this range of theories, very little work has been done to understand how LGBT+ young people with lived experience of suicide make sense of this themselves.

2.5.2 Minority stress theory

Minority stress theory (MST) builds upon stigma theory in a manner that is specific to the stigma and discrimination experienced by LGBT+ people (Hatzenbuehler and Pachankis, 2016). Although MST was not originally conceptualised to explain LGBT+ youth suicide, the appeal to stigma, discrimination and harassment has become a dominant explanation for the disproportionate burden of suicidal thoughts and attempts amongst LGBT+ young people (McDermott and Roen, 2016; Bryan and Mayock, 2017). MST was first theorised in the 1990s by Ilan Meyer to explain the relationship between discrimination and poor mental and physical health outcomes experienced by gay men (Meyer, 1995). However, over time the theory has expanded to incorporate the experiences of the broader LGBT+ community, although primarily within a North American context (Meyer, 2003; Kertzner *et al*, 2009; Schwartz and Meyer, 2010; Frost and Meyer, 2012; Calabrese *et al*., 2015).

Meyer argued that being an LGBT+ person living in a queerphobic society, adds additional, chronic stresses that are unique to being LGBT+ to the day-to-day stresses that everyone experiences, and that as a result LGBT+ people may experience worse health outcomes than cisgender, heterosexual people (Meyer, 1995, 2003, 2015). Meyer proposes that LGBT+ people experience four types of stressor, which range from distal (those which come from an external source) to proximal (those that are internalised) (Meyer, 2003), and can negatively impact LGBT+ people's mental health, physical health, or both (Meyer, 2003, 2010; Frost, Lehavot and Meyer, 2013).

They are hypothesised as follows:

1. Stress of experience: LGBT+ people experience stress through queerphobic experiences whether acute, such as queerphobic hate crimes, or chronic such as living in environments which are cisnormative and heteronormative.

2. Stress of expectation: the expectation or anticipation of queerphobia, leading LGBT+ people to be vigilant, to try to detect potential queerphobia and avoid instances thereof.

3. Stress of internalising: LGBT+ people may internalise negative social attitudes about LGBT+ people, which can influence self-perceptions and self-narratives.

4. Stress of concealment: LGBT+ people may feel pressure to conceal their LGBT+ identity when in particular social contexts for safety or acceptance.

Crucially, MST's conceptualisation of the four stresses recognises their impacts do not need to be a response to a direct experience of queerphobia, such as a hate crime. Instead, it takes a broader view of societal and structural, interpersonal, and intrapersonal factors. Meyer takes particular care to acknowledge that stress is not a consequence of perception alone, and that whilst interventions to reduce poor mental health may in-part aim to strengthen individual resilience, they must also more broadly address the societal prejudice at play.

Relatedly, although MST primarily focuses on the queerphobic stressors that an LGBT+ person may face, additionally Meyer discusses how LGBT+ people who experience a strong sense of community cohesiveness may be able to access what Meyer terms ‘minority coping’. Meyer uses this concept to articulate how through shared norms, values and experiences, an LGBT+ person may be able to access group-level resources for navigating and counteracting queerphobic stigma. However, it must be acknowledged that access to minority coping is unlikely to be evenly distributed across all LGBT+ people. It is well documented that for many, the notion of a welcoming and supportive ‘LGBT+ community’ is chimerical, and that is particularly the case for disabled, trans, bi, working class, and black people (Taylor, 2008; Browne and Lim, 2010; Fox and Ore, 2010; Cover, 2013; Formby, 2017). Therefore, whilst minority coping might provide group-level resources for some LGBT+ people to draw upon, for others, structural barriers (e.g. racism, classism, transphobia) may get in the way.

2.5.3 Cis-heteronormativity

Although overt experiences of queerphobia such as bullying, harassment and familial rejection have been explicitly discussed as contributory factors to LGBT+ youth suicide, more subtle signs of cisnormativity[16] and heteronormativity[17] may go unnoticed; particularly to those it does not affect (McDermott and Roen, 2016; Luong, Rew and Banner, 2018). In queer youth suicide studies the explicit focus on homophobia as overt hatred has been critiqued by Rob Cover (2013). Cover argues that although experiences of overt homophobic hatred have reduced in recent decades, there remains a pervasive heteronormative social

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[16] Cisnormativity describes the positioning of being cis as not only the ‘normal’, but also the desirable way for a person to be; this has also be referred to with the term cisgenderism (Bauer *et al.*, 2009; Ansara and Hegarty, 2012, 2014).

[17] Heteronormativity describes the positioning of being heterosexual not only as the ‘normal’ but also the desirable way for a person to be (Rich, 1980; Ahmed 2006).

order that is less frequently addressed, but that must be accounted for in efforts to understand queer youth suicide.

The pervasive heteronormative social order is subtle; it facilitates tolerance of queer sexualities and condemns overt acts of homophobic hatred, whilst still treating LGBT+ people as *different* or *other*, and maintaining heterosexuality as the desirable norm through a range of everyday actions, inactions and microaggressions. It is within these heteronormative conditions for living that Cover proposes queer youths come to understand their sense of selves both as individuals and as social actors, and in response to these conditions that shame for transgressing heteronormative expectations may begin to manifest. For Cover, and in later work, for McDermott and Roen (2016), shame in response to heteronormativity can shape both an individual’s relationship to their self and to others, and can for some feel like an almost inescapable emotion for which suicide may appear to present the only way out.

Whilst shameful and suicidal responses to heteronormativity are not ubiquitous, heteronormativity appears to be the pervasive and dominant social order in which LGBT+ people exist. In *Queer Phenomenology* Sara Ahmed proposes the process of coming out and living an ‘out’ queer life in a heteronormative society (in the UK) as a process of disorientation. Ahmed argues that one’s sexual orientation is not solely an orientation of desire, but also encapsulates how we are positioned and orientated within the world. Building on Adrienne Rich's (1980) work on compulsory heterosexuality, Ahmed argues that through constant, repeated exposure, heterosexuality becomes naturalised and expected. Within this context, living heterosexually is quite literally a life that goes with this expected flow: Ahmed reflects upon the ease with which she was able to live within these confines when inhabiting a heterosexual world in a heterosexual relationship. It was after also inhabiting the world in a lesbian relationship, that the ease with which she had occupied space previously became visible to her. In living queerly, Ahmed describes a process by which simply existing as a queer person in a heteronormative world, is a process of disrupting the expectations of others and correspondingly each disruption can be experienced as othering.

In my own understanding, this process is best explained through metaphor: if you are swimming in the sea and the tide is *with* you, you may not notice it silently helping you move forward or if you do it is with recognition that it is helping you to reach your destination. If, however, you are swimming *against* the tide its resistance is fully felt; it is unable to be ignored. By extension, it is important to understand this process of heteronormative othering not simply as related to moments of disclosure of one's sexual orientation, but also as an embodied experience of othering through both recognition as a queer person or misrecognition as a heterosexual person. In *Undoing Gender*, Judith Butler (2004) has argued that the gendered embodiment of LGBT people is so fundamental to personhood that it constitutes an essential part of recognition *as people*; the embodiment of LGBT identity is not simply a question of what we do, it is what we are and how we are human.

Complementing theories of heteronormativity, Bauer *et al* (2009) have argued that there are also potential serious negative consequences arising from the presumption that all people are cisgender and the accompanying erasure of trans people, termed cisnormativity. Relatedly, Ansara and Hegarty (2012) have proposed 'cisgenderism' as a term to recognise the institutions, structures and day-to-day practices that serve to reinforce gender norms and punish those that transgress them. They are explicit that this is not a phenomenon that solely affects trans people, as gender normativity and its accompanying social sanctions affect all people (cis or trans) considered gender non-conforming. Thus, they are reticent about constructing any theory that will further concretise a hard boundary between 'trans and gender variant' people and 'cisgender' people.

Taking these constructs, of heteronormativity and cisgenderism or cisnormativity together, I have previously argued that at times it is useful to consider them together under the label of cis-heteronormativity (Marzetti, 2018). To be clear however, this is absolutely not to diminish the utility of these concepts in their own right; it is instead to argue, drawing on the work of Butler (2004) and Ahmed (2006), that often the othering of LGBT+ people cannot be neatly assigned to the disclosure of LGBT+ identity, the display of queer desire, nor the embodiment of an LGBT+ person. Therefore I argue that at times it is not possible to disentangle cisnormativity from heteronormativity, and instead that these experiences of othering are often situated in the messy spaces in between gender and sexual orientation.

There has been limited engagement in the role of cisnormativity or heteronormativity in the study of LGBT+ youth suicide thus far (Cover, 2012; McDermott and Roen, 2016). Although it has been suggested that ‘feeling safe where one lives’ may play a role in the development of suicide risk (Rimes *et al.*, 2018), there has not yet been significant exploration of how or why individuals feel un/safe. This said, emerging research from the US regarding what is sometimes termed ‘community climate’ (Hatzenbuehler, 2011; Meyer *et al.*, 2019), has begun to attempt to visibilise signs of societal heteronormativity and their impact on LGB youth suicide. This research has used proxy measures to identify positive and negative environments for young LGBT+ people, including the proportion of married same-sex couples and registered Democrat Party voters in an area, as well as anti-discrimination policies. Whilst this research is in its infancy, studies have found that LGB young people living in locations which the researchers rated as ‘positive’, reported fewer suicidal thoughts and attempts than those living in those they rated negatively (Hatzenbuehler, 2011; Meyer *et al.*, 2019).

2.5.4 The ‘suicide consensus’

It is essential when trying to understand LGBT+ youth suicide that researchers look at multiple levels of influence: individual, interpersonal and structural (Poštuvan *et al.*, 2019), and do not overlook the social context of suicide behaviours (McDermott, 2015; Button, 2016; Rimke, 2016; Mills, 2018). As aforementioned, research focussing on LGBT+ youth suicide has been criticised for focussing on LGBT+ specific risk factors for suicide, without also examining the interactions between them and risk factors found to increase the likelihood of suicide behaviours in the general population (Savin-Williams and Ream, 2003; McDermott and Roen, 2016; Bryan and Mayock, 2017; Clements-Nolle *et al.*, 2018). Further criticism suggests that whilst there are two schools of research: those focussing on LGBT+ specific risk factors and those focussing on the prevalence of general population risk factors present in the LGBT+ population, they do not sufficiently interact with one another to give us a rounded explanation. Instead they leave us wondering how experiences of stigma and harassment ‘get under the skin’ and detrimentally impact a young person’s mental health (Hatzenbuehler, 2009).

It is argued that the disconnect between risk factors in the general population and LGBT+ specific risk factors may position LGBT+ people as particularly ‘at risk’ or ‘vulnerable’ and assume that there is something intrinsic to experiences of being LGBT+ that increases the risk of suicide. In turn it is suggested that this could somewhat normalise and routinise suicide amongst LGBT+ people (Savin-Williams and Ream, 2003; McDermott, 2015; McDermott and Roen, 2016; Bryan and Mayock, 2017). Bryan and Mayock (2017) termed this ‘the suicide consensus’, a phrase they used to describe willingness to view LGBT people as particularly vulnerable to suicide, without discussing critically why this might be. In doing so potentially perpetuating a direct link between LGBT+ identity and poor mental health. After publishing their research into the health and wellbeing of LGBT people in Ireland, they noticed that policy makers, charitable organisations, and the media picked up on and publicised their finding that LGBT people had higher rates of mental illness, poor mental wellbeing and, particularly, suicidal thoughts and attempts. Whilst this disparity was identified in their research, they felt that the apparent readiness to unquestioningly publicise their more negative findings demonstrated a readiness to accept LGBT+ people as more mentally unwell without fully understanding why this might be the case.

Additionally, it has been questioned whether this proposed readiness to accept LGBT+ people as being at higher risk of suicide has, in part, shaped LGBT+ people’s own thinking. In *Queer Youth Suicide, Culture and Identity: Unliveable Lives?*, Rob Cover (2012) suggests that he finds it difficult to imagine a queer life that has not in some way been touched by suicide. Cover proposes that through repeated exposure to queer suicide, both in close networks and through societal, media and fictional representations of LGBT+ people, suicide is positioned and subsequently reinforced as an endpoint for queer shame. The following key questions therefore arise from these criticisms. Firstly, whether a narrative which positions LGBT+ people as inevitably at risk of suicide contributes in some way to them being at that increased risk (Bryan and Mayock, 2017). Secondly, whether there are important factors missed when researchers fail to account both for LGBT+ specific and general population factors, and the interactions between them (Hatzenbuehler, 2009; Haas *et al*, 2011; McDermott and Roen, 2016; Bryan and Mayock, 2017). Finally, whether in focussing on risk, researchers miss opportunities to understand what keeps LGBT+ young people safe from suicide and what promotes recovery (Savin-Williams, 2001; Hatchel, Merrin and Espelage, 2019).

2.5.5 Empirical work to understand LGBT+ youth suicide in the UK

Research on LGBT+ youth suicide has primarily been rooted in psychology and has used quantitative methods to identify contributory and protective factors (McDermott and Roen, 2016). However, the reluctance of those researching suicide to approach the topic using a qualitative methodology is not limited to those researching LGBT+ youths (White et al., 2016). In a commentary on the methodologies used in suicide research, Hjelmeland and Knizek (2010, 2016) noted a focus on trying to explain suicidal thoughts and behaviours by testing associations between risk and protective factors, meaning the landscape of the discipline was dominated by quantitative research. They argue this has been at the expense of a more holistic understanding of the lived experiences of those who have thought about or attempted suicide, which could be achieved by using qualitative methodologies, and that now is the time to address the dearth of qualitative research in the discipline.

Although my doctoral research will take a solidly qualitative approach, existing research on the topic has predominantly used quantitative methods and therefore my discussion of the literature reflects this. Furthermore, established research on the topic has primarily been situated outside of the UK, and, as discussed in section 1.5.3, is particularly concentrated in North America. National variations in the protections and provisions for LGBT+ people, as well as the healthcare and support for people experiencing mental illness and suicidal distress, mean that it is likely that contributory and protective factors identified as influencing LGBT+ youth suicide are also likely to be, at least to some extent, specific to local context. As a result, it is difficult to estimate the extent to which the findings of international research help us to understand the experiences of LGBT+ young people living in the UK.

Fortunately, the last decade has seen a sharp increase in both quantitative and qualitative studies investigating LGBT+ youth suicide in the UK (Nodin *et al.*, 2015; McDermott, Hughes and Rawlings, 2016; Metro and University of Greenwich, 2016; Oginni *et al.*, 2018). Consequently, these studies have been able to address some of the criticisms highlighted in section 2.5.4. This research attempts to bring together both LGBT+ specific and general population factors influencing suicidal thoughts and attempts, beginning to consider the relationship between them. However, to date, the majority of research has focussed on understanding the suicide experiences of young LGBT+ people in England & Wales, with a paucity of research exploring the experiences of those in Scotland, which is a gap my research seeks to fulfil.

2.5.5.1 Quantitative Research on the suicide experiences of LGBT+ young people in the UK

The largest available data set on LGBT youth suicide comes from the Youth Chances project (Metro and University of Greenwich, 2016). In a secondary analysis of this data, Rimes et al (2018) extracted the data for 3,275 young lesbian, gay and bi (LGB) young people who responded to questions on suicide and self-harm, and analysed the relationship between self-harm and suicide and a range of LGB-specific[18] and general risk factors[19]. In the univariate analysis all risk factors tested were positively and significantly associated with previous suicide attempts, and the majority were positively and significantly associated with suicidal ideation (except having half or more of your friends being LGBT; students not speaking up against LGBT prejudice; and alcohol misuse) and self-reported future suicide risk (except alcohol misuse and students not speaking up against LGBT prejudice). After excluding familial responses to coming out due to

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[18] LGB-specific factors were: being bisexual; aged under 10 when they thought they were LGB; came out to someone before the age of 16; half or more of friends are LGB; doesn't feel accepted where they live; bad reaction from a parent to coming out; bad reaction from sibling to coming out; bad reaction from a friend to coming out; staff not speaking out against LGB prejudice; lessons referring to LGBT issues negatively; being the victim of anti-LGBT harassment; being the victim of anti-LGBT crime.

[19] Non-LGB specific factors were: female gender; having fewer than five friends to count on; help-seeking for anxiety or depression; abuse or violence; sexual abuse before the age of 16; alcohol misuse; weekly drug use; past suicide attempt.

the small sample available, as many were not yet out to their families, the risk factors that were significant at p<.0023 (significance set to adjust for multiple testing) were analysed in a multivariate model. The majority of general risk factors were significantly and positively associated with suicidal ideations, suicide attempts, and future risk of suicide: having fewer than five friends that participants could count on; having experienced violence or abuse; having experienced sexual abuse before the age of sixteen; and help-seeking for depression or anxiety. However, many of the LGB-specific risk factors failed to retain significance across the range of suicide behaviours in the multivariate model (being the victim of an LGB-motivated crime, negative school experiences, and not feeling accepted where the respondent lived each remained significantly associated with at least one suicide behaviour). This therefore provides the beginnings of a counter-narrative to research from outside of the UK, which has tended to focus on LGB-specific risk, at the expense of more general risk factors.

Although the Youth Chances study, and in particular Rimes et al (2018) analysis of it, provides the beginnings of greater insights into LGB youth suicide in the UK, as a cross-sectional study there are limitations. The Youth Chances dataset represents a snapshot of its respondents' lives at a specific socio-political and cultural moment (data was collected between May 2012 and April 2013), but cannot tell us how these experiences may affect participants over time. Furthermore, whilst negative mentions of LGBT issues in classrooms and anti-LGBT harassment were asked about, the researchers did not appear to include any specific questions on bullying which in previous research has been thought to be a factor particularly pertinent to this population (Almeida *et al.*, 2009; LeVasseur, Kelvin and Grosskopf, 2013; Mustanski and Liu, 2013; Ybarra *et al.*, 2015; Hatchel, Merrin and Espelage, 2019). It may have been presumed that the question on anti-LGBT harassment may have captured this. However, as discussed in section 2.4.2, Hatchel, Polanin and Espelage (2019) have argued that terms like 'victimisation' may be too vague or abstract to accurately capture such experiences amongst the youth population, and furthermore experiences of peer victimisation or bullying may not be LGBT+ specific.

Consonant with wider research on the prevalence of mental health problems amongst young people who think about and attempt suicide (Miller and Eckert, 2009; Nock *et al.*, 2013; Shain, 2016), Rimes *et al.* (2018) found that help-seeking for depression or anxiety appears to be associated with an increased risk of suicide; presumably due to the severity of depression or anxiety, rather than the help-seeking itself. Adding to this, in a secondary analysis of ALSPAC data (study described in full in Chapter One, section 1.5.3), Oginni et al (2018) found that amongst the 335 participants categorised as sexual minority, low reported self-esteem aged 17 and high reported depressive symptoms aged 18 were both independently associated with higher instances of self-harm and suicidal ideations at the age of 20. This perhaps suggests that whilst diagnosed mental health problems play a role in explaining suicide risk, so more broadly do symptoms of poor mental health, such as self-esteem, that have previously been assumed to be subsumed within diagnosed conditions such as depression.

2.5.5.2 Qualitative Research on the suicide experiences of LGBT+ young people in the UK

Qualitative research in this area has taken a more explorative approach to understanding lived experiences of suicidal distress, including factors identified as contributing to suicide risk and those perceived as promoting resilience and recovery. In an interview-based study of 17 LGBT adults in England who had attempted suicide in their youth, Rivers *et al.* (2018) proposed three contributors to suicidal distress. Firstly, they described participants navigating their first time coming out as particularly challenging, which could act as a pressure point for suicidal thoughts and attempts. Coming out in contexts where participants were repeatedly made aware of the unacceptability of LGBT people through cis-heteronormative and queerphobic microaggressions had resulted in some viewing suicide as the only available way to escape. Secondly, accompanying these LGBT-specific understandings of attempting suicide were more general mental health narratives. Participants were described as articulating understandings of their suicide attempts as a consequence of their mental illness, particularly where they had a specific mental health diagnosis. Finally, suicide attempts were understood in the context of grief and loss: whether through a bereavement or the breaking down of a relationship, which in turn could lead to feelings of isolation.

Although these three contributors could be understood in isolation from each other, Rivers *et al* (2018) suggest that they can also be understood as interconnected and mutually reinforcing. Underlying the three themes, participants articulated a range of ways in which they had been isolated in asymmetric relationships, felt unable to fit in with dominating social norms, and therefore had struggled to formulate a positive sense of self. Within this context, Rivers *et al* (2018) argued that finding ways to connect to LGBT communities and cultures in order to reduce feelings of isolation and begin to develop positive coping strategies and improved self-esteem was crucial to recovery.

Although clearly providing an important contribution to an under-researched area, a key limitation to Rivers *et al*'s (2018) study was its retrospective nature. As outlined in Chapter One, the twentieth and twenty-first centuries have seen rapid changes in social attitudes and legal rights for LGBT+ people in the UK, and therefore as some participants were reflecting upon suicide attempts that had happened decades earlier, their findings may not be fully applicable to today's young people. However, they did appear broadly consonant with the findings of other UK based LGBT+ youth suicide studies, in which participants reflected on more contemporary experiences (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; McDermott, 2015; McDermott and Roen, 2016; McDermott, Hughes and Rawlings, 2017, 2018), which I will now go on to discuss.

Scourfield, Roen and McDermott (2008) used focus groups and interviews to explore how young people think about suicide and self-harm. Within their sample 15 participants were gay/lesbian, 12 were bisexual, 2 were transgender, and 36 were heterosexual. An overview of the cultural context was provided, in which LGBT youths were perceived to experience both overt homophobia and normative pressures around gender presentation and sexual orientation from within their families and peer networks. It was within this context that suicide was understood by participants as 'genuine'; where experiences of homophobia or a lack of affirmation and support was viewed as a 'genuine' motivator for suicide. This was contrasted by participants with suicide attempts which were not perceived as genuine, due to being seen as 'incorrectly' motivated, for example a suicide attempt following the breakdown of, or difficulties within, a romantic relationship. This can be contrasted with Rivers *et al's* (2018) findings that the loss of interpersonal relationships was one of the central three catalysts cited by participants for suicide attempts in their adolescence. Suggesting a clear difference in what is *perceived* as a ‘correct’ or ‘genuine’ motivation for a suicide attempt and what is cited by those who have attempted suicide as a motivation.

In a second paper published from this study, McDermott, Roen and Scourfield (2008) specifically analysed the data from the 27 LGBT young people (14 of whom had lived experience of suicide or self-harm), excluding data from the 36 heterosexual participants. In this analysis, the researchers sought to explore whether young people made connections between their LGBT identity and what they termed ‘self-destructive behaviours’ (including self-harm and suicide attempts). Building on their previous analysis, they argue that LGBT youths experienced homophobia as a punishment for transgressing heteronormative expectations, and as a consequence could begin to feel shame. Some participants then positioned ‘self-destructive behaviours’ such as drug use, sexual risk-taking, self-harm and suicide as responses to homophobic shame they experienced (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008).

The researchers reported identifying two patterns within the narratives participants used to explain their experience of self-destructive coping mechanisms: firstly, that self-harm was a form of self-punishment for their LGBT+ identity and secondly that the homophobic reactions and harassment they experienced had ‘pushed’ them to self-harm (McDermott and Roen, 2016). Within both of these, homophobia appeared to be positioned as central: in the first instance blame was internalised and in the second instance it was externalised, suggesting that participants understood there to be a direct, almost causal relationship between homophobia and self-harm and suicide behaviours. In contrast, other participants actively and explicitly resisted shame. The researchers described how, in normalising homophobia, participants depersonalised these experiences, constructing homophobia as a normal part of gay life. In doing so, they were able to position themselves as mature, proud, resilient, and able to rise above homophobia. Some young people occupied this position by explicitly eschewing shame, appealing to a ‘born this way’ narrative, suggesting that if one was born LGBT it was natural and not something they could reasonably be expected to be ashamed of.

Whilst Scourfield, Roen and McDermott (2008) and McDermott, Roen and Scourfield (2008) begin to fill an important gap in understanding perceptions of the relationships between LGBT+ youths and suicidal distress, there are limitations to this study. The study’s sample included just 14 participants who had first-hand, lived experiences of what was termed by the researchers ‘self-destructive behaviours’. It was also unclear for the purposes of my own study, the specific understandings that were related to suicidal distress or how the findings related directly or indirectly to participants’ own experiences. This is however, brought into sharper focus in McDermott's (2015) later study focussing on the ways in which LGBT youth ask for help with self-harm and suicidal feelings online.

It was noted in McDermott, Roen and Scourfield (2008) work that the coping mechanisms described by participants, whether normalising and minimising homophobia experienced or by responding to homophobia in ‘self-destructive’ ways, were somewhat individualistic. Therefore, McDermott (2015) qualitatively analysed 49 text excerpts related to self-harm or suicidal feelings posted by LGBT people aged 13-25. The text excerpts were extracted from online blogs and forums to try and better understand help-seeking, with no interaction between the authors of the posts and researchers. McDermott’s analysis argues that whilst individuals were willing to anonymously share their emotions online, they explicitly discussed their inability to share them offline due to concerns that both queerphobic and mental health stigma would mean a disclosure could negatively impact their immediate circumstances and their futures.

Central to McDermott’s analysis was the notion of failure. She argues that due to queerphobic and mental health stigma, individuals had begun to conceptualise a sense of ‘failed self’, whereby they saw themselves as failing by normative standards by virtue of their LGBT identity. However, further to this, individuals also reflected upon times that they had expressed their emotional distress to people in their offline lives. They described how their distress had been made sense of as ‘normal’ teenage emotions, which was taken in turn to mean that help was not needed due to a perception that it would pass. McDermott argues therefore that in experiencing persisting emotional distress, some participants further understood themselves as having additionally failed by normative maturation standards. Consequently, the young people posting on the forums and blogs were understood not only to have learned not to ask for help, as they felt it would not be provided, but furthermore had come to understand their need for help as a failure in itself. This study answers some important questions left by earlier work, particularly related to the reported reliance on individualistic coping mechanisms. However, due to the study specifically sampling for LGBT youth who were asking for help and advice with self-harm and suicidal feelings online, there are clear limitations: namely that the study is not able to further our understanding of the help-seeking of young people who have not chosen to seek help online either because their offline help-seeking was working well, or because they felt unable to avail of online resources.

Understanding LGBT youth’s suicidal distress as failure was further explored in McDermott, Hughes and Rawlings (2017) and Hughes, Rawlings and McDermott (2018). These papers report on 29 interviews undertaken between 2014 and 2016 of LGBT young people aged 13-25 in England, who had lived experience of suicidal feelings or self-harm. This study shared the aims of McDermott, Roen and Scourfield’s (2008) study in which the researchers sought to question the ways in which sexual orientation and gender identity were related to LGBT youth’s self-harm and suicidal feelings. Through their analysis, they proposed five interconnecting factors contributing to participants’ self-harm and suicidal feelings: (i) homophobia, biphobia and transphobia; (ii) normative pressures related to participants’ sexual orientation or gender identity; (iii) the stresses related to managing sexual orientation, gender identity and differing levels of being ‘out’ across different areas of participants’ lives; (iv) difficulties discussing emotions; (v) and what were termed ‘other’ life crises, where these crises were not related to participants’ sexual orientation or gender identity (McDermott, Hughes and Rawlings, 2017).

Drawing on the same study, but aiming to explore the circumstances in which LGBT young people seek help for suicidal feelings and self-harm, McDermott, Hughes and Rawlings (2018) found that participants were reluctant to seek help before crisis point at which time they were no longer able to cope alone. Consonant with McDermott (2015), McDermott, Hughes and Rawlings (2018) found that participants reported being reluctant to seek help due to concerns that they would not be taken seriously because of both queerphobic and mental health stigma. They were also concerned that their help-seeking could be seen by others to demonstrate weakness or immaturity and therefore felt pressure to cope with their distress alone. Further to this, they found that some participants were concerned that their help-seeking efforts could be misinterpreted as attention seeking and therefore viewed negatively, whilst other participants expressed more generalised difficulties discussing their emotions.

Drawing this body of work together in *Queer Youth, Suicide and Self-Harm: Troubled Subjects, Troubling Norms,* McDermott and Roen (2016) propose that queer youth have to learn to navigate a range of neo-liberal norms that they transgress. In embodying queer genders and queer desires, they argue that queer youths are shamed by societal norms that validate and affirm cisgender, heterosexual bodies. In experiencing and expressing emotional distress for which help is required, they argue that queer youth transgress neo-liberal norms of self-governance and are shamed for being emotional subjects. As queer, embodied, emotional subjects therefore, McDermott and Roen (2016) argue that queer youths persist in having feelings and experiences that society expects them to ‘grow out of’ or ‘get over’ and are therefore socially shamed. In response to this, youths then feel mutually reinforcing senses of shame and isolation, from which they wish to distance themselves, and in this context suicide and self-harm can be viewed as one way of escaping.

2.5.5.3 International qualitative research on LGBT+ youth’s suicide experiences

Throughout this thesis thus far, I have argued that LGBT+ young people’s experiences of suicidal distress are likely to be significantly impacted by the community climate in which they live, and that research is particularly useful therefore when it is specific to the UK. As discussed at the start of section 2.5.5 suicide research has primarily been dominated by quantitative methods (Hjelmeland and Knizek, 2016), and this is also the case in LGBT+ youth suicide research (McDermott and Roen, 2016). Due to the very limited amount of peer-reviewed, qualitative research exploring LGBT+ young people's experiences of suicidal thoughts and attempts in the UK, with research published thus far focussing on England and Wales. To supplement this, I will briefly discuss the findings of some limited international qualitative research seeking to better understand LGBT+ youth suicide.

As argued in research from England and Wales, international research cited marginalisation, isolation and rejection, particularly where queerphobically motivated, as central to the development of suicidal distress (Wilson and Cariola, 2019). In a study of what life is like for gender and sexual minority youths at school in Canada, Peter, Taylor and Campbell (2016) analysed the qualitative comments from a mixed-methods survey of more than 3,700 Canadian high school students. They found that high school was created as a heteronormative environment, through everyday comments which either praised gender conformity or mixed-sex couples, or devalued LGBTQ people through homophobic or transphobic microaggressions, such as "that's so gay" to indicate that something was being negatively appraised. This was further reinforced where responsible adults did not intervene in situations where homophobic or transphobic microagressions were expressed or where there was a total absence of LGBTQ positive messaging to counteract the negativity expressed. Within this context LGBTQ youths experienced verbal, physical and sexual victimisation, as well as expressing more general concerns about their safety. Consequently, for some, suicide was constructed as a preferable option to enduring persistent bullying within the school environment.

In aiming to understand the school environment, this study spoke to both LGBTQ and cisgender, heterosexual students about what life was like for LGBTQ youths at high school. Whilst this is a strength of this study, when trying to understand the specific experiences pertaining to suicidal distress this may be a limitation. As discussed in section 2.5.4 the perception that LGBT+ youths experiencing queerphobia may almost automatically go on to feel suicidal has become a problematically accepted explanation of the disproportionate burden of suicidal distress experienced by LGBT+ young people. Therefore, whilst this may be an accurate representation of the experiences of the LGBTQ youths reported in

Peter, Taylor and Campbell (2016), this could be a further reproduction of accounts which position queerphobia as the central explanation for this disparity without sufficiently considering other potential contributors.

Focussing on participants with lived experience of depression or suicidal distress, Diamond *et al* (2011) interviewed 10 LGB youth in hospital in the USA: 10 of whom had reported clinically significant depressive symptoms; seven of whom had reported clinically significant suicidal symptoms. The data was analysed together, making it impossible to identify whether there were differences in the experience of youths who experienced solely depressive symptoms when compared to those who experienced depression and suicidal distress. This study focussed on factors identified by participants as impacting upon their psychological distress. They found that familial rejection of participants' sexual orientation, coupled with homophobic and biphobic victimisation from others outside of the family, could be compounded by broader negative family events (for example, a member of the family being incarcerated, poverty, or bereavement) leading to severe psychological distress. In particular, participants described a strong sense of hopelessness that was specifically related to situations in which their families had been unable to accept their sexual orientation.

Building on this, participants who reported having a supportive individual in their life, felt it provided a vital buffer against the psychological impact of other negative events (LGB-related or otherwise). This person could be a family member, friend, partner, or a supportive adult (e.g. sports coach or teacher). The researchers described participants undertaking significant emotional work both to come to terms with their own sexual orientations, but also to support their loved ones to come to terms with their sexuality. For some participants this was supported by a professional counsellor, however this required the counsellor to have knowledge of and sensitivity towards LGB issues, and where they hadn't this could cause further psychological distress. Whilst this study took into account both LGB specific and more general factors contributing to suicidal distress, it was limited by its small reach and lack of comment on potential differences between those who had and had not experienced suicidal distress.

In a somewhat unique qualitative study seeking to understand experiences of suicide amongst transgender youths, Hunt, Morrow and McGuire (2020) interviewed 66 transgender youths and sought to analyse them using a combination of Minority Stress Theory and the Interpersonal Theory of Suicide (both described earlier in the chapter). Their findings echoed those of Diamond *et al* (2011) but on a larger scale, finding that participants described a sense of thwarted belonging when they were rejected or isolated, predominantly because of their sexual orientation or gender identity. Correspondingly, a sense of resilience was fostered when participants experienced a sense of belonging or feelings of being loved by those in their lives. Furthermore, whilst participants expressed desire to be supported by mental health professionals, concerns about a lack of knowledge or acceptance of transgender people enacted a barrier to seeking professional help for suicidal distress. As this study specifically focussed on trans participants, the researchers were able to explore the relationship between gender dysphoria and suicidal distress. They described participants reporting using self-harm as a way to reconnect with their bodies at times where gender dysphoria had a disassociating effect. Ultimately however, suicide was conceptualised by some participants in this study as a tool for ending pain that they were experiencing, rather than being motivated by a desire to die. This therefore suggests that in order to prevent suicide, consideration perhaps needs to be given to how to make life more liveable for trans youths.

2.6 Youth suicide prevention and help-seeking

As a major public health concern, substantial effort has been put into interventions aiming to reduce suicide amongst young people. Suicide interventions can be thought of at three levels: universal interventions that are offered to all; selected interventions that are offered to those who share characteristics which have been found to be associated with increased risk of suicidal thoughts or actions; and indicated interventions which focus on providing interventions to those who have indicated need (Gvion and Apter, 2016; Robinson *et al.*, 2018). Interventions for young people are clustered in three main settings: educational, clinical and community-based (Gould and Kramer, 2001).

Educational settings are considered appropriate, particularly for universal interventions aiming to improve the knowledge, attitudes and skills of both young people and those that work with them (Robinson *et al.*, 2013). These interventions often focus on improving knowledge to help everyone better recognise signs that a young person may be thinking about suicide. They aim to dispel so-called ‘suicide myths’, encouraging more empathetic and accepting attitudes towards people experiencing suicidal distress (Gould and Kramer, 2001; Robinson *et al.*, 2013). They also aim to improve people’s confidence to intervene by encouraging them to talk to young people about their distress, signpost to specialist services, and, in recognition that adolescents often feel more comfortable talking to their peers, by encouraging peers, who are likely to be the first-line of support, to share disclosures with a trusted adult (Gould and Kramer, 2001). Such an approach relies on the premise that those adults will be able to provide effective intervention (White, 2016). Whilst these interventions are often widely used and considered broadly useful by those who teach them and those who participate in them, there is some concern raised about their long-term effectiveness (Kutcher, Wei and Behzadi, 2017; Robinson *et al.*, 2018). Many such schemes (such as Signs of Suicide or Applied Suicide Intervention Skills Training) are evaluated directly after delivery and it is unclear whether improvements reported to attitudes and practices persist over time (White, 2016; Kutcher, Wei and Behzadi, 2017).

There is not a well-established set of indicated interventions for young people who think about or attempt suicide (King, Arango and Ewell Foster, 2018), and evidence around effectiveness is limited (Calear *et al.*, 2016; Bailey *et al.*, 2018). There is some limited evidence that Dialectic Behavioural Therapy (DBT) and longer-term Cognitive Behavioural Therapy (CBT) can be helpful for adolescents who have previously thought about or attempted suicide (Gould and Kramer, 2001; Robinson, Hetrick and Martin, 2011; King, Arango and Ewell Foster, 2018). Whilst interventions delivered in schools give the greatest access to a large number of young people, many of whom otherwise might not have engaged with topics such as mental wellbeing and suicide awareness (Robinson *et al.*, 2013), they may not provide a space where those at the highest risk feel comfortable meaningfully engaging. Furthermore, young people at the highest risk of suicide may also be unwilling or unable to make use of clinical support (LeCloux *et al.*, 2017).

Due to the multiple, intersecting forms of stigma experienced by LGBT+ young people who experience suicidal distress (as discussed in section 2.5), there may be additional barriers to help-seeking experienced. As discussed in 2.5.5.2, in one study young people's awareness of stigma meant that they experienced difficulties expressing their emotions and were concerned that they might be viewed as attention, rather than help, seeking (McDermott, Hughes and Rawlings, 2018). As a result, participants expressed a desire to cope with their suicidal distress independently, understanding self-reliance as a marker of maturity (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; McDermott, 2015), until the point where this became unmanageable and they felt unable to cope (McDermott, Hughes and Rawlings, 2016).

Furthermore, some young people who had tried to communicate suicidal distress had been met with dismissive attitudes; with adults explaining distress away within the context of hormonal immaturity (McDermott and Roen, 2016). Consequently, as has been found broadly amongst young people (Gould and Kramer, 2001), young LGBTQ people were found to favour informal methods of support, for example through peers, online support, and LGBT youth groups (McDermott, Hughes and Rawlings, 2016). Given the massive expansion in young people's use of the internet, online interventions have been identified as potentially offering an opportunity for suicide prevention in the future (Rice *et al.*, 2016), particularly for LGBT+ young people who have reported difficulties accessing support due to stigma faced (McDermott and Roen, 2016). However, to date the majority of online interventions have screened out young people who have recently thought about or attempted suicide (Perry *et al.*, 2016; Bailey *et al.*, 2018, 2020), which may act as a prohibitive barrier in this population.

2.7 Summary

In this selective review of the research literature I have attempted to provide a broad overview of theoretical approaches to suicide and youth-specific contributory factors, alongside theoretical and empirical research specific to the

LGBT+ youth population; attempting to bring them into conversation with one another and identify gaps in understandings. To begin, I outlined two key theoretical approaches, the Interpersonal Theory of Suicide and the Integrated Motivational-Volitional model of suicide, which will be drawn upon throughout this thesis. I then moved onto discuss some central themes in youth suicide research, paying particular attention to the effects of adverse childhood experiences, bullying and mental health problems. I aimed to flag where there was evidence to suggest that LGBT+ youths might be at increased risk of each of these contributory factors and provide an account of why this might be the case.

In the second half of the chapter, I reviewed both theoretical and empirical literature seeking to understand the disproportionate burden of suicidal thoughts and attempts faced by LGBT+ young people. I began by outlining stigma and minority stress theories, and the ways in which although queerphobic hatred may have reduced over recent years, cis-heteronormative community climates appear to have persisted. As a result, this more subtle normative system maintains the othering and potential shaming of LGBT+ youths and stabilises cisgender, heterosexual norms as the desirable, socially sanctioned way of living.

I then moved onto problematise what has been described as an almost automated assumption of a relationship between queerphobic shame and suicide amongst LGBT+ young people. In discussing what has been termed ‘the suicide consensus’, I argued that researchers must apply criticality when considering the role of stigma and discrimination in LGBT+ youth suicide to avoid an almost re-pathologisation of LGBT+ youths. In particular emphasising the need to both consider LGBT+ specific and more general contributory factors when seeking to understand LGBT+ youth suicide. Finally, I briefly discussed youth suicide prevention, touching upon barriers to access and future opportunities.

To close this chapter, I want to draw attention again to the need for greater dialogue between disciplines and sub-disciplines which ran through this chapter. Although, in a limited way, the relationship between LGBT+ specific and more general factors influencing LGBT+ youth suicide is beginning to be explored within research on the experiences of LGBT+ youths in England & Wales, there is still a focus on the relationship between queerphobia and suicidal thoughts and attempts. Further to this, these contributory factors are often understood in individualising manners, dislocated from the broader cultural context in which they are embedded and experienced. Throughout this literature review and on-going through the thesis, I therefore aimed to facilitate dialogue between disciplines, and consider the embodied, emotional and cultural contexts influencing LGBT+ youth suicide. To honour this, I needed to design a methodology with sufficient space to facilitate this dialogue, which I will discuss in detail in the following chapter. Finally, drawing this chapter to an end, whilst existing research has solely focussed on the experiences of LGBT+ youth in England and Wales, there remains a gap in our knowledge about young LGBT+ people living in Scotland. Given the regional variations in policies and provisions for both LGBT+ people and suicide prevention outlined in Chapter One, this is a gap that this research sought to address.

Chapter 3 Methods and Methodologies

3.1 Introduction

Research design can be thought about in four distinct but interlinked parts: epistemology, theoretical perspective, methodology, and methods (Crotty, 1998). I open this chapter by detailing my constructionist epistemology, informed by feminist and critical perspectives, and my use of intersectional theory to construct my theoretical framework. Together these informed my methodology, how I planned and designed my research, and the methods I used to answer my research questions. Given the sensitivities of this study, throughout this chapter I will pay particular attention to its ethics and how I tried to keep both myself and my participants safe and well throughout the research process.

3.2 Epistemology

There are three main epistemological standpoints: objectivism, subjectivism, and constructivism (Crotty, 1998). Objectivism proposes that there are objects which exist in our world, including our social world, which inherently have meanings and properties. People then come to know these properties through a process of recognition, but the properties exist objective of us as knowers. For example, when I observe a red ball it is not simply that I perceive that ball to be red, instead it is that the ball has the property of redness that I am witnessing. Similarly, in the social world, it is not simply that one correctly perceives a person to be trustworthy, instead it is a social truth that a person is trustworthy, one comes to know their trustworthiness by recognising this objective fact about them. Subjectivism is diametrically opposed to this, and argues that our knowledge is constituted through our perceptions, that the truth-values of our perceptions are defined by our belief in them; subjectivism allows it to be true that someone is simultaneously trustworthy and untrustworthy dependent on the knower. Constructivism takes elements from both these positions and sees knowledge as constructed through an interaction between our perspective and the properties of the subject of our knowledge. I take a constructionist approach to knowledge: I believe that our knowledge is in part shaped by the properties of the social kinds interacted with and in part by our perceptions, which are shaped by our positions in the world and our individual life histories.

3.2.1 Theoretical perspective: background and critique

Our epistemology in part defines the theories that underpin our research. For those adhering to an objectivist epistemology, a positivist theoretical perspective may have more resonance. Positivism has its roots in the natural sciences, but when interest in the social sciences began to expand in the early 1900s, its principles were somewhat imported into the social (Denzin and Lincoln, 2003). Positivism seeks to observe and report on objective facts about the social world in very similar ways to how one discovers facts about the natural world (Godfrey-Smith, 2003), and to try to observe correlations between social phenomena (Giddens, 1974; Webber, 1974; Schrag *et al.*, 1992; Ryan, 2015). Owing to this belief in objectivism, positivism tries in the social sciences, much like the natural sciences, to avoid the contamination of data by the researchers. This means that it is desirable to suppress the social agency of researchers from their data, being careful not to share personal opinions, motivations, or goals with participants, to optimise their chance of collecting unbiased data. Ultimately, it is desirable using this theoretical perspective that should another researcher wish to replicate our research they should be able to pick up our research methods, apply them in the same manner, and generate the same results (Henn, Weinstein and Foard, 2006).

Positivism's commitment to objectivity is a central part of its claim to scientific rigour, but in the 1980s a range of critical scholars (including critical race scholars, feminist scholars, and critical theorists) began to challenge this assertion. They argued that it was simply not possible for a researcher to withhold themselves to the extent the positivism desired, due to the inherently social nature of the social sciences (Milman and Moss-Kantor, 1987; Smith, 1987; Stanley and Wise, 1993; Oakley, 2000; Denzin and Lincoln, 2003; Marinucci, 2016). These critical scholars argued that the subject matter, the research methods, and the ethical framework that had been prioritised in the social sciences were centred around the experiences of the most powerful (white, male, heterosexual, non-disabled, cisgender, upper-middle class interests), who often were the people who conducted it (Harding, 1987; Stanley and Wise, 1993;

Oakley, 1998; Narayan, 2004; Ackerly and True, 2010; Burgess-Proctor, 2015). They argued that this was particularly problematic as this highly homogenised perspective was presented as objective knowledge, constructed in a value-neutral manner, rather than a perspective constructed from a specific viewpoint. For those who viewed knowledge as constructed or subjective, this lack of reflectiveness on the researcher's position of relative privilege is a fatal flaw of positivist work (Milman and Moss-Kantor, 1987; Smith, 1987; Stanley and Wise, 1993; Ackerly and True, 2010).

In order to provide an alternative voice to the dominant order of social sciences, critical scholars had to offer alternative ways to organise and prioritise research (Denzin and Lincoln, 2003). A key priority of these scholars was to bring into focus the role of power both in the research created and in the research relationship itself, both of which they argued had previously been under-acknowledged. Firstly, they saw identifying and challenging the unequal and unfair distribution of power and resources in societies through research as key. There was an onus on researchers in these critical schools of thought to use their research to further social change, supporting oppressed or marginalised groups to have their voices heard (Stanley and Wise, 1993; Ackerly and True, 2010). Secondly, they no longer saw it as appropriate to unreflectively conduct research as if an outsider to the social world, and instead saw the social positioning of both researchers and participants as essential to understanding the research itself (Ackerly and True, 2010; Holbstein and Gubrium, 2011). They argued that it was a strength, and not a weakness, for researchers to acknowledge their role as an active agent within both the research process and the social world the research occurred within (Ackerly and True, 2010).

This acknowledgement of the researcher as socially constituted also helped to call into question the hierarchy between participants and researchers not simply as something to reflect upon, but also as a dynamic which needed directly addressing throughout the entire research process (Kvale, 2013). For example, it became increasingly important to consider possible benefits to research participants; constructing research that did not solely focus on fulfilling the needs of the researcher, but also providing space to share foci with participants' priorities (Riessman, 1987; Burgess-Proctor, 2015). There was increasing concern that the research process took more from research participants than they gained from their participation and that this imbalance was problematic, particularly given the privilege that researchers often have compared to their participants and the rewards, both financial and in terms of recognition that they receive (Ladner, 1987; Oakley, 1998). For some this has resulted in a feeling that researchers must move away from quantitative methods and towards qualitative methods in order to challenge hierarchical and exploitative dynamics in research and to enable us to be more responsive to participants' priorities (Oakley, 2000). However, this is not a sentiment I share. Browne (2010) has suggested that taking a queer approach to quantitative research, creates opportunities to question the limitations of options often offered to LGBT+ people in survey research and improve knowledge created. Building on this, I argue that neither qualitative nor quantitative research is inherently exploitative or non-exploitative, but that each can be designed to either emphasise or resist hierarchies, and to benefit from or resist exploitation.

Although schools of critical thought wished to challenge the dominant paradigm, they differed in their prioritisation of the challenges. For example, feminist scholars have tended to prioritise exploring the gendered relations that underlie social phenomena and challenge sexism in research, whilst critical race scholars have tended to focus on racialised elements and challenge the colonial nature of research. Although these critical approaches are not incompatible nor in competition with each other, their different foci mean they can provide critiques for one another. For example, feminist theorists have been criticized for prioritising the perspectives and issues of white women without critically examining how this might exclude women of colour, and for presenting this work as if representing all women's perspectives (Davis, 2011; Hill Collins and Bilge, 2016; Marinucci, 2016). Whilst all theoretical perspectives could share foci across positions of marginalisation or oppression, rather than bringing one single axis into sharp focus (hooks, 2000), in practice this has not been the case. In response to this, intersectional theory has offered an alternative perspective, refusing to choose a particular axis of oppression to focus on and instead using a framework that takes into account the interaction between them.

3.2.2 Intersectional theory

The term ‘intersectionality’ was coined by Kimberlé Crenshaw (1989), arising from observations made in employment law and from a long working practice in black women’s organisations (Hill Collins and Bilge, 2016). Crenshaw used three cases (DeGraffenreid v General Motors; Moore v Hughes Helicopter; and Payne v Travenol) to demonstrate that discrimination experienced by black women was dismissed because it was understood that white women and black men were not experiencing discrimination in these workplaces. The courts, taking an additive approach to understanding discrimination, therefore extrapolated that if black men and white women were not discriminated against in these workplaces, black women could not be either. Crenshaw used the term intersectionality to describe how these black women had a particular experience as *black women* that could not be reduced to the sum of its parts. It was not that they were having an additive experience, where they were experiencing racism and sexism, but more than that the interaction between racism and sexism gave them an experience unlike that of the racism experienced by black men and the sexism experienced by white women; it was its own unique experience.

Since Crenshaw’s coining of the term, intersectional theory has been used across many fields, providing an analytic framework that tries to understand the ways that multiple marginalisation can intersect in non-reducible ways (Yuval-Davis, 2006; Winker and Degele, 2011; Hill Collins and Bilge, 2016). Hill Collins and Bilge (2006) explain its utility thus,

> ‘intersectionality is a way of understanding and analysing the complexity in the world, in people, and in human experience’ (Hill Collins and Bilge, 2016, pp.25).

Taking an intersectional approach asks us to centre our research on understanding how multiple axes of oppression shape our experiences in inextricable ways (Yuval-Davis, 2006), in order to highlight needs for social transformation to further social justice (Rice, Harrison and Friedman, 2019). For example, intersectional research proposes that an individual’s experiences cannot be understand by examining their separate racialised, gendered, and classed experiences, and instead must look holistically at how the interaction of these marginalised positions has an effect.

3.2.3 From theory to practice

In my research, therefore, it was necessary to think about how to sensitively explore participants' experiences of multiple marginalisation, how to frame this research to be of use to those participating in the research, and how to be reflexive about my own experiences of power and privilege throughout the research process. Whilst my research questions centre on the disproportionate burden of suicidal thoughts and behaviours experienced by LGBT+ young people when compared to cisgender, heterosexual youths, (an experience of marginalisation in and of itself), I was keen that it did not treat LGBT+ young people as a homogenous group. Instead, I wanted to look at how, from recruitment to analysis, I could explicitly address the diversity of LGBT+ young people who experience suicidal thoughts or attempts and make this research useful across the diversity within this group.

3.3 Methodology

3.3.1 Developing Research Questions

I was drawn to this PhD project as a queer woman socialising in queer spaces, taking organisational responsibility in queer community groups, and volunteering as a youth work assistant for an LGBT charity. Occupying these positions has both given me my motivation for this project, and affected how I have conducted my research (Ackerly and True, 2010; Hill Collins and Bilge, 2016). Through my interactions and experiences, I noticed that the LGBT+ people around me both in my networks and in community spaces, and particularly young LGBT+ people, seemed to be experiencing what felt like high levels of mental ill health, self-harm, and suicidal thoughts and attempts. This lay observation led me to seek out academic work, and eventually this PhD project, in order to explore whether this was simply a phenomenon in my immediate circles or whether this was present in wider society and, if so, what could be done to help.

As I have noted in my literature review, I observed three gaps in research on the suicidal thoughts and attempts of young LGBT+ people. Firstly, although there is limited research on young LGBT+ people's suicidal thoughts and attempts, it is US focussed with very little research on experiences in the UK (Marshal et al., 2011; Miranda-Mendizábal et al., 2017; di Giacomo et al., 2018). Secondly the research that exists tends to focus on the experiences of LGB young people, with the experiences of trans young people often forgotten or ignored (IOM, 2011). Finally, although some research has tried to identify risk and protective factors particularly through quantitative research, in particular surveys, there is little work qualitatively exploring suicidal thoughts and behaviours from the perspectives of those young LGBT+ people who experience them (McDermott and Roen, 2016). This is particularly the case in Scotland.

My research aimed to begin addressing the three gaps in research identified through my literature review. Whilst there is a need for larger scale studies to identify risk and protective factors affecting the prevalence of suicidal thoughts and attempts amongst LGBT+ young people in the UK, and particularly in Scotland where there has been very little academic research in this area. However, I argue that before engaging in more quantitative work, it is worth pausing to try and gain a more nuanced and holistic understanding of LGBT+ young people who have experiences of suicidal thoughts and attempts in Scotland through qualitative research. Gathering these data may help us to better understand the complexities of experiencing suicidal distress, which could help to inform future large-scale quantitative research, interventions, and prevention work (Pope and Mays, 1995; Silverman, 2017). It may also help us to explore previously unconsidered factors and avoid unquestioningly focussing on the association between stigma, discrimination, and harassment, and suicidal thoughts and attempts; an association which, when accepted without sufficient interrogation, has been argued to be unnuanced at best (Cover, 2013; Bryan and Mayock, 2017) and ‘dangerous’ at worst (McDermott and Roen, 2016).

3.3.2 Negotiating levels of participation

From the outset of this PhD project I was committed to producing research that centred participants’ expertise in their own experiences and the priorities that developed from these. I was keen therefore to explore the extent to which participants in my study could and should be involved in designing and conducting research. Firstly, I considered highly participatory designs such as participatory action research (PAR) or community-based participatory research (CBPR). My understanding of these participatory approaches is that they involve centring community members (which in my study was LGBT+ young people who had experience of suicidal thoughts and attempts) from the initial design of the research until its completion: deciding priorities, formulating research questions, selecting methods, conducting research, analysing data, and writing it up. This design conceptualises research as by and for the community being researched and has a clear goal of political change (Wallerstein and Duran, 2006; Cahill, 2007; Gillard *et al.*, 2012; Rose, 2018).

Whilst I believe that using a participatory method to investigate this research topic could have had potential to provide evidence to improve practices and provisions and lobby for change, there were some key irreconcilable challenges. Firstly, I propose that in this specific project it would be disingenuous to take this approach. The foundations of intersectional feminist research rests on transparency about positionality and what as researchers, we stand to gain. Whilst this project aims to improve understandings of LGBT+ young people's suicidal thoughts and attempts in Scotland; it is a PhD project with all of the associated limitations. The academic endeavour of a PhD means that I have responsibility for this research, I am financially reimbursed for my labour and, ultimately, I take credit for the contribution made. For me there was a fundamental clash between participatory methods' key principle of centring participants' expertise, conducting research by and for the community at the heart of the study, and the nature of a PhD. I would have been the only member of the research team who would be paid a full-time salary and would be awarded a PhD and the associated credit at the end, yet the project would have involved a large investment of labour from the co-investigators. Therefore, I felt I would benefit in a starkly unequal manner from a participatory design, reinforcing exactly the kinds of researcher-participant hierarchies that these methodologies seek to disrupt.

Secondly, suicide can be a highly sensitive topic and as a researcher I am aware that I have a duty to minimise harm, keep participants safe, uphold confidentiality, and maintain participants' anonymity. Planning meetings for co-design are inherently collaborative (Cahill, 2007). Therefore, given the topic area and the small community this project focuses on, I was concerned that this type of collaborative working could act as a prohibitive barrier to participation at multiple levels; could negatively impact on the sample; and that I as a novice researcher would not have the skills to successfully and sensitively manage this. Co-researchers would have needed to be very comfortable discussing both their LGBT+ experiences and their experiences of suicide with others to participate in collaborative, co-design meetings, meaning that the research would have been designed by a specific subset of the population of interest. Furthermore, I was concerned that a larger team of co-researchers taking an active role in conducting research with participants or analysing data, might have acted a barrier to participants coming forwards. In a small community, it is possible that co-researchers and participants might share social ties and thus interactions around this research could have on-going implications for their social worlds. Instead therefore, I chose to work consultatively with organisations connected to LGBT+ young people, gaining advice about the knowledge that would be useful for their organisation and on the appropriateness of the research methods.

3.4 Methods

3.4.1 Early engagement: Third Sector organisations and community groups.

When reflecting upon some difficulties she had experienced around recruitment for a qualitative project on young people's experiences of self-harm, Chandler (2018) considered that earlier and more sustained engagement with youth work organisations might have helped bolster recruitment. Heeding this as a warning, I was very keen to ensure that I engaged early with organisations who would be able to give me feedback on the usefulness of my work, and who might 'gate keep' access to my target population. In order to select organisations to contact for early engagement, I searched for those that provide services for LGBT+ young people in Scotland and found the following: LGBT Youth Scotland, the Proud Trust, LGBT Health and Wellbeing, Aberdeen City Council, and Waverley Care, each of whom have a role in providing youth groups and/or one to one support for LGBT+ young people. In addition, I also searched for organisations doing research and lobbying for change in this area and found the Equality Network and Scottish Trans, Time for Inclusive Education, Stonewall, and YWCA: the Young Women's Movement Scotland who had a very active trans rights voice during the Gender Recognition Act (GRA) reform that was happening at the time the research was undertaken. Given the age group I aimed to engage with, I also identified the National Union of Students Scotland's LGBT and Trans liberation campaigns who do not exclusively engage with young people, but who have a large proportion of their membership that are indeed young.

I emailed organisations to explain my project and ask to meet with key individuals (for example youth work directors, mental health leads, or research leads). The primary aim of the meetings was to introduce the project and build relationships. However, I also wanted to discuss my research questions, my methods, and my recruitment, and better understand the services they provide. I knew before sending the emails that these organisations probably receive a lot of similar requests and therefore might be reluctant to meet or work with me (Vincent, 2018). To try and overcome this, I offered to share potential outputs they might find useful from the project or workshops developed from findings with their staff. For some organisations, participation was an insurmountable barrier, either refusing to meet with me because of a lack of capacity to support research or simply by ignoring my emails. However, three key organisations agreed to meet me, and were very helpful in providing feedback on my research plans, whilst some others took a more minimal role, sharing recruitment materials with their members or services users. I also explicitly asked the organisations I interacted with whether there were any particular groups they felt were under-engaged with their organisations or that they were trying to reach out to, to allow me to sufficiently plan for gaps.

3.4.2 Considering the selection of research methods

3.4.2.1 Considering diary-based research methods

In my PhD project proposal, I discussed using an interactive online diary preceded and followed up by individual interviews. The aims of enacting these methods were to give participants the opportunity to discuss their mental health and in particular to help record how day-to-day interactions influenced participants' mental health in a live or almost live setting (Almeida, 2005), and to offer participants a variety of mediums through which to express themselves (using written, video, audio, or photographic entry methods). The diary was proposed to be interactive, where participants could expect me to view their diaries at regular, agreed intervals over a six-week period, and comment on posts; and then would be discussed in the final interviews. However, as the focus of my project shifted from a more generalised interest in mental health and wellbeing, to concentrate specifically on suicidal thoughts and attempts, it became clear that this was not an appropriate method. I was interested in participants' reflections on times at which they had felt suicidal or attempted suicide, however for the purposes of maintaining participants' safety, I did not want to include people who were currently suicidal. This therefore both removed the value of collecting live data, as all reflections were designed to be retrospective.

3.4.2.2 Considering focus groups

After deciding against using diaries, I considered focus groups. I was conscious that individual interviews could emphasise power imbalances between participants and researchers, and that focus groups can help redress this, providing participants strength in numbers (Wilkinson, 1998). However, on reflection I was concerned about the potential negative consequences of using focus groups. Firstly, participants talking about suicidal thoughts, attempts, or deaths by suicide in their immediate circles could be distressing or triggering either for the participant disclosing the experience, or for other participants hearing it. In a focus group setting I was nervous that, given my inexperience as a researcher, it might be difficult to effectively manage the complexity of the situation. Secondly, this might mean that young people who wished to talk about more indirect experiences of suicide, for example losing someone to suicide or supporting someone with experience of suicidal thoughts or attempts, felt unable to do so. In a focus group setting, they might feel the need to censure themselves to maintain discretion or might accidentally disclose details of others' experiences without their consent. Thirdly, there would also be the problem faced in many focus group settings, that some people would simply not feel comfortable sharing their personal experiences in the presence of others (Barbour, 2008).

3.4.2.3 Considering research interviews

On the basis of these reflections, I decided that interviews would be the most suitable method of data collection for this project, offering the privacy of an individual interaction and the flexibility to allow participants to raise their own priorities without the complication of group dynamics. However, my concerns around the impact of personal relations, power and privilege still stood and required addressing (Mishler, 1991; Oakley, 1992, 1998; Wilkinson, 1998; Kvale, 2013). Interviews can be conceptualised as a type of pseudo-conversation where narratives are built around the topics covered and questions asked, but also around the non-verbal communication signifying rapport between the researcher and interviewee, the context of the conversation and the embodiment of the individuals involved (Oakley, 1992; Scheurich, 1995). However, they can also be steeped in meanings related to participants' own histories and experiences of interviews, such as job or educational interviews, where the dynamics of the situation is highly hierarchical (Mishler, 1991; Kvale, 2013). Taking into account that interviews could be viewed as hierarchical because of these previous experiences, and that this might be compounded by the social relations occupied by me and my participants (Duncan *et al.*, 2009), and the discussion of sensitive topics (Kumar and Cavallaro, 2018), I was keen to plan ways to minimise this.

3.4.3 Considering the inclusion of under 16s

One of the key decisions in my research was whether to include people aged under 16. There is a general ethical expectation that when people aged under 16 participate in research, informed consent will be obtained from a parent or carer in addition to the young person (Coyne, 2010; Detamore, 2010). This was complicated in my population on two fronts: asking for proxy consent would have necessitated that participants were 'out' or came out to their parents or carers both with regard to their LGBT+ identity and their experiences of suicide. In sexual health research there appeared to be an established precedent of allowing young people to participate in research without requiring parental consent. Indeed, it was seen as young people's right to participate in research which served to reduce health inequalities that they specifically faced and inform improvements to services (Mustanski and Fisher, 2016; Flores *et al.*, 2018; Smith and Schwartz, 2019). However, within youth suicide research, perhaps due to safeguarding concerns (Smith and Schwartz, 2019), for example, concerns that asking about suicide may indeed increase risk of suicidal distress (Blades *et al.*, 2018; Polihronis *et al.*, 2020), there did not appear to be an equivalent established practice.

Although it was imperative to ensure that young people were sufficiently safeguarded in order to minimise the risk of harm to them through participation in my research, I had some reservations. Whilst involving parents or carers in the consent process would mean that they were aware of young people's participation and could proactively initiate conversations about young people's reactions to the research and watch out for warning signs for distress (Mishna, Antle and Regehr, 2004; Duncan et al., 2009), I was also passionate about ensuring that I respected young people's autonomy (Flicker and Guta, 2008). I was concerned that a requirement for parental or carer consent could act as a prohibitive barrier to the involvement of young people who lacked supportive parents or carers (Grossman and D'Augelli, 2007), and was reluctant to facilitate further exclusion of young people who were already likely to face specific challenges resulting from this lack of support.

I was also acutely aware that research frequently overlooks the voices of people aged under 16, meaning that knowledge of their experiences is very limited. Furthermore, it has been argued that early adolescence is a crucial time in the development on mental ill health (Irish et al., 2018) and it has been hypothesised that there may be a link between coming out and suicide attempts (Hegna and Wichstrøm, 2007). Therefore, adolescents aged under 16 could be a particularly important group to understand for suicide prevention (Gould and Kramer, 2001; Russell and Toomey, 2012). Instead, researchers often operate under the implicit assumption that the experiences of people aged over 16 can simply be applied to under 16s; an assumption that remains untested (Gvion and Apter, 2016). As an inexperienced researcher however, it was not possible for me to carry out research without obtaining proxy consent, and for me this provided another dilemma. I could choose either to exclude all young people aged under 16, only working with those who could give consent for their own participation, leaving research with people aged under 16 for those researchers with more experience. Alternatively, I could include young people aged 13-15 who were able to obtain proxy consent, in addition to young people aged 16-24 who could consent for themselves; excluding only those aged under 16 who lacked supportive carers. The second option for me ran the risk of constructing a skewed representation of the experiences of young LGBT+ people who experienced suicidal thoughts and attempts, and further excluding those who lacked supportive carers, and as a result, I decided only to include those aged 16-24.

3.5 Undertaking the research

3.5.1 Recruitment

Prior to opening recruitment, I was aware of potential challenges. Firstly, because it was anticipated that it would be difficult to find people who fulfilled the study's criteria, and secondly, because they simply might not want to talk to a stranger about what could be personal and difficult experiences. To try and mitigate these challenges, I created a detailed plan for recruitment communications, using a combination of digital and print materials, and identified a range of recruitment sites: LGBT and young people's organisations; LGBT+ events and spaces; and social media. I worked with the MRC/CSO Social and Public Health Sciences' Unit (SPHSU) Digital Communications Officer to design a coherent visual for the project. Together, we came up with three designs that I posted on my personal Twitter and Instagram and sent to professionals from the organisations I had engaged with, asking for feedback both on how to improve the images and on individual's preferred single image. I then selected the most popular image for use across my digital and print recruitment materials to create a consistent brand, and drafted social media posts, which I tested on demo Twitter and Instagram accounts for presentation across different platforms and devices (Android and Apple, as well as across laptop, tablets, and smart phones). Some examples of these can be found in Appendix 1.

I chose to open my recruitment during Mental Health Awareness Week (May 13th, 2019), to engage at a time where people were already discussing mental health and wellbeing, and where individuals and organisations might feel more comfortable posting and sharing content about suicide. I planned a variety of different social media engagements, beginning with a tweet from my personal Twitter. Following this, I did a 'take-over'[20] of YWCA: Young Women Scot's Instagram, posting a story about my day as a PhD student, including the purpose of my research and advertising recruitment (this was viewed 398 times). I also posted three blog posts advertising the research's recruitment (Marzetti, 2019b, 2019a, 2019c). The aim of these activities was to ensure that there was a sustained period of engagement early in the recruitment to ensure visibility with different audiences and stakeholders. In addition to this, over the period of recruitment I had stalls at Pride events; distributed both digital and print recruitment materials through individual and organisational events and accounts; further to this young LGBT+ people proactively took resources I had created and distributed them through their own networks.

Throughout the recruitment period I wanted to be mindful of the diversity included in my sample, whilst recognising in a small-scale, qualitative project it is simply not possible for the sample to be representative of the LGBT+ population as a whole. In order to ensure that I had a mechanism by which to record this diversity, identify any potential gaps, and consider the axes along which an intersectional lens could be usefully applied, I asked participants to fill out a demographic monitoring form (a copy of which can be found in Appendix 2). This recorded a variety of participant characteristics: gender identity; sexual orientation; trans identity or history; ethnicity; disability; religion; experience of homelessness; experience of being looked after; current occupation and future goals; post-code (parental and personal); and parental or carer occupation. At around interview 16, I noticed there were some gaps in my sample: cis gay and bisexual men, trans women, and Black, Asian and Minority Ethnic people. As a result, I updated my recruitment materials to explicitly state that I wanted to recruit from these groups (please see Appendix 3), and re-contacted organisations that specifically worked with these groups to try and address this.

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[20] A 'take-over' here refers to being given the password to the organisation's Instagram account and posting for 24 hours as the organisation, whilst making it clear content is from a guest poster.

Although these groups remained under-represented in the sample, this proactive stance meant that I was able to redress this in part.

3.5.2 Initial contact with participants

Forty-four prospective participants contacted me over the six-month recruitment period by email, Twitter, or text message. Once initial contact was made, I provided detailed information about the project, explaining what participation involved, and suggesting that myself and the participant should speak briefly either on the phone or online (e.g. via Skype) for five-ten minutes to allow them to ask any questions they might have and for me to briefly go through the requirements of the study. Thirty-one prospective participants spoke to me via an audio or video call.

This initial conversation served three purposes for the study. Firstly, it allowed me to check that participants fulfilled the study's criteria: that they (i) were LGBT+; (ii) were aged 16-24; (iii) lived in Scotland; (iv) and had personal experience of either suicidal thoughts or a suicide attempt. Although the criteria were clear on all the study's digital and print materials, one participant I spoke to on the phone hesitated when I asked for her age. Although she was aware that you had to be 16 to participate, she was only 15, although almost 16. After discussing it with the participant, it turned out her birthday was within the recruitment period, and so we scheduled the interview for a couple of months later, after her 16th birthday.

Secondly, the call allowed the participant and I to begin to build rapport (Fontana and Fey, 2003). It gave them an opportunity to ask me any questions that they had about me as a researcher, with some participants choosing to ask about my connection to the LGBT+ community or about my motivation to undertake this study. I had anticipated that they might have questions about the interviews, however the only questions tended to relate to the practicalities of participation such as possible timings and locations of interviews, or about the parameters of confidentiality. Many participants were keen to begin telling me their story over the phone, almost feeling like they were ready to start the interview immediately. However, I was very clear to emphasise that I did not ask anyone to sign up for an interview during this initial conversation. I was conscious of how difficult it can be to decide not to take part in research, particularly in qualitative research (Mishna, Antle and Regehr, 2004; Duncan *et al.*, 2009). In order therefore, to remove the pressure of a live setting, give participants a chance to reflect upon the requirements of participating in the project, and to make it as easy as possible to refuse participation, I ended all initial conversations by asking participants whether they would like me to send them more detailed information about the study. Everyone I spoke to on the phone said that they would like more information and were emailed the participant information sheet (available in Appendix 4); I then emailed a week or so later to ask them if they would like to go ahead with the interview and 24 did so.

The phone call also gave me an opportunity to get a ‘feel’ for the participants. I met participants alone and often at a location and time of their choosing (sometimes outside of office hours, in the evenings or weekends), so I felt it was important for me to get an impression of them from a phone call to help me feel safe. It also gave me an opportunity to discuss young people’s access to support, and to explore how they might use this if they found their participation in an interview distressing. Finally, it allowed me to ask if there would be anything that I could put in place to make it more comfortable to participate, for example one participant asked if it would be possible to have print resources available in a large font format, which I provided.

Although this initial contact was designed to make both participants and I more comfortable, for one potential participant who contacted me by email, the phone call did the opposite. Unfortunately, she felt that as a trans woman who experienced significant gender dysphoria about her voice, participation in a phone call (which was required in order to go onto interview), would have been excessively distressing for her, and due to this requirement she decided that she could not go on with the interview. I therefore acknowledge that whilst this stage in the recruitment process was meant to safeguard both participants and myself, it was at least for her, although potentially for others, a prohibitive barrier to participation.

3.5.3 Overview of the sample

Twenty-four interviews were conducted. All participants had thought about suicide, and ten had attempted suicide, all of whom had done so more than once. Participants were aged between 16 and 24 years (with an average age of 19.6) and came from all across Scotland and all deciles of the Scottish Index of Multiple Deprivation[21], although as expected there was a greater concentration from Scotland's central belt[22]. The majority of participants were white, with three participants who were Black, Asian or Minority Ethnic (BAME). Twelve participants were living outside of their parental or carer home, the majority of whom had moved for university. Three participants had experienced homelessness, and two were care-experienced. Twelve of the participants were full-time university students, five were studying at college, and one participant was at school. Two participants were in full-time employment, whilst seven worked part-time (four in addition to full-time studies), and one participant was unemployed.

Nine participants disclosed via the demographic monitoring form that they considered themselves to be disabled and a further one participant disclosed that at the time of the interview they were under-going testing for an autistic spectrum disorder. Participants were not asked whether they had received formal diagnosis, and instead self-identification and declaration were used throughout this study. A free-text box was provided to enable participants to provide more details of their disability in their own words, should they choose to, and all did so with the majority using more than one term to describe their disability. Seven participants disclosed a physical health condition, chronic illness or sensory impairment[23]; three participants disclosed an Autistic Spectrum Disorder; four participants disclosed a learning difficulty, neurodevelopmental

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[21] The Scottish Index of Multiple Deprivation is a standard measure used by the Scottish Government to index 6,976 areas according to seven domains: income, employment, education, health, access to services, crime, and housing (Scottish Government, 2020).

[22] The Central Belt of Scotland is defined as the following localities: Edinburgh and the Lothians; Clackmannanshire; Ayrshire; Dunbartonshire; Falkirk; Greater Glasgow; Inverclyde; Lanarkshire; Renfrewshire; and Stirling (Scottish Government, 2020a).

[23] In this study I use 'physical health condition, chronic illness or sensory impairments' to include respiratory, cardiac, neurological, genetic and gynaecological conditions, chronic pain conditions and sensory impairments. These descriptions and groups are designed to preserve anonymity.

disorder or speech disorder[24]; and two participants disclosed mental health conditions[25]. In addition to this, during the interviews a further 17 participants disclosed mental health conditions (either current or prior), or that they had been, or were currently, taking anti-depressants or anti-anxiety medications; two participants disclosed that they were autistic; an additional one participant disclosed a learning difficulty, neurodevelopmental disorder or speech disorder; and a further one participant disclosed a physical health condition, chronic illness or sensory impairment. In total therefore, 22 participants disclosed either a physical health condition, chronic illness, sensory impairment, Autistic Spectrum Disorder, learning difficulty, neurodevelopmental disorder, speech disorder or mental health condition.

Linear or binary understandings of 'coming out' have been extensively critiqued for attempting to concretise 'closeted' and 'out' subject positions for a cisgender, heterosexual audience, obfuscating the dynamic nature of coming out as a social process (Klein *et al*, 2015). All participants in this study had come out, or attempted to come out, to at least one person in their life, although some participants (Fiona and Euan) reflected on their consideration of whether to come out to more people or in more contexts than they were currently out in. Seven participants described their gender as men or male (six trans[26] and one cis[27]); eleven participants described themselves as women or female (all cis); two participants described their gender as non-binary[28], and a further one as trans non-binary. One participant described her gender as female tomboy (and stated that she was not trans when asked if she considered herself a trans person); one person as a transgender demiboi[29]; and one person as a non-binary

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[24] In this study I use 'learning difficulty, neurodevelopmental disorder or speech disorder' to include the following: dyslexia, dysgraphia, dysfluency, Tourette's syndrome, and Attention Deficit Hyperactivity Disorder. These descriptions and groups are designed to preserve anonymity.

[25] In this study 'mental health conditions' include depression, anxiety, eating disorders and personality disorders.

[26] The term 'trans' is used to describe someone whose gender identity is not the same as their sex assigned at birth.

[27] The term 'cis' is used to describe someone whose gender identity is the same as their sex assigned at birth.

[28] 'Non-binary' is an umbrella terms used to describe people who identify their gender out with the binary terms 'man' and 'woman' (Scottish Trans Alliance, 2016).

[29] 'Demiboi' is a term used to describe someone who sees their gender as partially, but not entirely a boy (Holleb, 2019).

trans woman. Ten participants identified as trans. I asked people to describe their sexual and romantic orientation using as many terms as they felt were appropriate. Eighteen people used non-monosexual terminology: pansexual[30] (seven); bisexual (six); queer[31] (three); bi (two); biromantic[32] (one), whilst seven people used monosexual terms: lesbian (three); gay (three); homosexual (one). One participant described themselves as ace[33], one as asexual[34], and one as aromantic[35]. Participant bios are included in Appendix 5.

3.5.4 Designing the interview schedule

To create an interview space in which a highly sensitive topic could be explored, it was essential to develop a trusting and comfortable rapport with participants (Fontana and Fey, 2003). I was keen to design an interview structure in which participants would feel comfortable steering the conversation in directions they deemed important, rather than simply trying to provide me with answers in a manner they felt I wanted (Riessman, 1987; Burgess-Proctor, 2015). I was acutely aware of the 'interpretative problem', where participants try and frame their answers to the question that they think their interviewer is trying to ask, rather than the one they actually ask, particularly when the question is very open or deliberately vague (Silverman, 2001b).

To strike the balance between these, it was essential to provide enough clarity in the interview structure to allow participants to be clear about the topics I wanted to cover, whilst providing sufficient confidence in the space and flexibility created to facilitate participants sharing what they felt was important. In order to refine the interview questions and resources I sought feedback from the organisations I engaged with, my supervisors, and some youth

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[30] 'Pansexual' is a term used to refer to someone who is attracted to people of multiple or all gender, or to people regardless of gender (Holleb, 2019).

[31] 'Queer' is a reclaimed slur, used to describe one's identity whilst resisting definitions and boundaries; it is deliberately ambiguous (Barker & Scheele, 2016; Holleb 2019).

[32] 'Biromantic' is a term used to describe someone romantically, although not necessarily sexually, attracted to people of more than one gender.

[33] 'Ace' is used as short for asexual and aromantic (Holleb, 2019).

[34] 'Asexual' is a term used to describe a person who does not experience sexual attraction (Holleb, 2019).

[35] 'Aromantic' is a term used to describe a lack of romantic attraction, although a sexual attraction may be present (AVEN, 2017).

work colleagues. I also conducted three pilot interviews that were looked over by one of my supervisors and discussed. As there were no significant changes made to the interview schedule as a result of the discussions or pilots, these interviews were included in the final sample. However, as a result of the pilots I was careful to explain one of the activities in a clearer manner.

3.5.5 Interview Questions

To open the interview, help to relax the participant, and help me to understand their life in context, rather than only the parts pertaining to their mental health, I began with broad questions about participants' lives (Ackerly and True, 2010). They were as follows:

So to give us a bit of a chance to get to know each other, do you want to tell me a little bit about yourself?

What are you doing at the moment?

Where do you live? Who with?

Where did you grow up?

Do you want to tell me a bit about coming out?

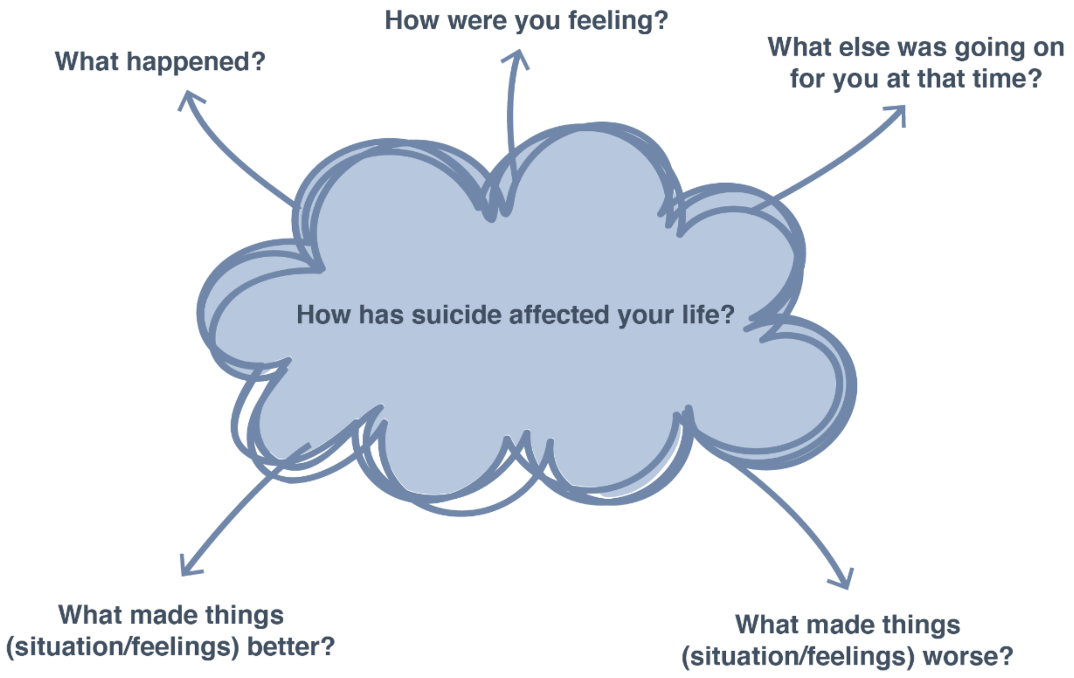
How do you get on with your family?

Any questions for me?

The questions were presented in a conversational manner. They were asked in the order that made most sense within the context of the participant's narrative and were worded conversationally. Throughout the interview I facilitated dialogue by actively listening and using silence, echo probes (repeating back a phrase the participants has used), neutral probes (encouraging noises), and follow on questions (Hesse-Biber, 2007). Most participants seemed to enjoy talking about their lives in general, often visibly relaxing. Some participants however, appeared to be either confused about the questions, perhaps interpreting me as euphemistically asking about their lives in the hope they would answer with their experiences of suicide or alternatively were simply disinterested in discussing topics that were not directly about their experiences of suicide. These participants responded to the ‘warm-up’ questions by quite quickly relating them immediately to their mental health or directly to suicide. This was sometimes done in quite a hesitant manner that suggested to me that participants perhaps were unclear of whether I had wanted to ask about suicide but hadn’t, which could be reflective of experiences from other contexts or an awareness of the social stigma often assigned to suicide. However other participants seem to immediately direct the conversation toward mental health and suicide in a manner that suggested that they were keen to get to the crux of the interview, taking control of their own narrative.

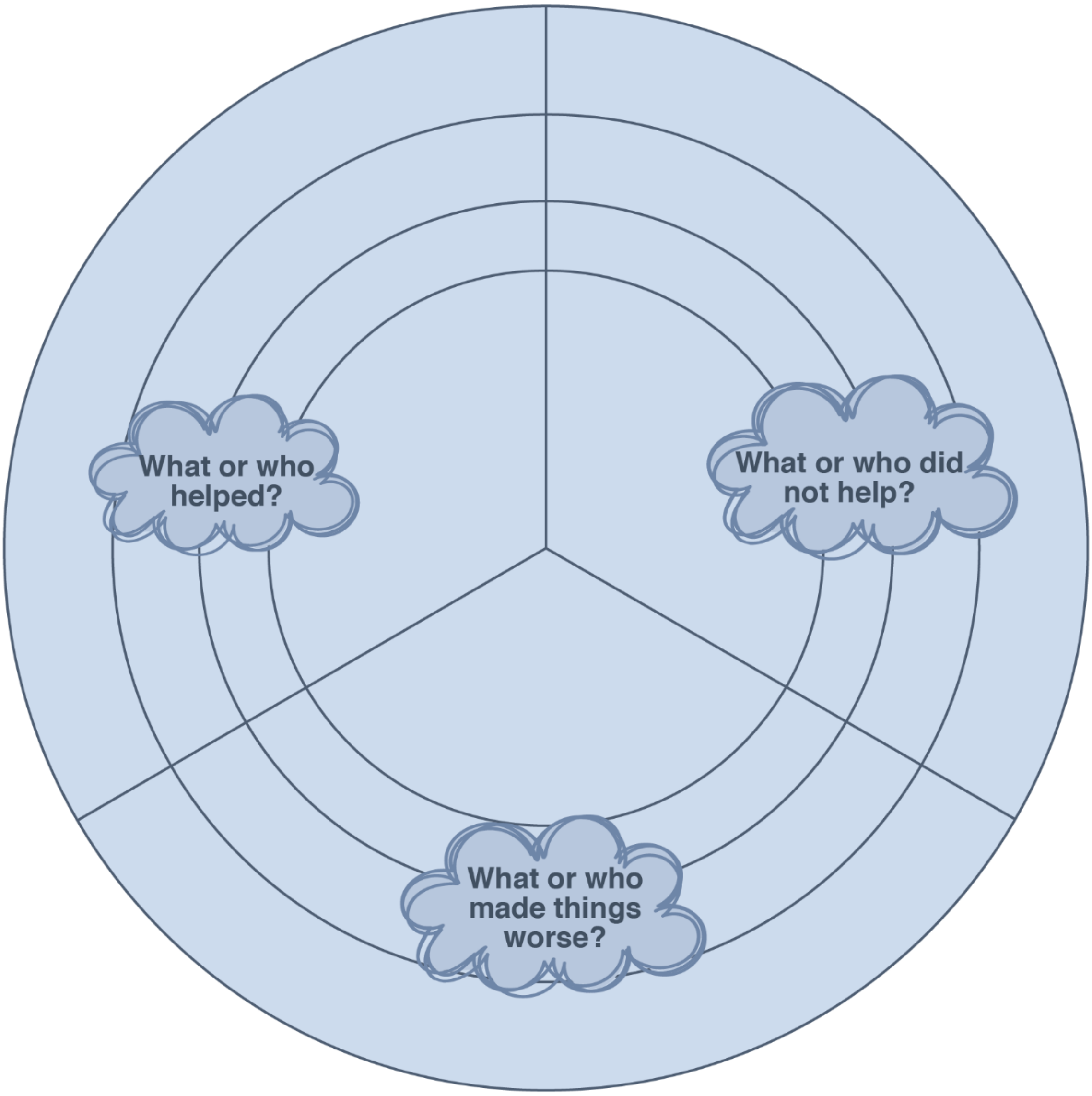
Following on from this discussion, I then moved onto the substantive part of the interview asking the central question of the project ‘how has suicide affected your life?’. The question was broad and was designed to allow participants to focus the question as appropriate to them. However as aforementioned I was very conscious of the ‘interpretative problem’ and therefore used the visual resource in Figure 3 to help keep a reminder of the central question and a variety of the prompt questions ‘what happened’ (action focussed), ‘how did you feel at the time?’ (emotions focussed), and ‘what else was going on at the time?’ (context focussed) visible to the participant. I wanted participants to be able to shape this question to their own experiences and would tell them to start wherever they liked, explaining that they could start with the first time they remembered suicide affecting their life, the last time they remember suicide affecting their life, or simply important moments they felt were significant to answer the question.

Figure 3 Interview Resource 1.



The bottom two questions (what made things better and worse) were used to move participants onto the reflection wheel (Figure 4). The reflection wheel was provided for participants as part of the participant information sheet sent prior to agreeing to participate. They were told they could take notes on the wheel if they would find that helpful in advance of the interview, but also could do it for the first time in the interview if they preferred. I was conscious that participants could get stuck with such open questions and therefore I created prompt cards which combined some areas identified from the literature that were considered pertinent contributory or protective factors, along with some more general terms pertaining to general areas of a young person's life that they might want to speak about (Figure 5). The cards were not introduced to participants at the same time as the reflection wheel, with most reflecting extensively. However, when participants appeared to have said everything they wanted to I offered the cards and they seemed helpful in facilitating participants' narratives and worked particularly well for participants who struggled to remember their experiences. For some, the terms were too vague and they asked me for clarity on what was meant. However, ultimately once confident they knew what was expected of the activity and what was meant by the terms on the cards, the participants all seemed to find the prompt cards useful.

Figure 4 Interview Resource 2 – Reflection Wheel.



Relationships

Work

Times

Places
Examples: local area, transport, housing, organisations and spaces accessed

Future goals and achievements

Conflict and arguments

Shame and hiding

Distraction

Online spaces, media and social media

People
Examples: family, friends, partners, neighbours, teachers, support workers, youth workers, medical health care

Belonging

Loneliness and isolation

Money

Triggers

Community

Activities
Examples: going out, staying in, doing sport, volunteering, music, TV, playing games, attending groups, self-care, activism

Where you live

Confidence, self-esteem and how you feel about yourself

Support

Harassment, discrimination and bullying

Education
Examples: schools, college, university, exams, assignments

Health care
Examples: hospitals, counsellors, medication, Gender Identity Clinics, doctors, nurses

Figure 5 Prompt cards

Once we had worked through all the questions about participants' own experiences, I closed the interview by asking participants what they thought might reduce LGBT+ youth suicide in the future. At the end of the interview I offered the opportunity to ask questions and asked how the young person was feeling, I then gave them their £20 'Love to Shop' voucher in exchange for participation, the 'signposting to support' resource that signposted to a range of charitable sector organisations and helplines, and offered to speak with them on the phone the following week if they wanted to.

3.5.6 Planning to minimise distress and harm

Throughout the interviews participants' safety and wellbeing was of paramount importance. Whilst I hope that the interviews were positive experiences for participants, I was conscious that talking about personal experiences of suicide had the potential to be distressing, although evidence suggests that it is not inherently harmful and has the potential to be cathartic (Blades *et al.*, 2018; Polihronis *et al.*, 2020). Therefore, in order to be as prepared as possible for anticipatable difficulties at each stage of the research process (Lothen-Kline *et al.*, 2003), I had rigorously planned how to respond if I became concerned for a participant's safety or wellbeing before, during, or after an interview. I constructed a 'minimising distress and harm protocol' (detailed in Appendix 6), providing me with step-by-step reminders of appropriate, agreed ways to respond and escalate where necessary. This was submitted as part of my application for ethical approval to the University of Glasgow's College of Social Sciences Research Ethics Committee. The protocol (along with the rest of the ethics application) were reviewed, amended in line with feedback and granted approval by my supervisory team, the University of Glasgow's College of Social Sciences Research Ethics Committee (400180127), and through LGBT Youth Scotland's ethical approval for research process. Although I had planned extensively, I was also acutely aware that whilst there are the elements of safe and ethical research practice I could consider and prepare for, research settings are hugely dynamic and unpredictable, and unexpected issues could arise (Gibson, Benson and Brand, 2012). Thus, I was prepared to be flexible in my responses to participants and sought advice from my supervisors where necessary.

Key to establishing safe and ethical research interviews was being honest and transparent about the interview process whilst actively and continuously establishing consent. The ways in which to end participation in the research project and the limitations of this, as well as the situations in which I would be obliged to breach confidentiality, were discussed during the initial contact with participants, in the participant information sheet, and at the opening of the interview in order to establish informed consent (the consent form is available in Appendix 7). Participants tended to be most receptive to an active discussion of this at the opening of the interview, and some participants, often those who had previously experienced breaches of confidentiality, asked for further details and remarked on feeling reassured by my clarity on this. I was also clear with participants that they were welcome to take breaks in the interview, as I wanted to establish a relaxing environment. I was conscious that the interview could be tiring and wanted participants to feel comfortable to take breaks when they wanted, rather than only in the instance that they needed a break due to distress, however only one participant chose to do so, taking a break for a phone call.

I was very aware that interviews can feel like formal events, particularly to participants. This is especially the case when they are audio recorded and therefore once the recorder is on everything that is said, including asking for breaks, is ‘on the record’ so to speak. Therefore, I also was careful to look out for any verbal or non-verbal cues that participants were becoming distressed or disinterested, and proactively offered to pause or end the interview where appropriate. Generally, most participants appeared comfortable talking throughout the interview but in an instance where a participant (Ayla) cried twice (once when talking about her mother’s response to coming out, and once talking about her own suicide attempt), each time I offered her a break it was accepted. During the two breaks we got some air, had some ‘small talk’, and I reassured her that she did not have to continue with the interview if she was finding it upsetting (mentioning in passing that she would still receive the voucher in case this was motivating her continuation). However, she was keen to continue with the interview. As with most participants, when asked, Ayla explicitly communicated that she had been motivated to participate in the interview by the hope that in sharing her experiences she would be able to help others. She had also forgotten, as many participants did, that she would be given the voucher. We therefore continued the interview, but reshaped it, instead choosing to concentrate on talking about the things that had helped her to keep safe and recover from feeling suicidal, rather than reflecting on her experiences of suicide and the contributory factors to this.

The process of taking time out to de-escalate the participant's distress and re-establish consent to participate in the research was reassuring to me, both because I viewed this as the participant prioritising her needs, taking time and space for herself, and because it allowed us to discuss what she was finding distressing and reshape the topics of the interview accordingly. However, a second instance of a participant expressing distress challenged me. The participant (Sophie) started to cry whilst talking about the death of her teenage girlfriend by suicide. When I offered her a break however, she refused it saying, she was "just emotional". Although I was concerned that telling the story had upset her, she stopped crying almost immediately and seemed keen to continue to talk (refusing my offer to take a break and continuing talking about Tina[36] without hesitation), I felt it was appropriate to respect her wish to continue. Instead, I had to manage my own concerns that visible signs of distress marked some failing on my part and accept that the nature of the topic had the propensity to be distressing which would, at times, be visible.

3.5.7 Anonymity

All interviews were audio recorded, transcribed in full by a professional transcription company that complied with the SPHSU's regulations, and then anonymised by me. All participants were asked at interview whether they wanted to choose a pseudonym to be used for them. I chose to do this in recognition that whilst anonymity is a university ethical requirement, this can be considered disempowering and a method of distancing participants from being able to take credit for their own work (Burgess-Proctor, 2015). Furthermore, it was particularly important within my sample, where 11 out of the 24 participants I interviewed identified as trans, non-binary, or both. As a cisgender researcher I was acutely aware that my sensitivity to the gendered meanings of

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[36] A pseudonym.

names might not be as sharp as trans and non-binary participants' understanding was (Vincent, 2018). In my study, some participants were very enthusiastic about selecting pseudonyms, whilst others were highly ambivalent and asked me to select one for them, which I did.

3.5.8 Analysis

All transcripts were checked for accuracy against the audio recording and then read in full to familiarise myself with the data. I used a process of noting to record my initial responses to the interviews, often in the forms of questions, as well as documenting ideas that I had for preliminary open codes written in the margins of printed transcripts (Braun and Clarke, 2006; Smith, Flowers and Larkin, 2009). Further to this, in separate documents I recorded reflections on my own emotional responses to the data, using as a guide Sustein and Chiseri-Strater's reflection questions 'what surprised me? What intrigued me? What disturbed me?' (2012; pp.115). In addition, I wrote a summary of each participant's story and elements of their experiences that struck me as analytically salient. Throughout the analytical process, I paid particular attention to the intersections of participants' identities and the ways in which they were or were not drawn upon. In doing so, I had to give careful consideration to balancing the desire to represent the diversity of LGBT+ people included in this study, with the need to preserve participants' anonymity and not include revealing details about their identities or life histories. In some instances, participants explicitly detailed in the interview the identity characteristics or particular incidents that they did not wish to be included in the write-up.

At the exploratory stage of analysis, I was less focussed on chapters to be written or research questions to be answered, and instead wanted to capture my organic, raw perceptions, interpretations and emotional reactions to the interviews. However, as the interview data are very rich, I also needed to avoid becoming lost in what could feel like endless interpretative possibilities. Therefore, following this more exploratory analysis I re-read my notes comparing across interviews for points of convergence and divergence and began the reflexive thematic analysis (Braun and Clarke, 2006, 2020), developing a series of preliminary, 'elemental codes' (Saldaña, 2016), to be shared with my supervisors. The ‘elemental codes’ were primarily focussed on descriptive coding to give a sense of what was going on in the data; ‘structural coding’ to think about how this related to my research questions; ‘emotional coding’, both to look at how participants described their emotions and how I interpreted this as affecting their story-telling during the interview; and ‘concept coding’ to think about how this might relate to broader theoretical perspectives (Saldaña, 2016). I wrote descriptively about these codes, which in turn allowed me to consider how to cluster them into axial codes and be explicit about what each code meant to me, focussing on those that I felt were either most relevant to answering my research questions (deductive) or stood out as being particularly novel or particularly prevalent across the data set (inductive).

The codes along with all data were uploaded to NVIVO12, where I began to code the data in detail both using the codes developed but also with an openness to the iterative nature of coding. As I went through this second cycle of coding, some codes were collapsed, some expanded, new codes were added, and some of the clustering was re-organised accordingly. During this coding round I was keen to think about the ‘how’ and ‘why’ buried within participants’ stories, and to consider whether differences in experiences could in anyway be explained by how participants experienced different types of marginalisation (Winker and Degele, 2011). Once comfortable with axial and elemental codes, I began to connect them with some of the existent theoretical perspectives on the disproportionate burden of suicide faced by LGBT+ young people when compared to their cisgender, heterosexual peers to understand what my work offered to the field.

As part of the process of analysis, I reflected upon some of the criticisms that have been levied against qualitative suicide research: namely that first-person narratives can be treated uncritically as a way of accessing the inner worlds of participants with lived experience of suicide (Bantjes and Swartz, 2019). It has been argued that treating interviews in this manner can result in researchers failing to analyse interviews as social interactions that are shaped by expectations of the interviewer and interviewee, inviting particular kinds of ‘performances’. For example, there can be an expectation that interviews produce revelatory accounts from participants that give ‘backstage’ access to their lived experiences. In turn, this expectation may encourage participants to provide coherent life story narratives which are themselves a type of interview performance that must be analysed in a manner that acknowledges the interview as an account (Whitaker and Atkinson, 2019). For example, in Amy Chandler's (Chandler, 2016a) work of self-injury narratives, she discusses the manner in which 'authentic' self-injury is performed by participants who draw upon notions of hidden or secret self-injury in order to perform authenticity within interviews.

Within this PhD study it was therefore important for me to attend to this in a number of ways. As discussed in Chapter One, given the possibility of stigma experienced within my sample (queerphobic, ageist and suicide stigma). It was therefore important for me to consider the ways in which participants might feel pressure to perform authenticity with regard to both their LGBT+ identities and their suicidal distress, responding to the potential of their accounts being undermined either through my analytic process or by potential future readers. Much of this performance work of social interactions is unsaid and therefore is somewhat invisibilised within the interview environment. I found Ruthellen Josselson's (2012) analytical constructs of a hermeneutic of suspicion and a hermeneutic of faith conceptually useful when considering how to analytically balance the content of a participant's story with how and why a story may be constructed in a particular way.

3.5.9 Reflexivity

Throughout this research project there have been two particular positions that I feel affected my research dynamic: firstly my role as a youth worker and secondly my personal identity, which will of course have affected my framing of the research, my interviews with participants, and my analysis of the data constructed. I will consider each in turn.

3.5.9.1 As a youth worker

Throughout the undertaking of this PhD (and for years prior to it), I worked as a youth work assistant in LGBT+ groups, and prior to the interviews had lots of discussions with my supervisors about resisting going into 'youth worker mode'.

In youth work, it is my role to support young people to explore their thoughts and feelings, and to achieve their desired aims through a facilitative process of group work and one-to-one support. As a researcher my role was more asymmetric, facilitating interviews that enabled young people to tell their stories, ultimately to fulfil the aims of my PhD project (Coles *et al.*, 2014). This asymmetry sat quite uneasily with me. The young people who participated in the interviews often discussed issues that would be quite common for me to work with in a youth work setting. I found questions floating into my mind that would be appropriate if I was intending to provide further support (as I would as a youth worker), but that were inappropriate in a research context where this was not possible. I was very self-conscious of the questions I asked therefore, trying to be very strict with myself about the boundaries between my youth work self and research self, as I did not want leave participants feeling exploited, expecting more than it was possible for me to provide (Hesse-Biber, 2007).

3.5.9.2 Personal identity

My own identity was at the foreground of this research, with my experiences as a queer woman motivating me to work on this project, affecting the ways in which I related to participants, and influencing my frame of analysis. I am an out queer woman and have been involved in LGBT+ activism and community groups in Scotland for over a decade. I also have written publicly about my experiences of queerness and queerphobia (and indeed did so in some of my blog posts for the recruitment for this study) and am out on social media. In addition to this, some participants asked me directly about my LGBT+ identity during their initial phone call, others presumed my queerness or had picked up on it from my online presence. As a result, many of the participants related to me as a fellow queer person: for example often correctly assuming a shared position on the media coverage of trans people around the Gender Recognition Act reform that was happening at the time of the interviews, or referring to queer cultural references that might otherwise have been taken at face value.

The presumption of shared knowledge, I believe, was rooted in a perception that I had ‘insider status’ due to my queer identity (Berger, 2015), but of course LGBT+ people are not a homogenous group, and so this construction of a shared queerness needed to be unpacked (Gorman-Murray, Johnston and Waitt, 2010;

Marinucci, 2016). As a white, cisgender, queer woman from London, participants related to different parts of my identity. For example, participants who had grown up in England would sometimes ask me where I was from and draw on this connection. Others would draw upon my identity as a queer woman as a similarity, whilst two of the trans men were quick to be almost apologetic to me after they had strongly pointed out that they were not lesbians. For example, one participant said:

> Stuart: Being read as a lesbian was very frustrating... Obviously 'cause I wasn't passing enough, not because lesbians are bad or anything.

Due to these shifting senses of sameness and difference between the participants and I, sometimes over the course of interview, I was keen that our perceived points of similarity were explicitly explored. I sometimes found myself saying 'can you tell me what you mean by that' whilst silently pointing at the recorder, which led to some comedic moments of shared understanding about the strange nature of interviews, but also allowed me to ensure that I wasn't reading into the participants' narratives incorrectly.

3.5.10 Self-care

From the outset it was clear that undertaking this research had the propensity to be emotionally demanding (Heckert, 2010; Boden *et al.*, 2016; Mckenzie *et al.*, 2017; Kumar and Cavallaro, 2018; Whitt-Woosley and Sprang, 2018). The subject area of this PhD is emotionally demanding in and of itself, but additionally because there is significant cross-over with my own personal and professional experiences. Many times whilst interviewing I heard participants relay experiences that reflected my own, my friends, or those of people I have worked with as a youth worker, and this could have of course been distracting or distressing (Kumar and Cavallaro, 2018). In order to manage this, it was necessary to have proactively considered this possibility and planned strategies that allowed me to remain in the participants' moment with them, and not get distracted by my own relationship to their experiences. I therefore created time, space, and resources outside the interview for me to acknowledge and explore my emotions, proactively building continuous self-care into the research process to try and mitigate negative effects before they happen (Robertson, 2000; Rager, 2005; Dickson-Swift *et al.*, 2007; Lewis, 2008; Coles *et al.*, 2014; Boden *et al.*, 2016).

Drawing on Rager's (2005) work on self-care whilst researching breast cancer, I designed proactive steps to safe-guard my wellbeing. It was very important to me that I proactively built an ethic of care into the design of the project, rather than waiting to see if there was a negative impact on my wellbeing and reactively responding to try and undo negative effects. Firstly, in advance of under-taking the interviews I consciously reflected upon what for me indicates that I am not only coping, but also doing well emotionally, and what slips when I am struggling. Having identified these factors of course did not mean that I was able to prevent difficult feelings at times whilst undertaking this research. However, it gave me some concrete indicators to be aware of, that prompted me to know when to take action to help restore my sense of wellbeing. I found this helpful as I have found that if I simply try and reflect on whether I am ok, I fail to do so meaningfully and tend to fall back on a default answer of ‘yes, I’m ok’, which does not accurately reflect my mental state. I find it easier instead to reflect on more concrete measures, for example if I have/have not been engaging in particular activities or behaviours which often mean that I am not doing as well as I would like to be, prompting me to look at what I’m doing and think of ways to address this.

To facilitate this, I kept a diary where I could reflect on these indicators (Rager, 2005). As I was not someone who normally journals, I did not want this to become an onerous task, rather than a beneficial one. I tried to fill out my reflections on most workdays, but always filled it out on either the days of interviews or the following day, depending on the timing of the interview. I also limited myself to one interview per day as I was nervous that if I did more, I would not be able to give participants my fully concentrated attention. After interviews, I ensured that one of my fellow PhD students was available for a phone call or message chat (Rager, 2005; Dickson-Swift *et al.*, 2007). I emotionally process best externally, so this gave me an opportunity as part of a reciprocal relationship to confidentially share my experiences, to minimise me reflecting and ruminating on them after an interview. It also helped me to develop my thinking about how to enhance my interview practice (Duncan *et al.*, 2009), and where there were specific actions to be taken I jotted them down in my diary. Furthermore, after interviews I ensured that I had options arranged for both socialising and relaxing (Mckenzie *et al.*, 2017), and that whenever I was returning home, I had easy options for food for the rest of the day. I also organised a monthly reflective practice group with two fellow PhD students where we could discuss some of the larger challenges and reflections on data collection and support each other to reflect upon and enhance our practice (Duncan *et al.*, 2009). Finally, as a precautionary measure I identified a counselling practice to contact if I felt that I needed emotional support whilst under-taking the research (Robertson, 2000).

3.6 Summary

This chapter has outlined my research approach. I began by explaining my constructionist epistemology and my commitment to an intersectional, feminist research design to underpin the study from design to write-up. Addressing the gaps identified through my literature review I took the decision that a qualitative methodology was the most appropriate to answer my research questions, and after careful consideration of the methods available to me and the ethical demands of the project, I selected interviews as my method of data construction. To ensure that my interview schedule was designed to be both sensitive to participants' needs whilst successfully facilitating engagement with the topic area, I gained feedback on the design from both supervisors and third-sector organisations working in the area as well as conducting three pilot interviews. Throughout the whole research process, I engaged in an ethic of care, attempting to be actively mindful to safeguard my own, my participants and my prospective participants' wellbeing. I closed the chapter by discussing my use of reflexive thematic analysis underpinned by an intersectional, feminist framework and a reflexiveness to both my personal and professional identities. The findings from which I will detail over the next three chapters.

Chapter 4 Making Sense of Suicide

4.1 Introduction

Suicidology has frequently been criticised for taking an overly psychocentric approach, predominantly focussing on individuals' 'maladaptive' psychologies to the exclusion of considering broader social factors (Rimke, 2016). The majority of young people who think about, attempt, and die by suicide are thought to live with mental health conditions, in particular depression (Miller and Eckert, 2009; Nock *et al.*, 2013; Shain, 2016). However, suicide can also be seen as a practice that draws upon bodily acts and bodily meanings (Jaworski, 2016), referencing the social context and life history in which it happens (Button, 2016; Mills, 2018). In order to understand suicide more holistically therefore, it is necessary to bring the psychological and sociological factors present within an individual's life into dialogue through the research conversation (Chandler, 2019). This chapter will address my first research question 'how do young LGBT+ people in Scotland make sense of their suicidal thoughts and attempts?' to facilitate this interdisciplinary dialogue. To begin, I will discuss how participants structured their stories and categorised their experiences, exploring how boundaries were (de)constructed between suicidal thoughts, self-harm and suicide attempts. I will then move on to discuss the roles that participants felt suicidal thoughts and attempts occupied in their lives.

4.2 Telling stories of suicidal experiences

All participants in this study had experienced suicidal thoughts. Ten of the participants had attempted suicide, all of whom had attempted suicide more than once, and a further two had made clear, detailed, specific suicide plans. 14 of the 24 participants also spoke about self-harm, the majority did so through self-cutting and self-poisoning (either with prescription or over-the-counter medication), although some participants mentioned head-banging, scratching or 'nipping', self-hitting, and self-burning. One participant spoke about restricting her activities as a way to punish herself for not making friendships with peers whom she idolised as a form of self-harm.

Participants tended to situate the stories of their suicidal experiences within a broader landscape of social context, interpersonal relationships, key events, and often long histories of fluctuating or deteriorating mental health. As detailed in Chapter Three, we started the interview by talking more generally about participants' lives: where they lived, what they did, their families, their coming out stories; before moving onto the section of the interview that focussed directly on their experiences of suicide, by asking the question 'how has suicide affected your life?'. In answering these questions participants tended to want to take me back through their histories to describe what they often presented as a causal chain in the deterioration of their mental health, narrated in chronological order. For example:

> Ayla: Maybe I can talk about some things briefly on a timeline of like how everything kind of ended up here.
>
> Damian: I think it would probably be best to start with what happened, because it's kind of, cause, and then effect.

Participants' stories tended to take a life history approach, focussing on the key moments in their lives that they felt had contributed to suicidal distress, which will be explored further in Chapter Five.

The narration of their stories almost presented suicide as a rational or logical response to a series of difficult life events. It has been argued that interview methods invite particular kinds of performances from both the interviewer and interviewee. For example, there can be an expectation that, when the interviewer has put the participants at sufficient ease, the interview can be a behind-the-scenes look at participants' lived experiences. This can lead to interview data being treated as direct representations of participants' realities and therefore not receiving sufficient analysis *as accounts* (Bantjes and Swartz, 2019; Whitaker and Atkinson, 2019).

To try and reflect on participants' interview practices in addition to the content of the interviews, I tried to balance hermeneutics of faith and suspicion (Josselson, 2012). For example, where participants told neat, organised stories of thinking about or attempting suicide, I considered whether this neatness could possibly act as a tool for countering pathologising narratives that have been used to describe suicidal distress solely as the tragic outcome of mental illness (Rimke, 2016; Hjelmeland and Knizek, 2017). In offering stories of suicide instead as the outcome of a series of clearly narrated, negative events, I considered that participants might be attempting to create distance between themselves as rational narrators and what could be viewed as more chaotic, messy or emotional understandings of suicidal distress. I was interested in this rationalising process in which the emotions of suicidal distress could remain unspoken and I therefore was keen to more thoroughly explore how participants came to make sense of the role of suicidal thoughts and attempts in the broader context of their lives, and particularly the affective states that they associated with them.

4.3 Constructing shared meaning

It has been noted that in research literature there is a lack of consistency in the terminology used to describe suicidal thoughts and behaviours (Silverman, 2016). Although this may be seen as a problem for comparing and synthesising research literature (Silverman, 2006), it has been suggested that a lack of neat language reflects an inability to neatly define and categorise experiences of suicide (Andover *et al.*, 2012; Marsh, 2016) and the moment-to-moment shifts in motivation and intention experienced by individuals (McDermott and Roen, 2016; Silverman, 2016). In order to ensure I understood participants' stories, I focused on developing a shared understanding of the language participants used to describe their experiences of suicidal distress. I hope that this in turn will help develop insights into the use of language by people with lived experience of suicide, contributing to this emerging literature.

Research (and in particular survey research) sometimes attempts to delineate suicidal thoughts, suicide attempts and self-harm as distinct entities. Whilst this neat delineation was reflected in some participants' narratives, others expressed a shifting sense of understanding of these categorisations. Although for some this may have been affected by the time elapsed between their suicidal experiences and interview (Hart *et al.*, 2013), for others it appeared to reflect rapid, real-time changes to their understandings. To begin, I will discuss the complex, yet somewhat binary, ways in which participants understood their suicidal thoughts, depending on whether or not they intended to act on them. I will then move over to discuss participants' descriptions of self-harm, exploring how for some participants there was blurring between self-harm and suicide attempts, whereas for others they were conceptualised as distinct yet linked. To close this section, I will discuss how participants understood their suicide attempt in relation to previous suicidal thoughts.

4.3.1 Suicidal thoughts

Some participants appeared to make an important qualitative differentiation between two types of suicidal thoughts: those they intended to act upon (regardless of whether enacted) and those they did not. Meryem articulated in detail her earliest memories of suicidal thoughts aged 9. She was highly anxious; had just moved to a new country and away from one of her parents; was attending a new school where she had to speak a language she was less confident in; had experienced sexual abuse; wasn't fitting in with her peers; and was extremely concerned about her educational performance. She began to think of suicide as a way that these high levels of stress could be resolved, seeming to conceptualise suicide as an escape.

The conceptualisation of suicide as escape will be discussed in detail later in the chapter. Instead, here I want to draw attention to the care Meryem took to express a distinction between early thoughts of suicide over which she was certain she was not going to act, which she described as 'not legitimate', and those that she experienced later in childhood, which she either intended to, or did, act upon. When asked to clarify why she felt that these thoughts were not legitimate when compared to suicidal thoughts she experienced later in childhood (starting at age 11 and consistent throughout her teenage years), Meryem clarified:

> Meryem: Like, never tried to act on it, and never had, never said anything, because it wasn't anything that I was like seriously considering […] But I distinctly remember being like, if I jumped out that window right now, everything would be over, and that would be kind of cool.

Other participants extended this distinction by talking about suicidal thoughts which they classified as 'intrusive' in contrast to thoughts which they had intended to act upon. Intrusive thoughts have been described in research literature as spontaneous in their origin and therefore not necessarily connected to a specific trigger. They are automatic cognitions and thus not deliberately called to mind by their thinker, and they are an interruption to one's thoughts (Batey, May and Andrade, 2010; Hales *et al.*, 2011). Many participants expressed that since the onset of suicidal thoughts, usually between the age of 12 and 14, there had been periods of time in which intrusive suicidal thoughts had been somewhat omnipresent.

> Leo: There's always I can't remember what it's called, like passive something where it's… there's… they're like intrusive thoughts rather than an actual intention. That's pretty much been constant since I was 16 or something. Like, that's just constantly there. But it's… isn't normally that big a deal, but sometimes if you're already feeling low it can, sort of, push back in.[37]

Leo exemplifies an attitude that was shared by others; that there was a perceived disconnect between what he termed passive suicidal thoughts, which were very regular but which he did not intend to act upon, and those that had been more active leading up to his two suicidal crises. He positioned thoughts that he perceived as intrusive as not being 'that big of a deal' and when asked how he coped with them, he appeared to portray them as wearing but manageable.

> Leo: I discovered the best way to get rid of those thoughts is to just interrupt them with another thought really. 'No, fuck off'. Which works surprisingly well once you get good at doing it.
>
> Hazel: Okay. How did you find that, kind of, coping strategy?
>
> Leo: I don't know. I think I just, sort of, got sick of feeling like that. I was like, no fuck this. 'Cause I think that's what used to wear me down a lot at 13 was these thoughts.

This sentiment was shared by Sophie and Damian. Sophie reported that she often experienced thoughts about chance opportunities to attempt suicide in her day-to-day life. She gave an example of walking down the street and seeing a passing car, triggering a thought that 'it would be so much easier just to jump in front of

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[37] Although Leo is referring to intrusive suicidal thoughts starting at 16, he had experienced suicidal thoughts which he planned to act on aged 14.

that car'. Sophie found it important to emphasise that this wasn't about how she was feeling at the time, that these thoughts could happen anywhere and anytime, and that she was uncertain why they happened. In contrast, Damian experienced intrusive suicidal thoughts as internal ticks as part of Tourette's Syndrome.

> Damian: It [suicidal thoughts as internal ticks] feels like a consistent, kind of really, really dark stand-up routine that's going on, like, ah-ha, murder, murder, murder, I don't know. Like, it's just kind of normal, and it's kind of a part of life for me, and it's just sort of there. But then, then when I was feeling really depressed, like, they did change, like, that my attitude was, like it just wasn't cheery anymore.

Sophie presented these thoughts as unrelated to her surrounding circumstances, whereas Damian linked an increase in intrusive suicidal thoughts to an intervention that forced him to re-attend school. Damian described the return to school as very stressful; in particular, because he felt forced to 'hold in' external ticks during the school day, and as a result experienced an increase in internal ticks, which for him presented as intrusive suicidal thoughts.

In order to understand participants' experiences of suicidal distress it is necessary to consider the function that suicidal thoughts occupied in their lives, and the manner in which they made sense of them (Crane *et al.*, 2014). For some participants, the presence of suicidal thoughts was portrayed as a negative consequence of distressing life events and emotions, which participants found at best draining and at worst distressing. However, Damian and Meryem both appeared to present suicide as an avenue through which they could take control of their lives at times where they felt out of control, over-whelmed, and in need of escape. Rather than expressing these suicidal thoughts as intrusive or distressing, these participants appeared to view suicide as a proactive, agentic practice to address the difficulties they were facing, which seemed, for them, to have an almost positive affect.

The possibility of increases in positive affect after a period of suicidal thoughts due to a comforting and relieving effect has been explored in research literature (Holmes *et al.*, 2007; Selby, Anestis and Joiner, 2007; Hales *et al.*, 2011; Crane *et al.*, 2014; Kleiman *et al.*, 2018). It has been argued that suicidal thoughts

(Crane *et al.*, 2014; Kleiman *et al.*, 2018) or ‘flash-forward’ visual imaginings of one’s suicide (Holmes *et al.*, 2007; Hales *et al.*, 2011) can, in the short-term, decrease negative affective states and increase positive affective states. Although this is unlikely to be the case for all who experience suicidal thoughts, it has been observed in a significant minority (Crane *et al.*, 2014). It has been proposed that this momentary relief might be attributed to suicidal thoughts providing a level of cognitive escapism from what is often intolerable pain (Kleiman *et al.*, 2018).

As discussed in Chapter Two, both the Interpersonal Theory of Suicide and the Integrated Motivational-Volitional Model have proposed that envisaging death and dying may act as a cognitive rehearsal for suicide attempts, thus increasing suicide risk (Van Orden *et al.*, 2010; O’Connor and Kirtley, 2018). This has raised concerns that although thinking about or visualising suicide may be used as a tool for emotional regulation, providing short-term relief; in the long-term it may act as a cognitive rehearsal – establishing easier, faster access to suicidal thoughts even without distress triggers (Selby, Anestis and Joiner, 2007; Crane *et al.*, 2014; Kleiman *et al.*, 2018). This sense of ever-increasing ease of access to suicidal thoughts was clearly articulated by Euan:

> Euan: I would say it’s always been there. It’s been like a very young age, so I remember being 12 years old and thinking, god, I have to go through another 80… 70 years of this, it was just a bit like…so it’s always been…I mean, it’s like moments of…it wasn’t serious back then, it was kind of like, ugh, and it’s not real at that point but it’s still like that thought is in your head now, like I wish I was dead. And then it kept going up and it’s slowly just more consistent, it’s more…like the first thing you think of when something bad happens, but, you know, you don’t see a future, you just see, like, you’re going to get to a point where it’s either going to suddenly be better and something you’re not going to think about anymore, it’s going to be something you wouldn’t even imagine doing, or it’s eventually going to get you. And it’s always felt like that for me, it’s always made me feel like do[38] or die, it’s got to completely change or it’s not going to change at all.

Again, Euan makes a distinction around how ‘serious’ or ‘real’ his suicidal thoughts had been aged 12, which like other participants, seemed to relate to his immediate intention to act upon them. However, his description appears to

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[38] When asked what he would do, he clarified he meant come out.

position these early experiences as the beginning of an escalating trajectory, during which suicidal thoughts became an increasingly automatic response to times of challenge or crisis and, by implication, perhaps were seen as more ‘serious’ or ‘real’. Additionally, Euan describes himself as part-way through this trajectory. He foresaw his situation either getting considerably better, allowing him to come out, or further deteriorating and resulting in him dying by suicide.

For a moment, I wish to consider why participants may have made the distinction between suicidal thoughts that they did, and did not, have an intention to act upon. In Scourfield, Roen and McDermott's (2008) work, a distinction was made between suicide attempts that were, and were not, considered ‘genuine’ based upon whether young people considered the attempt to have been ‘correctly’ motivated. This was further reflected upon by participants in McDermott, Hughes and Rawlings' (2018) study where concerns were expressed that help seeking for suicidal distress could be misinterpreted as ‘attention seeking’. I therefore suggest that it is possible that in carving this distinction between ‘serious’ or ‘real’ suicidal thoughts and those portrayed as ‘not legitimate’, participants in this study were perhaps trying to direct my attention towards the suicidal thoughts they thought would be harder to dismiss or portray as ‘attention seeking’, ‘correctly’ demonstrating suicidal distress.

Taken together, this suggests that early passive or intrusive suicidal thoughts, whilst perhaps constructed as being less serious or less concerning by some young people, may need addressing to prevent further escalation. This is particularly important given the relationship thought to exist between suicidal thoughts in adolescence and mental illness in adulthood (Cash and Bridge, 2009), and the seemingly worsening trajectories of suicidal distress expressed by participants in this study. The majority of participants who had early suicidal thoughts they felt were not serious, did indeed go onto experience suicidal thoughts they considered serious. Furthermore, Damian and Meryem, who appeared to understand suicide as a way to reclaim control over their lives, had gone onto attempt suicide multiple times throughout their adolescence. This suggests that there might be opportunities for suicide prevention activities in early adolescence, when young people express a lack of intention to act on suicidal thoughts, which could help with the management of suicidal distress and mitigate escalation.

4.3.2 The relationship between self-harm and suicide

Fourteen participants in the study disclosed having self-harmed. Self-harm is an established risk factor for suicide (Whitlock *et al.*, 2013; Franklin *et al.*, 2017), and has been cited as a way through which individuals may increase their tolerance for, and decrease their fear of, pain, thus increasing capacity for suicide (Gordon *et al.*, 2010). Therefore, if participants disclosed self-harm, I explicitly explored how they understood their experiences of self-harm. For some participants, the boundaries between self-harm and suicide attempt were blurred. Whilst others, perceived self-harm as distinct from, but linked to, suicide, playing a role in the regulation of suicidal distress. I will explore each in greater detail.

4.3.2.1 Blurring

The blur in participants' accounts of whether an act was considered self-harm or a suicide attempt appeared rooted in both an emotional ambivalence to whether they lived or died and a physical test of injurious actions.

> Ayla: I self-harmed then I…oh, wait, I'm sorry. I had another attempt, but it wasn't an attempt. There was this time where it was very blurry for me whether I wanted to do self…like I wanted to do self-harm but at the same time I would sometimes test out the waters to see how far I could go.

For Ayla, the process of testing the waters to see how far she could go, was both an important and distressing feature of her experiences. Ayla self-harmed through both cutting and poisoning. She had attempted suicide twice: once taking an overdose and once through self-injury. She described instances in which she began to self-harm feeling that she wanted to be alive, but that this feeling could shift as she tested how much she could physically withstand. It was this sense of shifting intention between self-harm and suicide attempt that Ayla found particularly 'worrying', 'sad', and 'scary'.

> Ayla: I wasn't thinking about that fact but now that I look back I realise, wow, like the blurriness between those two [self-harm and

> suicide attempts] is really scary because it's maybe…like maybe that day I only woke up because I didn't take like one more pill, like maybe there was like a tipping point, like how stupid could I be? Like… But I just didn't care. It didn't matter to me and the fact that it didn't matter is very saddening.

In this passage, Ayla reflects upon an instance of self-poisoning during which she felt a sense of emotional ambivalence about whether she lived or died, and a sense of confusion about her own motivations.

This opacity of intention was also reported by Harley. Harley described experiencing intrusive suicidal thoughts, affecting her particularly intensely as she tried to fall asleep, since her early teens. Although Harley did not report having attempted suicide, she did express a lack of clarity about her injurious actions, reporting uncertainty and ambivalence about whether she was motivated by a desire to self-injure or attempt suicide.

> Harley: I was standing in the kitchen and there was a really big knife on the bench and my brain was like do, do it! I picked up the knife, and I put it down. I actually went upstairs and I cried so much, because I just felt really guilty. I was like… the original intent I think more was just self-harm, but I was also at the same time kind of like go for it, do it, blurgh, which was awful.

The lack of clarity expressed by these participants about the intentions underlying their self-injurious actions, can perhaps be further understood using Kovacs and Beck's (1977) Internal Struggle Hypothesis. They argued that individuals experiencing suicidal distress can experience an internal struggle between wanting to live and wanting to die, which can be interpreted as ambivalence about their life. This internal conflict can be constant and therefore the desire to live or die can change from moment to moment (Bergmans, Gordon and Eynan, 2017). To further unpack this, Brüdern *et al.* (2018) explored whether in the immediate aftermath of a suicide attempt, individuals who have attempted suicide were able to identify more reasons to die and less reasons to live than those who have not recently attempted suicide. After their study found that this was not the case, they hypothesised instead that in a moment of suicidal crisis people may go into a 'suicidal mode', a state in which they experience restricted thoughts and emotions, solely focussed on suicide.

Whilst the internal struggle between wanting to live and wanting to die was expressed quite clearly by Ayla and Harley. Ayla's account sits in contrast to the idea of a 'suicidal mode'. Her narrative appears to suggest that her ambivalence around suicidal intention was maintained through this instance of self-harm. She articulated feeling unsure whether her intention was to harm herself or to die before, during and after this act. This suggests that whilst some people may experience a 'suicidal mode' of actions (as will be discussed later in this chapter), for others opacity of intention and ambivalence about life and death may be maintained throughout and beyond a moment of crisis. This may be important when trying to understand boundaries or distinctions between self-injurious acts and suicide attempts, and adds to the argument that in some instances the boundary between them is too blurry to attempt disentanglement (Andover *et al.*, 2012; Marsh, 2016).

4.3.2.2 Distinct but linked

Both Ayla and Harley explained that whilst their intention was initially to self-harm this had quickly become ambiguous, suggesting an ambivalence in their desire to live. However, other participants spoke about self-harm as clearly distinct from, although often linked to, their suicidal thoughts and attempts. In many instances, they referred to self-harm as a somewhat preventative measure that kept them safe from suicide.

> Amber: So, the times that I do have suicidal thoughts, I tend to self-harm. So, I guess I have a more unconventional way of self-harming, through scratching. Like, it's not the usual way. But again, when it came to those two times of actually trying to commit suicide, the scratching didn't work, it was like, I properly cut up my arm, through just constant scratching. I then tried other ways of self-harming, and again, the pain just, it didn't bring anything, I was still far too numb […] And then I thought, you know what, this is not how to live life, and that [suicide attempt] felt like the only option.

There seemed to be a sense of momentum through Amber's story in which self-harm played a dual role. Initially, she described self-harming as a way to try and resist suicidal thoughts. However, when this failed to provide the anticipated relief, it instead became a step in the escalation of harmful acts in her trajectory toward a suicide attempt. Despite this, Amber still maintained that ‘self-harm worked’, and felt that self-harm had been a useful tool for emotional regulation during other instances of feeling suicidal.

Self-harm has been explored as a tool for emotional regulation, reducing negative affective states (Laye-Gindhu and Schonert-Reichl, 2005; Mikolajczak, Petrides and Hurry, 2009; Paul *et al.*, 2015), and can be understood as a practice of self-care (Chandler and Simopoulou, 2020). Envisaging self-harm as an agentic practice enacted to emotionally self-soothe, allows us to understand self-harm as a tool through which young people find ways to regain some control in situations that feel unmanageable and over-whelming (Chandler, 2016a; McDermott, Hughes and Rawlings, 2016). Consistent with this conceptualisation, participants in this study reported enacting self-harm as a preventative tool to de-escalate suicidal distress. However, in reflecting upon this, participants often articulated that they thought this unusual or undesirable.

> Andrew: At the time I think it was like it let me cry. It kind of made everything I was feeling in my head almost feel visible, which for me at least I’d convinced myself it made me easier to feel it and get rid of it; because when it was all just locked up in my head it would just build; so it almost felt like a way to convert that mental energy into physical energy and be able to be upset about it, cry about it, and then call it a day. Which, I don’t know, I think I convinced myself that it works on a few occasions; I don’t know if it did. I think it’s quite scary if I turned around and said it did, so…
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> Archer: She [the educational psychologist] was like, what do you do to stop yourself from trying to commit? And I was like, well obviously I just self-harm. And she’s like, well you can keep doing that then. And it was just, sort of like…should you actually be saying that? Like, I was just confused and sort of like angry that she said to keep doing something that was so bad for me. Like, ‘cause everyone I've talked to is like, oh you shouldn’t self-harm. And then she was suddenly like, yeah, keep self-harming.

Andrew and Archer expressed a dualistic interpretation of their self-harm practices. They positioned self-harm as an effective tool for regulating suicidal distress, as well as an undesirable act that both themselves and those around them wanted eschewed. There was a clear tension for both participants between the role they had found self-harm to play and the role they believed self-harm should play. This may be rooted in the multiplicity of both contradictory and complementary understandings of self-harm across clinical, research, and social settings. For example, experience of self-harm is established in research as increasing the likelihood that an individual will also experience suicide behaviours (Whitlock *et al.*, 2013; Franklin *et al.*, 2017) and as discussed in Chapter One is the subject of social stigma (Lewis, 2016; Hasking and Boyes, 2018). However, it is also seen as a possible way of taking care of one's self, regaining control over one's life and deescalating emotional distress (Laye-Gindhu and Schonert-Reichl, 2005; Mikolajczak, Petrides and Hurry, 2009; Paul *et al*, 2015; Chandler, 2016b; McDermott, Hughes and Rawlings, 2016; Chandler and Simopoulou, 2020).

Archer's narrative around self-harm explicitly reflects upon this tension. Whilst he felt that self-harm had at times kept him safe from suicide, he reported that others around him had encouraged him to stop self-harming. Therefore, when they interpreted their educational psychologist as not immediately encouraging him to stop self-harming, he reported feeling 'angry' and 'confused'. His narrative suggests ways in which pluralistic understandings of self-harm can be troubling to those looking to get well. Similarly, Andrew stated that it would be 'scary' to recognise self-harm as de-escalating suicidal distress. He described the relationship between the physical action of self-cutting and the emotional experience of distress, positioning the act of self-harming as almost a bridge between them, providing a physical catalyst for emotional expression.

In work on the corporeality of self-injury, Chandler (2016) discusses how clinical and academic literature as well as social narratives, have reified self-harm as a tool for transforming emotional distress into physical pain. As a result, self-harm is now often understood as a method of distracting away from and coping with emotional pain, drawing distress out of the mind and inscribing it on the body. In Andrew's account we witness this explicitly in his description of self-harm as a method of 'converting' mental energy into physical energy, making 'visible' the emotional pain that was 'locked up' in his mind, and in doing so enabling him to cry as a way of emotionally processing.

It is important here to consider whether gender plays a role in interpreting Andrew's account of self-harm. The pressure for men to be seen as emotionless to conform with norms of hegemonic masculinity (Connell and Messerschmidt, 2005), has been identified in both societal narratives and academic literature as a contributor to low levels of help-seeking amongst men, and ultimately to the disparity between male and female suicide (Player *et al.*, 2015; Sweeney, Owens and Malone, 2015). This notion expressed by Andrew that physical injury, albeit through self-harm, allowed him to cry, could be interpreted as consistent with this literature. However, it also appeared consonant with other participants' accounts of self-harm's role in emotionally processing, and thus de-escalating, suicidal distress. Participants' understanding of self-harm appeared to express that the link between self-harm and suicide attempts was as a tool for emotional regulation, and not as necessarily a contributory factor. Although, as expressed by Amber, when this method of de-escalation did not work, its role could transition and become part of a suicide attempt.

4.3.3 Defining a suicide attempt

As discussed in section 4.3.2.1, it was understood that the boundaries between self-harm and suicide attempts could, in some instances, blur. However, other participants articulated an almost criteria-like way of classifying suicide attempts conceptualising them as active, intentioned, and following a clear plan. For example, Laura described 'reckless' behaviour which she associated with her experiences of depression. As a teenager, on her way to school, she talked about walking into traffic with her eyes closed:

> Laura: I didn't really feel joy in my life at that point, like I didn't feel like I wanted anything else. But I wasn't going to actively do anything, I was just going to set up situations that something could happen, hence the closing my eyes and stuff.

Laura recognised that the setting up of these situations was related to her suicidal feelings and articulated this as the first time she was affected by suicide. However, it appeared important for her to make the distinction that she was not 'actively' trying to attempt suicide, although she recognised that she was putting herself in a risky position. I interpreted her language as echoing the type of ambivalence about living or dying discussed in section 4.3.2 (Kovacs and Beck, 1977; Bergmans, Gordon and Eynan, 2017), again presenting evidence of the challenges there are to neatly classifying suicide attempts.

Damian reported three suicide attempts by drowning. He had picked a spot, visited it, taken off his clothes (as he wished to die naked), but had aborted all three. He reflected in the interview that he now realised that two out of the three times, his attempts would not have been lethal due to the water's depth. Whilst Damian explicitly conceptualised his experiences as suicide attempts, others with very similar experiences did not. For example, both Euan and Leo had constructed detailed suicide plans, in Euan's case purchasing and unpacking necessary equipment for his chosen method. However, both these participants considered these to be suicide plans, rather than attempts. I draw attention to these differences in interpretations, not to question the validity of participants' understandings of their experiences, but rather to serve as a reminder of the existing variation in language used in conversations about suicide. Whilst researchers might presume a common understanding of how people use language to label their experiences, without taking steps to explicitly check, we have no guarantee this is the case.

4.4 Understanding suicide as….

Once I felt more confident that I had a better understanding of the ways in which participants' used language to describe their experiences of suicide, I sought to consider how they made sense of the role of suicidal thoughts and attempts in their lives. When detailing stories of suicidal distress, participants tended to focus on what had happened rather than how they had felt, and so to try and draw this out I explicitly asked them about their feelings at times when they were thinking about or had attempted suicide. These understandings are not mutually exclusive, but moreover representative of the multiple, over-lapping ways in which participants came to understand their own lived experiences of suicidal thoughts and attempts.

4.4.1 A surprise or loss of control.

Despite long histories of suicidal thoughts, participants often described suicide attempts as impulsive or with some level of surprise. Although participants described complex clusters of contributory factors (which will be discussed further in Chapter Five), for some there was a single critical incident they saw as a catalyst for their suicide attempt.

> Ayla: I feel like it was like multiple things were happening at the same time and then this one little drop made me do it [about the overdose discussed in 4.3.2.1].

> Meryem: I don't remember exactly what triggered it. I'm pretty sure it was, I got a real anxiety inducing message, like a text message from someone, and I was just like, well my life is over, I'm going to fucking die. My life doesn’t matter anymore, like, nothing is going to get better, like it's all downhill from here. Obviously, not true, I was 15, and admittedly, it was a pretty bad message, and it brought back some bad stuff, and like okay, my life was not over, but it was, you know. And then like, I was just like, ha-ha, I have so many pills out right now. Because at the time, my parents let me have medication in my room, because I wasn’t leaving my room. And if it was there, I would actually take the pills. So, I basically just downed everything.

Meryem described her suicide attempts as part of a series of ‘impulsive’ reactions, where she would react in quite a fast and extreme manner to a problem. Impulsivity is a trait that has been of much interest within suicide research, although the relationship between this personality trait and suicide risk is complex and not yet fully understood (Baca-Garcia *et al.*, 2005; Zouk *et al.*, 2006; Klonsky and May, 2010; Gvion and Apte, 2011). Meryem attributed her own impulsivity to frontal lobe damage to her brain. However, this notion of an impulsive or surprising suicide attempt was shared by other participants. Participants often clearly articulated the circumstances in which they had begun to feel suicidal and the management strategies they had engaged with in order to try and keep these feelings under control. However, when participants told their stories of attempting suicide, these were often narrated as a loss of control:

> Isabel: I had these, like, moments…I don’t know, it’s just where I don’t feel like I’m myself, like I’m watching over myself.

> Amber: I struggle to, like, I can recognise that I'm going down a dark path and I need to do something, but once I step over the threshold, it's very hard to then stop myself, because I have, it's like you don't have control of your own body after that.

Isabel’s description of watching over herself was also used by Ayla. Similarly, a sense that suicide attempts were confusing acts or moments in which participants’ bodies were out of control were used widely. Amber expressed that at times where she was attempting suicide she felt ‘totally irrational’, whilst

Sophie described waking up after attempting to hang herself thinking ‘what the fuck was that about?’, and Lynsey described the moments after her suicide attempt thus:

> Lynsey: The thing is the minute…so I took, as I said, an overdose both times and both times after I’d taken all these pills, the minute someone came and spoke to me, I was like, oh god, what have I done? Like that was really stupid.

In Lynsey’s case this sense of losing control may, in part, be linked to her alcohol consumption at the time of both her suicide attempts. However, no other participant mentioned being intoxicated at the time of a suicide attempt.

For the aforementioned participants there appeared to be a disconnect between their thoughts after, and their actions during the attempt, perhaps supporting the idea of a ‘suicidal mode’ discussed in 4.3.2.1 (Brüdern *et al.*, 2018). Many reported a strong sense of their bodies being outwith the control of their minds during these moments of crisis. The notion of the rational mind losing control over the unruly body has been explored using a Cartesian lens in Chandler’s (2016) work on self-injury. Chandler argues that conventionally western society interprets the mind and body, emotional pain and physical pain, as highly separate. She suggests that in order to achieve a more holistic understanding of self-injury, researchers need to conceptually dismantle this separation and acknowledge self-injury as a necessarily and essentially embodied practice. I offer that a similar interpretation can be applied to the narratives of attempting suicide in which participants described almost entirely severing the mind from body. In these, they described the mind as the rational self that despite suicidal distress was unwilling to act in a life-threatening manner, and represented the body as breaking free of it, autonomously going ahead with the suicide attempt.

In each case participants articulated clear, often linear, chronological stories of the development and escalation of their suicidal distress; again preserving the rational nature of the narrator. These were interspersed with methods enacted to keep them safe and factors they perceived as preserving their wellbeing. However, when participants moved on to describe their suicide attempts these were often presented as a surprise, a loss of control, or an irrational act. Narratively, distancing their attempts from the long histories of emotional and suicidal distress that most of the interview had focussed on. One possible interpretation of the disjoint in participants’ narratives could be attributed to the time elapsed between suicide attempt and the interview, which was often in excess of a year and in many cases multiple years. Given the time elapsed, participants may have forgotten their past selves’ desire to die as a coping mechanism to deal with a painful time in their history. Alternatively, participants may have retrospectively reinterpreted their role in their suicide attempt (Hart et al., 2013). Potentially influence by suicide stigma (as described in Chapter One), participants may have wanted to create narrative distance between their current self, as a rational agent and narrator of their interview story, and their past actions as out of control, suicidal bodies.

Conversely, this disconnect may also be understood as a type of disassociation. Disassociation is used to describe an embodied state of cognitively detaching one’s mind from body and losing control over one’s physical actions (Orbach, 1994). This can happen in response to unbearable emotional pain (Orbach, 1994; Levinger, Somer and Holden, 2015). In section 4.3.1, I discussed how suicidal thoughts can sometimes offer temporary emotional respite from what can often feel like constant unbearable emotional pain (Kleiman et al., 2018). Suicidal dissociation can be understood as the physical counterpart to this. As discussed in Chapter Two, reducing one’s fear of both pain and death is stated in key theories of the development of suicide behaviours as a crucial transition from thinking about to attempting suicide (Van Orden et al., 2010; O’Connor and Kirtley, 2018). It has been suggested that disassociation may act as a critical mechanism for reducing one’s fear of physical pain (Orbach, 1994; Levinger, Somer and Holden, 2015). Therefore, the notion expressed by participants of separation from, or losing control of, their bodies may describe the embodied moment of disassociation through which fear of physical pain is decreased and capability for suicide is increased.

4.4.2 Numbness and social disconnection

Although for some participants, a suicide attempt was presented as a surprise or a loss of control, a moment in which physical actions were perceived as discontinuous with their thoughts and emotions. For others, suicidal thoughts and attempts were expressed as part of the progression of emotional distress.

Participants described an emotional cycle that began with a period of feeling highly distressed, overwhelmed, struggling to cope, and ultimately feeling suicidal distress. This was followed by a period of emotionally ‘feeling nothing’ or ‘feeling numb’, during which participants felt more actively suicidal. Expressions of emotional numbness have been explored as part of the process of disassociation associated with feeling suicidal (as discussed in 4.4.1) (Orbach, 1994). Due to the wide usage of phrases such as ‘feeling numb’, ‘feeling neutral’, ‘feeling nothing’ amongst my participants as my interview practice developed, I became interested in asking people explicitly what they meant when they said this and how they responded to these feelings. For some this sense of numbness or nothingness was disconcerting.

> Eilidh: I just don’t feel anything and I think that’s a lot of the problem that I kind of panic because I’m like ‘I don’t feel anything’. And I go through phases like this time last year I was really emotional and cried every single day and then I got really depressed and was like I haven’t cried in like months, like what’s wrong with me. I think I was just getting really panicked about it and people were being like ‘what’s wrong?’, and I was like kind of ‘nothing’. So I think everyone was like oh you must feel really sad and I was like not really, like I just don’t feel anything.
>
> Archer: It was just, sort of like, I was in my own space and I couldn’t do anything to get out. It was very overwhelming, very claustrophobic at times, I just, sort of, sat in darkness and stared at a wall for ages. It’s just, sort of, that feeling of just nothingness.

Both Eilidh and Archer experienced high levels of distress followed by a period of feeling ‘nothing’; a pattern echoed by other participants. It seemed for some that numbness was an emotional response to prolonged periods of complex and intense negative feelings. Furthering this, Jamcake described numbness as a way to stop themselves from having to deal with other painful emotions; positioning it as a defence mechanism:

> Jamcake: I think I felt, just kind of numb, at that point, or I stopped feeling, because my depression was like, yeah, I'm not dealing with this [parental negative response to name change after coming out as trans], goodbye feeling.

However, Jamcake also felt that it was at this point that her suicidal thoughts started to ‘snowball’. This adds to the findings discussed in section 4.4.1, where participants explicitly articulated the manner in which they experienced a disassociation of mind from body, which I argued could play a role in acquiring capability for suicide (Orbach, 1994; Levinger, Somer and Holden, 2015). Here however, participants describe an emotional disassociation, in which they experience a numbness as they emotionally disconnect from their own feelings of unbearable distress as they become more actively suicidal. These suicidal thoughts are in contrast to the emotional respite discussed by some participants in section 4.3.1, in which a positive affect was experienced (Holmes *et al.*, 2007; Selby, Anestis and Joiner, 2007; Hales *et al.*, 2011; Crane *et al.*, 2014; Kleiman *et al.*, 2018).

Whilst for Archer, Jamcake and Eilidh numbness was described as the emotional endpoint of escalating distress, for others numbness was actively engaged with in attempts to disrupt feeling numb with acts of self-harm.

> Lewis: The first time I felt suicidal must have been about 13, 14, didn't really know what it was, to be honest, didn't know what suicide was, I just was like, I don't really feel anything, so like self-harm was a way to feel anything, like to feel that I was actually still alive, like because of just constant numbness, you're like, am I really alive, can I feel things? Because I don't think I can feel anything, so even just pain is like, okay, I'm still alive, seeing blood, still bleeding, my heart's still working, still here, but then that becomes into a habit, and it's like the only way to feel. Don't want to do this. And because like nobody had really noticed, and I was like, well, nobody would really notice if I wasn't here then. Yeah. Kind of ran away for like three days and nobody really noticed.

Here Lewis' account of self-cutting positioned self-harm as a way of seeking an embodied confirmation of existence for himself, a physical confirmation that he was still alive, as well as inviting a response from those around him. Existing research has argued that self-harm, as well as being used as an emotional release, can also act as a tool for sensation seeking, allowing people to feel something (anything), when otherwise they feel numb (Paul *et al.*, 2015). Furthermore, it has been proposed that this can have a grounding effect and serve as a tool to disrupt disassociation (Hunt, Morrow and McGuire, 2020). The use of self-harm by Lewis is starkly different to the role of self-harm described in section 4.3.2, where self-harm was positioned as either blurred with suicide attempts or used as a preventative tool used to de-escalate suicidal distress.

This therefore emphasises the importance of plural and nuanced understandings of the relationship between self-harm and suicidal distress.

Another important feature of Lewis' account was the interactive position that self-harm and suicide seemed to occupy. Lewis appeared to describe each of his actions as a step on a trajectory escalating towards attempting suicide, in response to what he perceived as a non-response from those around him. Key to this seemed to be variations of the phrase 'nobody really noticed', from which he concluded that if he attempted suicide this would also not be noticed. This was echoed by both Amber and Andrew, who also forged a connection between feeling numb, thinking about suicide, and a desire for existential confirmation.

> Amber: I think it was numbness. I think, for me, when it comes to suicide and suicidal thoughts, it's because I don't feel anything. It's like, I don't exist, it's like I'm looking in on my life and I see all the crap, and I'm like it doesn't seem to be getting better, therefore why continue?
>
> Andrew: I never fully, I never completed an attempt or anything like that, but it was something that would linger in my mind, the kind of existential questions, like who's going to notice, and what else was it? What difference is it going to make, those kinds of existential questions.

Following on from this, Meryem described herself visualising how others might respond if she re-attempted suicide, for example visiting her in hospital. Although she described these thoughts as intrusive and as 'egging me on in a really toxic way', it perhaps suggests that for her, suicide played a role in affirming that her existence mattered to others in her life. Meryem was the only participant to mention visualising her suicide attempt and the aftermath in this way. However, the importance of visualising suicide attempts, one's own death, and deathbed scenarios has been identified as an under-explored and potentially important element of acquiring the capability for suicide. For example in Holmes *et al's* (2007) work they have argued that clinically, great weight has been given to assessing whether patients have detailed, intentioned suicide plans. Conversely, less attention has been paid to flash-forward visualisations of suicide attempts and related scenarios, which they found also significantly contributed to increasing suicide risk.

Participants' existential questions could be interpreted at face value, situating self-harm and suicide as an embodied check on participants continued physical existence despite on-going feelings of numbness. However, I suggest that they can be further understood as questions about whether participants' existence mattered *to others*. Dating back to Durkheim, (1897/1952) social connectedness and isolation have been central to explanations of suicide behaviours. They maintain a position of importance in both Joiner's Interpersonal Theory of Suicide (IPTS) and O'Connor and Kirtley's Integrated Motivational Volitional model (IMV) through the concept of thwarted belonging. In this study, the relationship between feelings of social dis/connection, belonging and suicide were widely reflected upon. Therefore, I interpreted the relationship forged between participants' existential questioning and their suicidal distress as a response to their acute experiences of social rejection, isolation and a lack of belonging (these will be examined in depth in Chapter Five). In contrast, participants who reported having established, supportive social connections, reflected upon this connectedness during times of suicidal crisis as helping them resist attempting suicide. For example, Stromberge wrote notes to friends and loved ones to leave after his death. Although this began in what he described as a 'morbid' manner - as he intended to leave the notes behind when he attempted suicide - the process of writing the notes served as a reminder of all the people that would miss him, helping to keep him safe.

4.4.3 An escape

Entrapment, along with defeat and humiliation, are key constructs within the IMV model used to explain the development of suicidal thoughts and behaviours. Participants' experiences of social isolation as well as of rejection from their families, friends, peers, and local communities (further detailed in Chapter Five), could be classed using the IMV model as experiences of defeat and humiliation. Furthermore, feelings of internal entrapment, which are characterised as the desire to escape from one's own thoughts and feelings, and external entrapment, characterised as the desire to escape from unbearable situations, were clearly present across the sample (discussed further in Chapters Five and Six) (De Beurs *et al.*, 2020). Many articulated difficulties imagining their own futures, due to challenges in education or around their LGBT+ identity. Although over time participants had often been able to find other ways to change their circumstances, many had, at times, experienced a narrowing of their options and referenced seeing suicide as an ‘easy’ way to escape feelings of being trapped.

> Harley: I'm just like this is bad, this is awful. I just could do it, there's so many ways as well just within my own household. And I know that's probably not a great way of thinking, to be perfectly honest, but that's just how it feels. It feels like no matter how much I breathe I'm just not getting enough air. Do you know? I guess that's the best way to describe it. It's kind of like not forgetting who you are but if you've ever watched like a spy film and they are on the run or something and they're looking behind them at every moment, that's kind of how it feels. It feels like I'm running away from something and I don't know what it is.

Here Harley describes suicide as a way of running away from a life that she found unbearably suffocating. It is important to note however, that this was not a reaction to a specific incident, but rather a response to an adolescent life that she was struggling to bear. The connection between suicide and running away was also made by Meryem, Alex and Lewis.

> Alex: there were times when I wanted to run away because that was like…it was like this will be a quick and easy way to get out of the situation where I feel trapped or I feel, like, alone, almost guided by just getting out of the situation.

Alex described a sense that his suicidal feelings in adolescence were somewhat related to, and possibly an extension of, his earlier desire to run away from home. To me, this suggested that both his suicide attempt and running away were rooted in a desire to escape a situation that he found intolerable, again appealing to a notion of external entrapment. When he was younger, he stated that this had been motivated by a desire to escape emotional and physical abuse at home from his mother, bullying at school, and a general sense of not fitting in with his peers. As an older adolescent, he related it specifically to feeling trapped in his medical transition, without which he felt that his life was going to be ‘entirely pointless’, and he increasingly thought about suicide.

There appeared to be a particular sense of entrapment that participants associated with their LGBT+ identity. For example, those desiring but struggling to access medical transitions expressed feeling ‘stuck’. Long waiting lists for initial appointments, followed by protracted processes to access gender-affirming medical treatments have been identified as having a detrimental impact on trans people's mental health (Bailey *et al.*, 2014; Ellis, Bailey and McNeil, 2014; Dhejne *et al.*, 2016; Carlile, 2019). This may particularly be the case for trans young people for whom longer waiting times may diminish the effectiveness of hormonal treatments (Carlile, 2019). This situation, could once again be seen to contribute to a sense of external entrapment, feeling confined within a situation over which participants had little control.

> Lewis: transitioning felt like a different dimension, like it wasn't possible, like I would never be able to be free as such, kind of felt as if it was a cage that I couldn't get out of. So, kind of the last resort was…. The only way to escape it…

However, by the time of the interview, Lewis expressed experiencing a much greater sense of wellbeing. He had both experienced many elements of his desired medical transition and described it having been 'years' since he had thought about suicide. However, several other participants were still going through the process of seeking to access medical transitions, and expressed experiencing practical difficulties and emotional distress while doing so, which will be further explored in Chapter Six.

Although there appeared to be a sense of external entrapment associated with medically transitioning, for other participants, both trans and cis, there was a further sense of external entrapment around familial non-acceptance of LGBT+ identities.

> Lily: Yes, definitely through this rollercoaster of emotions and everything there have been times when I've just been like, oh, if I just ended my life it would just stop everything […] No one would have to deal with it, no one would have to be like, oh, we've got a gay daughter – no one would have to deal with it, it would just stop all the problems. I felt like that was the only way out of it all was just to like disappear.

As will be discussed at greater length in Chapter Five, Lily's family had not been able to come to terms with her sexual orientation and as a result she had begun to see herself as a burden upon them. In section 4.4.2 suicide was interpreted as responding to the call of social rejection, with an embodied questioning of the value of participants’ existence as a response. In this section, I interpret participants as offering a somewhat less interactive alternative. Lily appeared to have come to understand herself as a burden to her family, largely because it was indicated to her that she was. It seemed that she had come to understand suicide as both a way for her and her parents to escape a situation that was perceived as irresolvable.

The conceptualisation of suicide as an escape from familial non-acceptance appeared in many cases to be motivated by a perceived immutable conflict. Many participants who faced a queerphobic rejection, often perceived this reaction as unable to be changed, frequently because it was presented as such, even if later revoked. Given the central importance of LGBT+ identity to participants’ senses of self (see also section 2.5.3), this type of rejection could be interpreted as an ontological denial of a central piece of participants’ personhood. Thus, this conflict could feel irresolvable: with neither participants’ LGBT+ identity nor their families rejection, able to be changed. It could therefore result in participants experiencing ‘tunnel vision’ (Harris *et al.*, 2010), in which suicide was perceived as their only option for escape.

Viewing suicide as an escape was not only the case for participants who had experienced non-acceptance on coming out, but was also the case for Euan who, uniquely in this sample, considered himself to not be out, having only come out as a gay man to his brother and myself as his interviewer. Minority stress theory proposes that concealment of LGBT+ identity due to anticipated experiences of queerphobia can act as a major stressor, detrimentally impacting on individuals’ mental health (Meyer, 2003). This resonated with Euan’s narrative, who expressed an intense sense of shame around his sexual orientation, and anticipated a stigmatising response should he come out. As a result of this anticipated stigma, he articulated a sense of ‘do or die’ about coming out, feeling his only options were coming out or suicide.

4.4.4 Evidence of severe distress

Although thus far I have discussed suicide as somewhat a response to the cumulative weight of difficult life events, for some participants expressing suicidal thoughts to others or enacting suicide attempts served to explicitly communicate their distress. With this understanding, suicidal thoughts or attempts could be positioned as evidence that participants’ mental health had deteriorated to a sufficient level that it should be taken seriously and that they were deserving of support. This is not to say that participants’ communication of suicidal thoughts or attempts *only* existed as evidence of severe distress, nor that they *should* need to demonstrate suicidal distress before receiving support. Rather it is to suggest that given participants’ experiences of unsuccessful help-seeking (which will be further explored in Chapter Six), some participants came to understand evidence of suicidal distress as necessary for accessing support.

The role of suicidal distress as necessary for accessing support was most explicitly expressed by Yasmin. Yasmin described feeling she was treated dismissively prior to her first discharge from Child and Adolescent Mental Health Services (CAMHS). As a result, after securing a second referral from her GP for her ongoing mental health problems, she felt too anxious to attend her appointment. When she eventually got to a place where she felt able to use the service and requested a third referral, she found her GP reluctant to re-refer her due to concerns about non-attendance. In order to persuade her, Yasmin felt pressured into disclosing more information than she felt comfortable with her GP.

> Yasmin: I had to be like I'm going to kill myself if you don't refer me. Like I had to say that to her more than once and I had to talk about like self-harm and things like that I didn't really want to talk about with her, because she had already been dismissive, but I felt this is the only way. You know, I feel like it's like that at the doctor a lot. So, she was quite, you know, snippy and looked down her nose at me, but she referred me in the end.

Yasmin’s disclosure achieved her desired outcome, as she was referred to CAMHS by her GP and developed a successful therapeutic partnership with a new psychologist. Yasmin felt this therapeutic relationship had a profoundly positive impact on her recovery from Post-Traumatic Stress Disorder and in reducing suicidal distress.

Whilst some participants found that articulating suicidal distress demonstrated to others their deteriorating mental health and need for support, this was not always the case. Isabel attempted suicide by overdose three times in one week, presenting to her Accident and Emergency Department for help. She explained this to me by saying, ‘that’s how low and bad I was feeling’, seeming to point towards the three suicide attempts to evidence the severity of her mental ill health at that time. However, this demonstration of distress was not well received by those around Isabel. Whilst she was referred to therapy, which she found helpful; she felt her parents saw her repeated suicide attempts as ‘attention seeking’; a response which may reflect broader social stigma around mental health, suicide and help-seeking (Oexl*e et al*, 2019; Mayer *et al*, 2020; Sheehan *et al*, 2020; Steggals, Lawler and Graham, 2020). This response, she reported, in turn made her feel worse.

It has been argued that active help-seeking is crucial for gaining effective support for deteriorating mental health (Calear, Batterham and Christensen, 2014; Rowe *et al.*, 2014; Labouliere, Kleinman and Gould, 2015). However, participants’ experiences, in agreement with existing research literature, highlighted a paradox. Participants felt that others viewed them to not be sufficiently unwell until they had severely harmed themselves, but when severe harm was done this was often still interpreted as attention seeking rather than as significant of a need for mental health support (Horne and Wiggins, 2009; Chandler, 2016a; McDermott and Roen, 2016).

These paradoxical and stigmatising ideas about help-seeking may have had an impact of participants own self-stigma. Some participants expressed concerns that if they disclosed suicidal distress their loved ones would be worried, voicing a commitment to maintaining secrecy around suicide and self-harm in order to safeguard those closest to them. Others felt that disclosures would somewhat invalidate the authenticity of suicidal feelings. Eilidh strongly argued that privacy was of key importance within her mental health history, which included anxiety, depression, self-harm, disordered eating, and suicidal thoughts. Eilidh used privacy as a tool for positioning her experiences, particularly of self-harm, as different to her peers’ experiences.

> Eilidh: I wouldn’t say they were doing it for attention but like a lot of them did it in a very different way to me […] A lot of my friends were doing it and then they would immediately tell someone and I was not like that at all […] I think back when I was at high school it didn’t help to have all these people being like show-offy about it and things.

Eilidh found her peers' communication of their self-harm to others (friends, parents, teachers and herself) 'showy-offy', and raised the possibility of her peers' behaviour being attention seeking by use of apophasis saying, '*I* wouldn't say they were doing it for attention'. In doing so, she introduced the idea of another individual who might indeed say they were self-harming for attention and distanced her behaviour from the possibility of similar judgement.

Although Eilidh repeatedly emphasised the importance of privacy regarding her mental health, there were contradictions in her account. She gave numerous examples of sharing her mental health difficulties with others. She stated that the peers (from whom she differentiated) often spoke to her about their self-harm specifically because they knew she had self-harmed; she spoke about phoning friends to tell them when she believed that she was going to pass out whilst driving due to restricting her food intake; she mentioned that her friends often became concerned about her self-destructive behaviours; and she said that whilst drunk on 'nights out' she often shared feeling suicidal with peers.

The seeming contradictions in Eilidh's narrative, placing significant emphasis on privacy whilst at the same time repeatedly referencing moments of disclosure, made me question why she had originally positioned non-disclosure as a key difference between herself and her peers. Whilst it may have been the case that she was unable to appreciate the contradiction in her portrayal, this account may also have been an attempt to construct an 'authentic' story of suicidal distress to ward off being labelled as 'attention seeking'. This further exemplifies the paradox of help seeking, where, as Yasmin and Isabel discussed, to some extent they viewed the disclosure of suicidal distress as necessary for accessing mental health support. However, in contrast, once suicidal distress was disclosed, one could experience both actualised and anticipated mental health and suicide stigma, feeling that others lacked empathy for their difficulties and instead interpreted their reaching out as attention seeking.

4.4.5 Strength or bravery

Whilst some participants described suicide as an 'easy way out' or an 'easier option' to escape a life that felt unbearably difficult (as discussed in 4.4.3), both Lynsey and Eilidh positioned suicide as somewhat a show of strength or an achievement. Lynsey regularly experienced suicidal thoughts and had attempted suicide by overdose twice, both times when she was at home drunk. Reflecting on her suicide attempts in the interview, Lynsey commented that she felt she 'was almost too much of, like, a coward or too scared to actually do anything about it until I was drunk'. Lynsey's mention of cowardice here appears to position attempting suicide as a brave act.

Similarly, Eilidh reflected on her friend's suicide attempt. Eilidh described how, due to their knowledge of Eilidh's poor mental health, some of her friends had concealed the attempt from her. In the time that followed, Eilidh noted that her friends behaved strangely and eventually after confronting them they explained that they had hidden the attempt from her as they were worried that she might find it triggering. Although Eilidh had found her friends' attempted concealment very difficult to cope with, she reflected that on finding out about the suicide attempt she did indeed find the experience triggering.

> Eilidh: I was trying to be nice to her and it was all very…while at the same time still being like triggered by it in a way because I was already really suicidal. And I was like she tried and she didn't manage but I was like jealous that she'd tried sort of thing which is like messed up but…

Eilidh conceptualised mental health in highly competitive terms. Elsewhere in the interview, she talked about deriving a sense of achievement and success from knowing that her mental health was worse than that of her peers, friends, and people she connected with via social media (to be further explored in Chapter Five). This method of constant comparison with her friend and her expression of jealousy that her friend had attempted suicide, was consistent across both her online and offline behaviour.

Narratives around bravery and cowardice in suicide have been discussed as having a particularly gendered nature (Jaworski, 2016). Lynsey and Eilidh's stories made me consider why attempting suicide was considered the brave or strong option, whilst actively resisting acting on suicidal thoughts was not. I reflected whether this might once again stem from broader mental health and suicide stigma, which informed the repeated dismissal of participants' mental health (as discussed in 4.4.4). Thus, as a result, attempting suicide was seen by participants as evidence, both to self and others, of the severity and seriousness of mental health difficulties that they were facing. Whereas the management of suicidal distress, as often invisible emotion work, was not similarly valued as proactive or an achievement.

4.5 Discussion

This chapter has focussed on how participants expressed their understandings of the functions and emotions of suicidal thoughts and attempts in order to answer my first research question 'how do young LGBT+ people in Scotland make sense of their suicidal thoughts and attempts?'. Although the trajectory from suicidal thoughts to suicide attempts is at times represented as linear, there is an appreciation that the development of suicidal distress is often cyclical (O'Connor and Kirtley, 2018). This chapter explored participants' accounts of experiencing suicidal distress which often began between the ages of 12 and 14 and then fluctuated throughout participants' adolescence. Although participants in this study labelled some of their early experiences of thinking about suicide as less 'real', 'serious' or 'legitimate' than those they experienced in their later teens due to a lack of intention to act on the former that was present in the latter, I queried this. Participants' narratives and existing literature encouraged me to question whether repeated suicidal thoughts or visualisations of a less 'serious' nature acted to habituate suicidal thoughts. These could be seen to act as a cognitive rehearsal for suicidal thoughts participants did intend to act on, therefore increasing suicide risk (Selby, Anestis and Joiner, 2007; Van Orden *et al.*, 2010; Crane *et al.*, 2014; Kleiman *et al.*, 2018; O'Connor and Kirtley, 2018). As a result, it could be the case that early thoughts experienced by participants as almost irritating but manageable, may be of clinical importance when considering how to prevent suicide.

Participants presented two distinct accounts for the relationship between suicidal thoughts and attempts. For some participants suicide attempts were seen as an escalation from the intentioned suicidal thoughts that had intensified throughout their adolescence. For others, suicide attempts seemed to take them by surprise despite having sustained experiences of suicidal thoughts, and were represented as either a loss of control or an act of impulse. Those who expressed surprise at their suicide attempts, often articulated an acute sense of either physical or emotional disassociation, which I suggest may have reduced their fear of pain and death (Orbach, 1994; Levinger, Somer and Holden, 2015); which is considered key in acquiring the capability for suicide (Van Orden *et al.*, 2010; O'Connor and Kirtley, 2018). Whilst for some the feelings of numbness associated with disassociation were the last thing they felt before a suicide attempt, for others this numbness acted as an alert that they tried to actively resist by seeking out sensation. For these participants, numbness was underpinned by experiences of social disconnection that have long interested suicide researchers. Acts of self-harm and suicide attempts seemed to act as a response to experiences of social rejection that will be further discussed in Chapter Five; they served to call into question whether participants' existence mattered *to others*.

Throughout the interviews I undertook for this project, it became clear that participants who were struggling or who had struggled with suicidal distress (often daily for periods of their life) went to enormous efforts to manage that distress and stay alive. The majority of participants in this study had struggled with suicidal thoughts throughout their adolescence and some from childhood. Over time, the cumulative weight of difficulties in their lives (to be further discussed in Chapter Five) had resulted in some experiencing a narrowing of options and envisaging suicide as their only way to escape (Harris *et al.*, 2010). It was clear to me that many participants did not seem to credit themselves with undertaking what appeared to be hugely demanding emotional work. More validation around the management of suicidal distress was needed to enable participants to recognise this achievement and to encourage self-compassion. This was highlighted in discussions of suicide as an act of strength or bravery, which runs counter to many of the socially stigmatising narratives about suicide as selfish or weak (Oexle *et al.*, 2019; Mayer *et al.*, 2020; Sheehan *et al.*, 2020).

A somewhat linear trajectory can be hypothesised between deteriorating mental health, self-harm, suicidal thoughts and eventually a suicide attempt, with self-harm identified as a significant risk factor for suicide attempts, potentially due to reducing individuals' fear of pain and death (Gordon *et al.*, 2010; Whitlock *et al.*, 2013; Franklin *et al.*, 2017). However, some research suggests that self-harm can in fact play a crucial role in managing distress, regulating emotions, and can be understood by some as an act of self-care (Laye-Gindhu and Schonert-Reichl, 2005; Mikolajczak, Petrides and Hurry, 2009; *Paul et al*, 2015; Chandler, 2016b; McDermott, Hughes and Rawlings, 2018; Chandler and Simopoulou, 2020; Hunt, Morrow and McGuire, 2020). It was clear that self-harm played multiple different roles for participants in this study. For some, the boundaries between self-harm and suicide attempts were entirely blurred. They expressed changing motivations from moment to moment (Bergmans, Gordon and Eynan, 2017), alongside an ambivalence about whether or not they wanted to die (Kovacs and Beck, 1977). For others, self-harm was seen as a tool which in many instances had been helpful in managing suicidal distress. This came with an acknowledgement that when self-harm did not 'work' to soothe participants, it could go on to comprise part of a suicide attempt. Relatedly, there was a recognition from two participants that whilst self-harm had been effective at regulating emotional distress, it was also an unwanted coping strategy that they were keen to find alternatives for. In discussing this, I wish to join the call for more nuanced understandings of self-harm. In particular, when exploring the delicate balance between self-harm for managing suicidal distress, and self-harm as escalating suicidal distress.

In this chapter, I explored the emotions and functions of suicidal thoughts and attempts amongst my study's sample. In recognition of the challenges posed by different interpretations of terminology around suicide and self-harm (Silverman, 2006, 2016), I began this chapter by working towards a shared understanding of language that could be applied to my data and throughout this thesis. I then moved on to examine the role that participants felt suicide played in their life. In recent times researchers have questioned whether established wisdom on the disproportionate burden of suicide faced by LGBT+ young people has impacted on their own understandings of suicide (McDermott and Roen, 2016; Bryan and Mayock, 2017), raising concerns that this may have normalised suicide as a response to queerphobic stigma and shame (Cover, 2012). However, my exploration of participants' accounts on the functions and emotions of suicide did not suggest that they saw suicide as a normalised response to queerphobia. Instead, the response was far more complex, and although queerphobic stigma was often placed centrally in participants' narratives of suicidal distress, this was complexified by many additional contributory factors which I will now discuss in Chapter Five.

Chapter 5 Contributory Factors

5.1 Introduction

In this chapter, I seek to answer my second research question, addressing the contributory factors to suicidal distress identified by participants. As discussed in Chapter Two, existing research has been criticised for focussing on LGBT+ specific factors contributing to suicidal thoughts and attempts, without paying sufficient attention to factors affecting both the general population and young people specifically (Savin-Williams and Ream, 2003; McDermott and Roen, 2016; Bryan and Mayock, 2017; Clements-Nolle *et al.*, 2018). To facilitate exploration of both LGBT+ specific and more general contributory factors deemed important to my participants, I used an open question asking what had contributed to a worsening of suicidal distress, the responses to which will be discussed in this chapter.

To begin, I will discuss participants' experiences of stigma, discrimination, and harassment through community climate, school bullying, and negative reactions to coming out (both anticipated and actualised) as ways in which they experienced social disconnection and entrapment and at times felt like a burden, all of which have been identified as key factors in the development of suicide behaviours (Van Orden *et al.*, 2010; O'Connor and Kirtley, 2018). I will then move onto educational difficulties as both contributory factors to suicidal distress and catalysts for suicide attempts, impeding participants' senses of futurity which has been identified as a motivational moderator in the Integrated Motivation-Volitional model (IMV) (O'Connor and Kirtley, 2018). In the final section, consistent with existing literature (Dube *et al.*, 2001; Miller *et al.*, 2013; Serafini *et al.*, 2015; Fuller-Thomson *et al.*, 2016; Merrick *et al.*, 2017), I will discuss the role of abuse as a contributory factor to suicidal distress amongst my sample. To conclude, I will explore the interactions between these factors which may explain the heightened experiences of suicidal thoughts and attempts amongst the LGBT+ youth population.

5.2 Community climate: experiences of marginalisation as an LGBT+ person

The majority of participants reported directly experiencing queerphobia either in their personal networks (friends, family, peers or colleagues) or from strangers in public spaces. As discussed in Chapter Two, feeling accepted where one lives has been considered important in understanding the development of suicide behaviours amongst LGB young people (Rimes *et al.*, 2018). However, as discussed in section 2.5.3, it has been difficult to define the factors influencing whether a community's climate is considered un/safe outwith direct experiences of harassment and bullying, often due to their subtle and normalised nature (Goffman, 1963; Cover, 2012; Link and Phelan, 2014; McDermott and Roen, 2016). Within this study the impact of everyday reminders of LGBT+ non-acceptance and the associated stigma and shame was described succinctly by Yasmin who said,

> Yasmin: For LGBT+ young people specifically, just societally, if you have a feeling, especially when you're young, that you're not going to be accepted and it's going to be harder for you to sort of move through the world because of your identity, that brings a real feeling of hopelessness.

Participants felt they were reminded of societal non-acceptance of LGBT+ people because they perceived where they lived as inherently narrow-minded; witnessed transphobia in popular culture and the media; were attacked in hate incidents; and experienced everyday reminders of gender norms and cis-heteronormativity. Whilst these factors were not identified as direct catalysts for suicidal thoughts and attempts, they both had a detrimental effect on participants' mental health and provided a context for which many other contributory factors were possible. I therefore argue that it is essential to gain a detailed understanding of the community climate in which participants lived in order to more fully understand their experiences. Furthermore, I suggest that this community climate may have contributed to a sense of 'thwarted belonging' in which participants experienced a sense of loneliness in response to a lack of mutually caring relationships, which, as discussed in Chapter Two, has been identified as an important stage in the development of suicide behaviours (Van Orden *et al.*, 2010).

5.2.1 Inherently narrow-minded.

Many participants had grown up in rural areas or small towns, and often pointed to these settings as almost synonymous with narrow-mindedness, as if it was inherent to the area.

> Damian: there's a sort of ingrained sexism, and racism, and homophobia, within the town, and then people teach it to their children.
>
> Sophie: there's loads of farmers, very stereotypical, but loads of farmers round here that are farming families, or sheltered families, that are quite judgmental, and not very open.
>
> Lynsey: Yes, I kind of…[redacted town name] is the type of place where if you deviate from the norm, the norm being like what a typical idea of what a man and a woman is, you get kind of weird looks, like when I go home now, people stare at me on the street, because obviously I walk about with [redacted physical feature], so it was very…like when I say small-town mentality, it was very, like, if you're different, you were like… it was not a pleasant place to live so…

Although these three participants lived in different parts of the country, they each articulated that where they lived had a shared mentality of narrow-mindedness which they attributed to its size or rurality. For most participants, the suggested narrow-mindedness tended to be tied to sexism, homophobia or transphobia and participants from small, rural locations experienced a strong sense of what was expected of them and judgement if these expectations were not fulfilled. There seemed to be a perception amongst participants that where they lived people were less tolerant than in other (normally non-specific) places. It was often assumed that cities would feel less queerphobic, either because people there would be more tolerant, or because it would be possible for participants to go unnoticed.

> Fiona: like because in the city it's because there's a lot more people you're more likely to run into someone who's got very supportive views of the LGBT community. In [rural home community], like because there's not that many people it's hard to, kind of, network and join people up.

However, a similar inherent narrow-mindedness was described by Isabel who lived in an economically deprived area of a large city.

> Isabel: a lot of people in my high school were quite homophobic, just because of the area we were in and stuff like that.
>
> Hazel: Okay. What do you mean by that, tell me?
>
> Isabel: We live in [redacted]. So, some people around there aren't too open-minded about things.

For participants who felt that their local area was narrow-minded, there seemed to be little explanation around this belief with it presented as factual, as exemplified by Isabel's slightly circular description in the quote above. Although participants did not tend to offer an explanation for these beliefs, it often appeared to be rooted in a type of local knowledge that participants had garnered from everyday looks and comments they received either in the area in which they lived or at school. However, an alternative explanation could be an internalised classism. It has been argued that working class communities have been viewed as inherently less accepting of LGBT+ people, despite no evidence to suggest this is the case, and it is possible that young people have internalised these attitudes about their communities and understood these experiences through this lens (Taylor, 2008; Formby, 2017).

Both UK and international literature has suggested that LGBT+ people migrate towards places they perceive to be more queer-friendly and that this has tended to mean that they move away from more rural areas and towards cities (Valentine and Skelton, 2003; Frye *et al.*, 2014; Keene *et al.*, 2017). In the UK, it has been suggested that this has resulted in people moving toward places that have more developed 'scenes' (concentrated areas of LGBT+ commercial venues) such as London, Manchester and Brighton (Valentine and Skelton, 2003; Browne and Bakshi, 2013; Formby, 2017). Although the majority of work on UK 'scenes' has focused on England, it has however been noted that there are established scenes in Edinburgh and Glasgow (Taylor, 2008). The notion of urban areas as inherently more tolerant than rural locations has been critiqued. An example of this can be found in Brighton, where despite general consensus positioning it as the LGBT+ capital of the UK (Browne and Lim, 2010), more detailed exploration has identified this as somewhat imaginary, with the LGBT+ friendly Brighton situated in far smaller 'gay ghettos' within the city (Browne and Bakshi, 2013). This was also the case within my sample where despite cities being positioned as more LGBT+ friendly by participants living within small towns or rural locations, for Isabel, who lived in a more economically deprived area of a city, an LGBT+ friendliness was not her reality.

In my sample, perhaps due to the young population, participants had only planned or made moves related to university study. For young people who continue their studies into higher education, moving away to university can be an important transition, but amongst LGBT+ young people, this transition has been identified in research as crucial to many for facilitating coming out and living authentically (Formby, 2015). For youths feeling trapped within queerphobic environments, the transition to university can provide a move away without having to explicitly address the queerphobic conditions in which they are living. However, this of course has classed implications, as it only provides an escape for those who are willing and able to go on in higher education (Taulke-Johnson, 2010; McDermott and Roen, 2016). Therefore, participants who were not in higher education (either because they did not yet have the qualifications or because they did not intend to ever go onto university), often remained in situations that could be difficult (as will be discussed later in the chapter). Furthermore, although the move to university could enable an improvement in participants' living conditions, it was not a panacea. For many there was regular need to return to the places they were from, which meant there was a need to navigate two seemingly separate worlds; for others queerphobia was still present in the places they moved to for university. Consequently, whilst a move to university could provide short-term improvements for some, for many the difficulties remained.

5.2.2 Transphobia in popular culture and the media

Participants also discussed elements of cultural climate that transcended physical location and encompassed the virtual world too. My research was undertaken at a period of particularly heightened media discussion of trans people because of the (2018-2020) Gender Recognition Act (GRA) Reform consultation and deliberation. The GRA defines the process of obtaining a Gender Recognition Certificate (GRC), through which an individual can change the legal gender marker on their birth certificate. At the time of writing, a standard application for a GRC costed £140, and required an individual to submit the following evidence: their birth certificate; evidence they have lived in their acquired gender for two years; evidence of name change where applicable; evidence of any gender-affirming medical interventions if applicable; evidence of a diagnosis of gender dysphoria in the form of two reports from two gender dysphoria specialists; and if married, their marriage certificate along with evidence of divorce, or death of spouse, or alternatively a statutory declaration from their spouse confirming their support (UK Government, no date). This evidence is then sent to a panel who decides whether to grant a GRC. The proposed changes were to move to a self-declaration model of gender recognition that has been adopted in numerous other countries (Sharpe, 2020).

Discussions around proposed reforms to the GRA triggered a broader public discussion, particularly around the rights afforded to trans people through the Equality Act (2010) such as bathroom and changing room usage, as well as services' applications of the single-sex exemption (Sharpe, 2020). As a result, trans young people who participated in the study were particularly aware of the media coverage of trans people and commented on how this made them hyper-aware and hyper-vigilant around their everyday safety. Alex spoke about how this affected his everyday life, for example when there had been a particularly intense period of negative media coverage of trans people, he expected to be misgendered more often and was more concerned about the safety of his girlfriend, who he described as 'visible' as a trans woman, in public spaces.

> Alex: if I'm in the middle of uni, I can go four weeks without seeing a single, like, cishet[39] person. And it's great sometimes, like honestly, it's just like everything's fine, you don't have to worry about any of that. But then you come out of that bubble or that bubble is burst for you by reading an article you were hoping was going to go the right way, and it [the article] not [going the right way].

These concerns were echoed by other trans participants, most starkly perhaps by Stuart, who described the negative media attention given to trans people as 'reinforcing my personal need to stay stealth[40] in most things'. Whilst participants had an awareness that transphobic views were probably only shared

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[39] 'Cishet' a colloquial term used to abbreviate the term cisgender and heterosexual.

[40] 'Stealth is a term used to describe a trans person who passes as cis and chooses not to come out within a particular context as trans (Holleb, 2019).

by a small, yet vocal, minority, there was a sense of danger and a lack of safety for trans young people expressed, and further it appeared there was a perception that caution needed to be exercised when interacting with people and contexts that were unknown. This was summed up by Alex who said, ‘it’s really difficult to have trust in the general public when there is so much [transphobia] spewing around’.

5.2.3 Hate incidents

Although negative media attention had a disproportionate effect on trans participants, both cis and trans participants had a range of examples of homophobic and transphobic harassment in public spaces by strangers. For example, Sophie had experienced a range of homophobic incidents including having stones thrown at her and an incident on a bus where, aged 16, she and her girlfriend at the time had a bible thrown at them.

> Sophie: we got on the bus, and this lady, and we hadn’t even said anything, or we weren’t holding hands, we were just dressed quite, what would be taken as butch. And she flung a bible at us, like it was this wee tiny wee red book, and we turned around and picked it up, and it was a bible. And we just kind of awkwardly handed it back. That was an experience.

Similar attacks were faced by other young people: Andrew reported frequent verbal attacks, particularly when on public transport in the daytime dressed in drag, and a physical assault. Damian had been refused service in a fast-food shop after another young person told the staff that he was trans. Euan had been followed back to his university accommodation by men shouting homophobic abuse after leaving a gay club. These examples were numerous and whilst they usually only happened to each participant once or twice, it was clear that, for participants in this study, going out in public whilst visibly or perceptibly queer came with risks. Experiencing these incidents was presented as unsurprising by participants suggesting, as has been found in other research, that young people normalise and routinise experiences of queerphobia and learn ways to live alongside it (McDermott, Roen and Scourfield, 2008; McDermott and Roen, 2016). However, despite tending to downplay the impact of these incidents, as several participants reported them in their interviews, it seemed that they contributed to a community climate that was not safe for LGBT+ young people.

5.2.4 Gender norms and cis-heteronormativity

As discussed in section 2.5.3, cis-heteronormativity is the term I use to describe the societal valuing of being cisgender and heterosexual as both ‘normal’ and desirable (Marzetti, 2018). Thus, having a sexual orientation or gender identity that varies from being simultaneously cisgender and heterosexual can be viewed as socially undesirable and stigmatised (Rich, 1980; Ahmed, 2006; Ansara and Hegarty, 2012, 2014). It has been argued that subtle reminders of this are embedded in day-to-day comments and questions present in casual conversations, sometimes known as microaggressions (Munro, Travers and Woodford, 2019). For example, the presumption that participants would have different-sex partners, which participants acknowledged was not malicious, still had the effect of communicating heterosexuality as a societal expectation that they had violated, or were going to violate, by coming out. For example, Euan spoke about an office party at his work where employees were encouraged to bring along their partners with the statement ‘guys bring your girls, girls bring your guys’. Euan had found himself emotionally unable to come out or to have relationships and felt that these heteronormative social cues reminded him of how different he was to his heterosexual colleagues, contributing to his difficulties coming out.

Although it might seem unclear at first how this element of community climate might contribute to suicidal distress, as discussed in Chapter Four, Euan had expressed a sense in which his coming out and suicidal distress were tied together. He described feeling as if he would either find a way to come out or die by suicide. Therefore, although cis-heteronormative comments in the workplace did not instigate a suicidal crisis, they did contribute to a community climate which positioned LGBT+ people as ‘other’ and made it harder for Euan to come out, and in doing so created an environment in which suicidal distress was able to grow. I argue that this highlights the importance of not only looking at direct catalysts of suicidal distress, but also at the broader context in which the individual is situated, to more fully understand suicidal thoughts and attempts.

Subtle cis-heteronormative cues reinforced participants’ expectations of queerphobia. Prior to coming out, participants frequently feared that a disclosure would elicit a mocking or disturbed reaction (peers), or a disappointed or angry reaction (family). There was a perception from participants, often because their parents had explicitly communicated it with them, that they were expected to have different-sex partners and give their parents grandchildren. Yasmin spoke about her mum talking to her about having a husband when she was young (prior to coming out), letting her know that she was presumed heterosexual, which she felt contributed to a sense of shame.

> Yasmin: I think any type of gay person is, you know, taught shame. Just in not even in like a malicious way always, but just because society is really heteronormative, less so, you know, as time has gone on. But, you think just through little things, like that only men and women end up together and things like that you think, well that's what we have to do then. […] I've remembered like my mum saying things like, like she never meant any ill, but when I was younger she would say things like, oh, you know, if you have a husband, somebody, but it's not like I might not have a husband, just things like that that was all around you when you are...

Whilst parents are likely to have been trying to take an interest in their child's dating and had simply not considered their child might have a same-sex partner, for participants this signalled that their sexual orientation was going to be a disruption to parents' straight expectations. The majority of participants therefore formed and communicated their LGBT+ identities in contexts where they felt that being cisgender and heterosexual was both the desired and expected life-course trajectory for them. As a result, they experienced stigma and shame in response to their violation of these expectations which, as has been explored elsewhere, can exacerbate feelings of isolation (McDermott, Roen and Scourfield, 2008; Cover, 2012). This, paired with the negative messages they often heard societally, from family, and from peers meant that identity formation co-occurred with an increasing awareness that being LGBT+ was undesirable and unexpected. Consequently, I interpreted that participants' coming out was often experienced as a process of identifying away from societal and familial expectations and into a stigmatised grouping. This affected participants across a range of settings as they often acted to try and avoid experiencing stigma. For example,

> Sophie: It wasn't until, like, two years ago, that I started telling, like, the hospital and stuff, that I had a girlfriend. And like, any time I'd go somewhere to do with, like, gynae, and stuff, and they'd be like, oh is

> there any chance you're pregnant, and every time, I'd be like, no I use contraception. But now I'm like, no, I'm gay, I'm definitely not pregnant.

However, although this has been identified as a coping strategy to try and avoid queerphobic stigma, efforts to conceal one's sexual orientation or gender identity, as a method of navigating or trying to mitigate experiencing discrimination, has been identified itself as a stressor that can detrimentally affect people's mental health (Meyer, 2003). As a result, although in the short-term concealment might work to help participants cope with difficulties, in the long-term it might create additional stress in which young people have to work to navigate contexts in which they are, and are not, 'out'; which will be returned to later in the chapter.

The three participants in the study assigned male at birth (AMAB) explicitly discussed masculine gender norms and the ways they felt they did not fulfil them. Both Andrew and Jamcake felt that they had violated their dads' expectations of what they would be.

> Jamcake: He [dad] was wanting to be very active when he was younger, like, football, skateboarding, and I'm like, I want to sit and play Minecraft in a skirt. And he's like, no, go outside, and I'm like, no.

> Andrew: I think when he'd [dad] got a wee boy he was expecting you to kind of fit the stereotype; and then I started growing up, and you know I like pink, and I liked Totally Spies, and I liked all these things that I shouldn't be liking. And it's like almost every gay guy stuff, so like, you know, I'm forced to do sports, and all that kind of stuff; and then it does just take him a really long time to come round to things, maybe because it's just not the normal.

The pressure to conform to hegemonic masculine gender norms has been identified as a risk factor for worsening mental health, associated with increased incidence of distress and decreased engagement in help-seeking behaviours (Seidler *et al.*, 2016). However, both Jamcake and Andrew although aware of the pressures to conform, had to some extent, rejected them. Jamcake presented her violation of their dad's expectations as a positive character trait, demonstrating independence and that her parents had raised them to think for herself. Although, later in the interview she spoke about how angry it made her for people to tell her to ‘man up’. They felt that, as someone AMAB, she was expected ‘just to be a brick wall’ and not to show any emotion, whether positive or negative, unless there was ‘a really, really, big deal of a reason’, which they found unhelpful and unachievable.

Andrew understood himself to be constructing his gender outwith what was considered normal for a stereotypical boy, yet typical for a gay man growing up (although he now understands his gender to be non-binary). I interpreted this as a process through which Andrew realigned his sense of belonging with a different type of ‘normal’, perhaps drawing on resources of minority coping as proposed by Meyer (2003). The notion of the ‘normal gay man’ was also discussed by Euan, as he did not feel he was normal by gay standards. Euan had experienced attraction to men in his teenage years, but at the time of the interview, aged 21, he had only come out to his brother and to me, as his interviewer. He had also tried to come out to some work colleagues, but immediately took it back and covered it up after his colleagues reacted in a shocked manner and asked a series of intrusive questions. Euan articulated what he believed was ‘normal’ for a man by saying that he wished he just played football and ‘went after girls’. However, he also felt that he did not fit in with other gay men. He articulated being gay as far more than simply who a person was attracted to, and instead saw sexual orientation as also including gender expression and broader interests, which were at odds with how he perceived himself. For him, being gay was at odds with his own self-perception, and he felt that coming out would fundamentally change who he was to those around him.

Euan therefore saw himself as somewhat trapped. He did not want to come out because he felt that doing so would fundamentally change how he was seen by others, particularly as he made proactive efforts to present himself as masculine and straight so as to not arouse suspicion that he was gay. However, he also found it distressing that people assumed he was straight and therefore on the occasions he had tried to come out, people had expressed surprise, thus reinforcing his feeling that coming out fundamentally changed their perception of him.

> Euan: I’m not ashamed but I am ashamed, but I don’t want people to think I’m gay but I want people to think I’m gay. It’s just, you know…

> It’s just trying to navigate, trying to…you know, big aspirations but I just wish it wasn’t a factor, you just wish it didn’t matter or never mattered, but even if that did happen now, my past is always going to bring it down, it’s always going to be like never happy with it, it’s always going to be just bad on myself. That’s why I think…I put down on what I want for the future as coming out, and it’s like I don’t think it’s going to happen, I want for it to happen, that’s what I want for the future, I want to be that perfect image of myself, fully accepting myself, fully happy, but trying to live it? I can imagine it, but I can’t live it. It’s like when I try to go towards it, it feels different than thinking it in my head, and it’s like it’s so much effort, it’s so much work and it’s so…I don’t know how people have the strength to stay out because it’s, like, if I tell my family, whatever they know now, then I have to tell my friends, I have to deal with them doing it, I have to tell my co-workers, housemates, uni mates, classmates, future jobs, future people I meet, it’s always going to keep happening. It’s like you’re never stopped being in that semi-closet phase of, like… I mean, that’s why I kind of regret not fully giving myself to it, like, you know, people are always surprised when I say I’m gay, I don’t know why, but I’m quite proud of that. I’m quite proud, like, yes, they didn’t figure it out. But you know, I don’t want to do that, that’s why I wish I had a really camp voice, really flamboyant where it’s like I don’t need to do that anymore, everyone knows as soon as they meet me. But, I don’t think that’s ever going to be me.

I interpreted Euan’s description as being an articulation of entrapment in homophobic shame, which has been identified as a core construct in the development of suicide behaviours in the IMV model (O’Connor and Kirtley, 2018). Euan wanted people to know that he was gay so that he could stop hiding his sexual orientation and avoid the awkwardness of having to come out and face people’s surprise and questioning. However, simultaneously he had internalised stereotypes about gay men and negative views attached to these that he had heard from peers, colleagues, and friends, and felt proud that he did not fit them. Furthermore, he predicted that the coming out process would be continuous, with the idea of having to come out repeatedly in new contexts to new people seeming unbearable to him. Not only did Euan find it hard to come out in an environment where doing so would force him to give up his straight-passing privilege and open him up to homophobia, he also felt that he simply did not fit in with what he understood to be a gay man; he neither fitted in with what he perceived to be ‘normal’ for gay or straight men.

5.3 Bullying and social isolation

Bullying has been identified as a risk factor for thinking about, attempting, and dying by suicide amongst the wider youth population (Hinduja and Patchin, 2010; Bauman, Toomey and Walker, 2013; Holt *et al.*, 2015; Rodway *et al.*, 2016; Shain, 2016). As described throughout section 5.2, participants were growing up in cis-heteronormative community climates, which queerphobic experiences of bullying appeared to be an extension of. Heightened levels of peer victimisation through bullying of LGBT+ people (Fedewa and Ahn, 2011; Toomey and Russell, 2016; Myers *et al.*, 2020), may mean bullying is a risk factor that has a particularly strong affect amongst this population (Almeida *et al.*, 2009; LeVasseur, Kelvin and Grosskopf, 2013; Mustanski and Liu, 2013; Ybarra *et al.*, 2015). In my study, the majority of participants had been bullied at school, and some explicitly linked this to a decline in their mental health.

> Ayla: up until high school I struggled with bullying, which is like the main reason or like one of the reasons for my mental problems, mental illnesses in later dates.

Some participants felt they were bullied for being perceived to be different to their peers, describing themselves with language that reflected a negative self-appraisal and elements of self-blame. For example, saying they had been ‘weird’ (Leo), ‘a weak target’ (Eilidh), or ‘nerdy’ (Alex). However, for many, the bullying they experienced had been queerphobic in nature.

5.3.1 Bullying about LGBT+ identity and gender non-conformity

Some participants had experienced bullying specifically related to weight, attractiveness, or gender conformity. In particular, people assigned female at birth (AFAB) were punished for not conforming to expected beauty standards, such as wearing make-up, having long hair, and wearing skirts. Ayla explained that her bullies had taunted her for being ‘genderless’.

> Ayla: one of the slurs the guy used was genderless because I hung out with boys as much as I did with girls and like that…and I do [did] not really care that much about my physical appearance, to be honest, when I was like younger but I wasn’t again an exact tomboy because I had [redacted hobby], so I was like in the middle thing, like people were like, ‘what are you?’

In this quote, Ayla communicates a type of unintelligibility due to her lack of conformity to feminine gender expectations. As discussed in section 2.5.3, Butler (2004) has argued that some bodies, particularly gender non-conforming LGBT+ bodies, are made unintelligible by normative societal standards and consequently are perceived as less than human. In asking the question, 'what are you?', Ayla's bully appeared to be doing exactly this, fundamentally questioning her personhood and letting it be known that she was transgressing normative expectations. Similarly, Bun was bullied for 'looking like a boy' in response to a short haircut and was one of two participants who had experienced bullying through unwanted sexual contact. Similarly, Harley was bullied for wearing trousers to school, and had her sexual orientation questioned as a result.

> Bun: I was getting bullied and called a dyke every other day […] It happened a lot at school [having his body touched without his consent], it made me hate my body more and it made me want to cut things off and hurt myself a lot more.
>
> Harley: I had people coming up to me in the corridors, like people that I knew, kind of, like classmates and stuff being like 'gay is not okay, I'm really funny'. This still happens, but used to happen a lot more, like people just call you a dyke. I got called a faggot, I've been called just like generally, ooh, fucking queer and that sort of thing.

It seemed that even prior to coming out, participants who were identified by their peers as being gender non-conforming were often interpreted as having a non-heterosexual orientation and consequently were queerphobically bullied. For these participants, it was not their actions, but their physically embodied selves that were treated as troubling within cis-heteronormative communities (as discussed in section 5.2).

For some participants, this negatively impacted upon participants' self-esteem, appearing to damage their relationship to themselves and their bodies, for others it resulted in physical limitation to their lives. For example, when Archer tried to use the boys' toilets at school he reported being filmed by other boys, which he very understandably found frightening. As a result, they stopped using the toilets at school, and after further transphobic bullying, eventually stopped attending school altogether. Stuart was also transphobically abused at school, with other pupils throwing food at him and trying to insult him:

> Stuart: A lot of the time, it was the younger years [at school] that didn't actually know me as well, that were being a bit of a pain about it. I think there was definitely a small group of them who thought I was a trans woman, and it was very confusing. Especially, 'cause they'd try and call me masculine stuff to annoy me, and it's like, yes, well done.

Whilst in this quote Stuart appears to downplay his experiences of bullying, describing his bullies as 'a bit of a pain', bullying had a lasting impact on Stuart's life. Despite the years elapsed since he had left school, he spoke about avoiding local LGBT+ gatherings, such as Pride, due to the queerphobia he perceived locally, preferring to participate in LGBT+ events and groups in a nearby city instead. Similarly, Andrew and Sophie had both been subject to what Sophie described as 'changing room chat', which involved bullying specific to sharing a changing space with a queer person. As a result, after coming out, Sophie had stopped doing PE, doing detention instead, and was still too nervous to participate in organised sport outwith the school environment because of these experiences.

5.3.2 Intersecting experiences of stigma

In addition to experiences of bullying and social isolation related to participants' LGBT+ identities, participants also reported experiencing bullying and social isolation related to a number of other elements of their identity, such as their disability[41] or class. For example,

> Tam: My disability certainly didn't help with feeling depressed and feeling suicidal because I felt like if I weren't disabled, I would have a better chance with making friends and I would just be a better person.
>
> Eilidh: In late primary school, early secondary school I had a lot of that kind of people just picking on me and stuff. I don't know, I kind of was like, oh, it's fine and stuff, but really it kind of wasn't and people would be like, oh, you're just a bastard child, you smell of smoke when you come in here because your parents smoke fags all the

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[41] Disability is used here in a broad sense to include physical disability or illness, mental health condition, learning difficulty or autistic spectrum disorder.

> time – people who didn't know me but just chose me because I was like a weak target really.

In these accounts both participants seemed to have internalised the societal stigma that they experienced, negatively impacting their self-esteem, with Eilidh describing herself as 'weak', whilst Tam stated that she would be a 'better person' without her disability. For participants including, but not limited to, Eilidh and Tam, these stigma experiences were understood as separate to other challenges they faced such as queerphobia and cis-heteronormativity. However, although articulated as separate and separable, the multiple stigma experiences appeared to work in intersecting ways to compound participants' experiences of social isolation.

Drawing on McDermott and Roen's (2016) work, these participants were subject to normative pressures additional to cis-heteronormativity through which social stigma was enacted. In addition to this, one participant, Stromberge, described the ways in which he considered coming out as a trans person, in relation to his previous experiences of ableist stigma.

> Stromberge: I was kind of figuring out I was trans when I was 14, and that was quite intimidating, might be the word I would use. And so, there was a lot of sort of researching stuff, and thinking, oh my goodness. Because, especially, you wouldn't think it would be related, but because I've grown up [with a sensory impairment[42]], and I also have [a health condition][43], those are both permanent, long-term things, which I've always had to deal with, and they affect how people view you in society. So I almost already had a basis for what it would be like, in a certain sense, in like, a societal sense, in a long-term medication sense, in all those sorts of things, I was like, I know how much weight that already has. And it was sort of that feeling of, oh do I really need, like a third strike, almost, you know, that's what it felt like.

In this quote, Stromberge gives an account that compares both the stigma and medical experiences of being trans to having a health condition and sensory impairment. In doing so, he describes both as affecting how society viewed him, as well as experiencing them as being a 'weight' and a 'strike' against him. In this account therefore, Stromberge not only experienced ableist stigma and

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[42] Redacted for anonymity.

[43] Redacted for anonymity.

anticipated transphobic stigma, these stigma experiences additionally played an active role in shaping his identity development and exploration. Fortunately however, whilst Stromberge had anticipated transphobic stigma, he reported in the interview that after coming out he had experienced less stigma for being trans than he had anticipated. This said, he commented that he often chose not to disclose his trans identity nor his sensory impairment unless the situation necessitated it or he was with people he was very close to, in order to avoid potential stigma, and, as aforementioned, concealing one's identity can itself have a negative impact on individuals' mental health (Meyer, 2003).

5.3.3 Responding to bullying

Experiences of bullying were often sustained, sometimes starting in primary school and lasting throughout participants' secondary education. The impact of bullying on participants' mental health was central to their stories of the development of suicidal thoughts, and were particularly raised whilst describing what had made suicidal distress worsen. Despite this, some participants tried to minimise the impact of bullying, for example saying 'boys will be boys' (Alex) and that it was 'just people being immature' (Lewis). This may be, in part, explained by the cis-heteronormative cultural climate described in section 5.2, meaning that participants anticipated discrimination, stigma, and harassment, accepting it as somewhat inevitable. Leo positioned this as a demonstration of his resilience saying, 'I've always been pretty good at letting it just roll off my back', whilst Eilidh said, 'it's not a big deal, everyone is bullied'. However, when further probed Eilidh described deliberately positioning herself in this way.

> Eilidh: Even now I'm like people can say what they want about me, that's totally not what I really think but it's what I like to put on the show like I don't care what people think about me when I do. And I think that's why I play down the whole thing [childhood bullying] because I don't want people to think that I was affected by something other people like said to me.

Andrew addressed this specifically with regard to homophobic bullying and his identity as a gay person.

> Andrew: It's just your kind of playground kind of gay bullying, kind of gay bashing, if you like.

> Hazel: Okay.
>
> Andrew: Just the usual, it was just like being intimidated, I think I was beaten up a few times, I've been followed home a few times, only run of the mill [laughter]; which is really sad that I say that, but I think it does ring true, it's your kind of run of the mill gay sob story almost. But yeah, that was just really isolating in school.

Andrew made sense of the homophobic bullying he had experienced as part of a normal gay experience of growing up; it was articulated as continuous with his expectations of a queer teenage existence. He had been bullied for 'being gay' long before he had come out. The minimising and routinising of bullying has been discussed as a method of resisting shame and victimhood, and positioning one's self as mature, strong, and proud (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; McDermott and Roen, 2016). This is particularly true in an LGBT+ context, where expressing shame can be viewed as a lack of pride in one's LGBT+ identity, which is almost expected amongst LGBT+ young people (McDermott, Roen and Scourfield, 2008). Through enacting this method of normalising queerphobic bullying, I interpreted Andrew as both depersonalising the bullying he faced, whilst also forging a connection to the wider gay community, allowing himself to experience a sense of community connectedness, despite describing the ways in which he had not belonged with his peers at school.

As a method of navigating hidden shame, some researchers suggest that young people may engage in 'self-destructive' coping mechanisms such as drug use, risky sex (whether risking physical or emotional safety), and self-harm (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; McDermott, Roen and Piela, 2015). In my sample, two participants talked about trying to reclaim their identity from bullies by coming out. In response to questions about their sexual orientation, both Andrew and Harley had come out to try and stop the bullying, with Andrew commenting that he was trying to 'own that [his gay identity] somehow'. They both had hoped that in making this proactive statement, speculation about their sexual orientation would end. Unfortunately, the bullying did not stop for either of them, with Andrew describing his attempt as having 'backfired miserably'.

Despite attempts by some to minimise bullying, bullies' messages had clearly been internalised and continued to impact upon their self-esteem and self-worth long after the bullies had left.

> Ayla: some of the things they said on a regular basis was like, 'you are the ugliest person in the world, like no-one will ever love you', and things like that. Like once I feel like that becomes a thing you hear all the time you believe in it. It's like, although after I finished secondary school, although I didn't hear from them again for a long time, it was like they left but I kind of created this bully that was inside me and like even after losing my contact with them I realised I had the same pressure on me, myself now, like 'why are you like this? You are so ugly. You're never enough!', and things like that.

Ayla had internalised this negative self-appraisal, judging herself very harshly and lacking self-compassion. Similarly, Andrew and Alex spoke about the impact of low self-esteem on their ability to have relationships. Andrew spoke about how he found it difficult to have sex without having 'a few drinks', whilst Alex experienced a pressure to engage in sexual activity, when he realised he was viewed as attractive by others at university, to prove his bullies wrong, rather than because he wanted to.

> Alex: the years of bullying with people being, like, oh, you're going to be one of those 40 year-old virgins, you're going to….relating to all these sort of things, kind of you get to the point where it's like, oh, my God, it's happening to me, I have to make this last [feeling sexually attractive and being sexually active], because otherwise they'll be right.

Bullying had a profound negative impact on participants in this study's lives and worsening suicidal distress, as has been found across the youth population (Hinduja and Patchin, 2010; Bauman, Toomey and Walker, 2013; Holt *et al.*, 2015; Rodway *et al.*, 2016; Shain, 2016), potentially through the mechanism of thwarted belonging (Van Orden *et al.*, 2010; O'Connor and Kirtley, 2018). For many, this was motivated by queerphobia or alternatively by peer sanctioning of gender non-conformity, as has been identified across a range of qualitative and quantitative research (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; Fedewa and Ahn, 2011; Toomey and Russell, 2016; Myers *et al.*, 2020), but could be compounded through other stigma experiences such as classism or ableism.

In section 5.2, I discussed how some people tried to avoid both queerphobia and cis-heteronormativity by moving away. However, in this section, I have discussed how, for some participants, the effects of bullying were internalised, and used as tools for negative self-appraisal. Therefore, whilst moving away was hoped to offer better (less queerphobic) living conditions for those able to do so, the long-term effects of bullying lived on, and for some, were taken with. This may explain, to some extent, why historic experiences of face-to-face bullying have been found to be associated with deaths by suicide (Rodway *et al.*, 2016), perhaps through the detrimental effect that participants reported on self-esteem and self-worth, which some research has suggested can be independently associated with increased suicide risk (Cha *et al.*, 2018; Oginni *et al.*, 2018). As a result, bullying could have an impact on participants' suicide risk long after the bullies were gone.

5.4 Coming out

Coming out was identified by participants as a significant and often difficult process, not aided by the community climate discussed in section 5.2. Coming out was described as an endless process, with people having to come out (or indeed choose to not come out) to any new people they met and in any new contexts they encountered. As discussed in section 2.5.3, coming out and living a queer life has been described by Sarah Ahmed as a process of disorientation. In a world that is organised and oriented around heterosexuality, living a queer life is portrayed as a process of almost swimming against a tide of unrelenting straight expectations, in the knowledge that every time one comes out, it acts as an interruption and disruption to the established order (Ahmed, 2006).

Initial instances of coming out have been identified as a critical time for emotional and suicidal distress amongst LGBT+ young people (Rivers *et al.*, 2018), and this was echoed by my participants. At the time of interview, all participants had come out to at least one person and the majority were out to most of the people in their life. For example, all except two participants (Euan and Fiona) were out to at least one parent. Three participants had unfortunately had the choice to come out removed from them. Both Lewis and Bun had experienced 'outing' by their schools, where teachers had felt obliged to notify their parents about their gender or sexuality. Whereas Stromberge's mother had 'hacked' his Facebook account in order to read his private messages, through which she discovered he was bi.

The coming out process often, although not always, began in participants' early-mid teenage years, and frequently coincided with a deterioration in participants' mental health and, in some cases, the beginning of self-harming. It has previously been identified that the time around coming out (preparing to come out, coming out, and coping with reactions to coming out) can be highly stressful, and therefore can result in an increase in suicide behaviours (Skerrett *et al.*, 2017; Rivers *et al.*, 2018). In particular, coming out to others before the age of 16 has been thought to have a detrimental effect on suicidal distress. It may be associated with increased peer victimisation and it is hypothesised that younger people have fewer resources to cope with negative reactions (Rimes *et al.*, 2018; Ream, 2019). Consistent with the literature, the times immediately preceding and directly after an initial disclosure of LGBT+ identity were discussed by participants as pressure points of stress and distress. During these times, participants were coming to understand and explore their LGBT+ identity, which in itself could be emotionally demanding. However, further to this, as discussed in section 5.2, they were often doing so in an environment that had long told them that being LGBT+ was not socially acceptable. As a result, they negotiated the development of their LGBT+ identity whilst mentally preparing themselves for negative reactions, up to and including rejection, from their closest relationships with friends and family. This was made more difficult as many participants were already experiencing high levels of social isolation due to their childhood bullying, as discussed in section 5.3. This was described by Sophie thus,

> Sophie: So, at one point I would have people at school, my dad, and my brother, all at the same time, with different intents, telling me, you're disgusting, it's fucking wrong. And if someone tells you something enough, you start to believe it, and that's where I was really badly self-harming, or I was staying out late, so I didn't have to go home.

Whilst expectations or anxieties about negative reactions can themselves be stressors that result in negative health outcomes (Meyer, 2003), it is important to note that the expectations participants had of negative responses to their coming out were often fulfilled. The majority of participants had experienced a non-affirming response from someone they had come out to, and positive responses tended to come from friends as opposed to family members. This was not a given however, for example Sophie had experienced rejection within her friendships,

> Sophie: I lost so many friendships. Like, my best friend, [name redacted], like, when we would change in a room or anything, or we could share a bed, and there would be nothing wrong. And then it was like, a personality transplant overnight, as soon as I came out. It was like, even hugging me to say, goodbye, was quite awkward. So, I just kind of cut that tie, there, which was absolutely heart-breaking, we'd been friends for so long […] I've lost a couple of friendships recently, like, especially when we all started hitting the age, where we were becoming sexually active, or having relationships. And one of my, she was such, like, one of my very best friends, and she'd been like sleeping with this guy, and I'd been sleeping with a girl. And she would be talking about it, and talking about it, and I'd be listening, and some of the things, I'm like, oh, and she was telling me other things. And I was like, oh that's how that works. But then when it was my turn to talk, she would be like, oh no, kind of like, hmm.

The lack of reciprocity in listening remarked upon here by Sophie, signalled to her a lack of acceptance of her as a lesbian by her friend, and in doing so fundamentally undermined their friendship for her. Reciprocity in caring relationships (for example with friends, families, partners) has been proposed as a central component in feelings of not/belonging thought to contribute to suicidal thoughts and attempts (Van Orden et al., 2010). In this study, across multiple parts of participants' lives they lacked a level of acceptance from friends, family and peers, that they desired, which appeared to contribute to the lack of belonging experienced by participants.

5.4.1 Navigating negative reactions.

Coming out to parents was of particular concern to participants. In order to navigate the anticipated and actual negative parental responses, some participants described a process of trying to strike the balance between their own and their parents' needs. For example, Stromberge anticipated a vehemently adverse reaction from his mum, but reached a point where he felt he could no longer withstand presenting his gender in a way that made him feel deeply uncomfortable. He described building up the confidence to wear the clothes he wanted and cut his hair short, which he found somewhat alleviated his gender dysphoria.

> Stromberge: There was lots of things which just took a lot of time, a lot of build-up, and it got to the point where I thought, I cannot do this anymore, I need to do something else. Even if that thing is really hard, I've got to do it, because I can't keep doing this [...] Like, with hair, like it was just bothering me so much, that I thought, you know what, I know I'm going to get, like it's going to be hell for however long afterwards with mum, but at least I'll feel better within myself. So I guess, I've got to do it, because I can't keep going on like this.

Stromberge’s mother had an angry reaction to him coming out as trans and the associated changes to his gender. She was particularly concerned about potential long-term (unknown) effects of taking testosterone, as well as having worries that he might change his mind. To try and compromise, he had suggested exploring all the possibilities for non-permanent changes: haircuts, clothes, using different names and pronouns, that would be easily reversible should he change his mind. However, for Stromberge’s mother, this was still unacceptable.

This period of conflict was identified by Stromberge as crucial in the development of his suicidal thoughts. Stromberge described feeling that most areas of his life were very positive, such as his educational achievements, his romantic relationship, and his friendships. However, he and his mother had found it impossible to find an amicable resolution to their conflict over his transition, and as a result he had found himself feeling increasingly trapped.

> Stromberge: I always think you know what, if I work hard, and I put the effort in it’ll work out. Whereas, this was something where I couldn’t even figure out how to work hard, and put the effort in, not to mention, do that and get it to work out you know.

As discussed in Chapter Four, feeling trapped is identified as a core construct within the IMV model (O’Connor and Kirtley, 2018). When a young person begins to feel trapped in a situation where, as described in this quote from Stromberge, they have tried several options (such as the compromises with his mother) but have found themselves unable to find a way to ameliorate a difficult situation, they can begin to experience the tunnel vision that is associated with beginning to see suicide as their only option.

The emotional work of navigating the space between parental satisfaction and young people's own life satisfaction, with regard to sexual orientation and gender identity, has been described by McDermott and Roen (2016) as a 'constrained space'; where the choices that one can make that will allow everyone to maintain wellbeing are extremely limited. This appeared to be the case for Stromberge. He experienced dysphoric distress at having to express his gender in a manner that he felt was understood as female. However, he further experienced suicidal distress in response to the conflict he had with his mother who responded negatively to him presenting a more masculine gender expression. He therefore appeared to express a sense of entrapment between making changes that allowed him to alleviate distressing gender dysphoria, whilst simultaneously trying to minimise the distress this caused to his mother. The feeling of existing within a constrained space seemed to be further exacerbated by some participants' material dependence on their parents either for accommodation (Lily and Archer) or for financial support whilst living independently (Stromberge).

Some participants found queerphobic reactions so difficult to navigate that they came out to their parents at a distance, leaving letters or sending videos, or avoided doing it altogether. Laura's mum had suggested that she should refrain from telling people she was bi, and additionally she experienced her gran expressing homophobic views, not directed at Laura, but more generally. As a result, she tried to minimise their interactions by self-medicating in order to sleep through her visits.

> Laura: when I found out my gran was homophobic, whenever she came over, I didn't want to see her. So, what I did, was, I would just take a lot of painkillers, around eight, so that I would just knock myself out. Which was a very strange way of dealing with it, but it made it so that I didn't have to see them.

Other participants simply chose not to come out in contexts where they felt they would not be accepted.

> Fiona: ...that like just, kind of, realising that [she was bi] ...I accepted it quite quickly, it was just like, okay, so this...like I know this now, but what do I do in terms of like my parents and back home and like the people around me that I've just like left behind. Like here's fine, I can pretend...well, no, I don't mean to pretend, but like

> here it’s fine, I don’t need to come out, but like what about back home?

Fiona had chosen not to come out ‘at home’, describing coming out at university as easier because she was newly introducing herself to people who had already assumed she was attracted to women. However, she had decided not to come out ‘at home’ unless she had a relationship with a woman that she felt necessitated this. She presented her life at university and her life prior to university as ‘two distinct worlds, and two...like two very different places. Very two...two very different mes [sic]’. Whilst the choice to be out in selected contexts and not in others in some ways mitigated the potential negative impacts of coming out, it also created new stresses around the management of two identities and the need to conceal LGBT+ identity in particular contexts (Meyer, 2003; McDermott and Roen, 2016). This reinforced the idea explored in 5.2.1 that some locations were considered inherently narrow-minded, and consequently that people viewed themselves as only able to live authentically ‘out’ LGBT+ lives once they had moved away. However, when they returned they were somewhat pulled back to a previous version of themselves.

5.4.2 Religion

Whilst in the general population religion has been identified as having a protective effect against suicide attempts (Lawrence, Oquendo and Stanley, 2016), conflict between religious and LGBT+ identities has been found to increase suicide risk amongst LGBT+ youth (Gibbs and Goldbach, 2015). Participants who were religious, had been brought up in a religious family, or educated within a faith school tended to have experiences of queerphobia or expectations thereof that were specific to the religion they engaged with or practiced. Nine participants considered themselves to currently be religious (five Christian; one Wiccan; one Satanist; one Muslim; and one unspecified), and a further five discussed a religious up-bringing or faith-based schooling although they did consider themselves to be religious. The idea of being able to change one’s sexual orientation through prayer, therapy, or trying to date partners with a different gender to their own was mentioned by four participants. Euan was brought up within a Presbyterian family, whereas Eilidh was brought up an atheist, and had begun following Christianity of her own volition during her teenage years (although she no longer considered herself a Christian). They both spoke about trying to psychologically convert themselves away from being gay due to the clash they perceived between being gay and being Christian.

> Euan: I don't want to go to hell, and I don't want to…even if it isn't real, what if it is real? And that's what stops me [coming out]. I see other stuff, like the rational thinking, it's like can I kinda brainwash myself out of being gay, and it's like I probably could if I really committed to it. If I really gave myself and obviously it's not a very positive thing, but I could probably get rid of it if I wanted to, if I gave myself fully to it, and it feels like, because I don't, I could have everything I wanted when I was back with like being normal, I could have had that, but because I didn't, it's bad.

> Eilidh: I used to like pray to God, don't make me gay, I'll be like such a good Christian. It's hilarious like none of my family are religious but I was just very like I'll do all these things for you. And that never worked. And I'd be like I'll google at-home conversion therapy because I was like I don't want this.

Although Euan and Eilidh's actions to try and change their sexual orientation were individual, their desire to change their sexual orientation was situated in a perceived Christian non-acceptance of homosexuality, and within a historic legacy of so-called 'conversion therapy': a homophobic practice to change one's sexual orientation to be heterosexual.

The concept of conversion is not a uniquely Abrahamic practice and was, at one time, a mainstream psychological practice (Drescher, 2010, 2015; Carr and Pezzella, 2017). Although it is now widely condemned as unethical in the UK (UK Council for Psychotherapy, 2017), it is still approved of and recommended in some religious settings (Gooch and Bachmann, 2018). An example of this was experienced by Sophie, who was educated at a Catholic school where she was homophobically bullied. Sophie reported having so-called 'conversion therapy' suggested to her by a teacher during a meeting between Sophie, her parents, and her teachers to try and improve things for her at school. Although fortunately Sophie's dad refused, the teacher's suggestion demonstrates that despite being condemned, it is kept alive in some settings.

A perceived lack of Abrahamic religious acceptance of LGBT+ people troubled participants from Abrahamic religious backgrounds. This was particularly the case for those who found that their religion had previously provided them with emotional support in times of trouble. However, some participants had found their religion supportive of their LGBT+ identity. In previous work, the relationship between family perception of religious tolerance of LGBT+ people has been identified as a significant source of LGBT religious youth's distress, and therefore an area in which support is needed (Gibbs and Goldbach, 2015). For example, Harley's mother expressed concerns about Harley's sexuality, believing their religion to not accept non-heterosexual orientations. Fortunately, as Harley had found her church to be very supportive when they had discussed LGBT+ issues as part of their church youth group, she shared her mother's concerns with her youth worker. To try and support reconciliation, the youth worker gathered resources and met with Harley's mother to help her resolve the concerns that she was having for her.

> Harley: Faith is a really big part of my life. The church that I go to is hugely accepting. I could not honestly ask for like a better church to come out to, I guess. So most of the youth leaders know that I'm like…if not bisexual then I'm like generally queer. And one of the leaders actually came and spoke to my mum about how I'm not going to hell, I'm not a bad person and stuff, so now my mum's really chilled with it, which is great.

Although participants frequently anticipated religiously motivated intolerance of their sexual orientation, in some instances their religious communities or relatives positively surprised them and were very supportive. Undoubtedly, this did not ease the period of anticipation prior to coming out, which has been found to be a time in which suicidal distress can be heightened (Skerrett *et al.*, 2017; Rivers *et al.*, 2018). However, it did mean that once the participant had come out and invited a response, they were reassured.

However, for one participant this was not the case. Lily, who was raised in an Abrahamic faith, also described a sustained period of conflict about her sexual orientation with her parents. Due to her religion's views on LGBT+ issues, Lily's family struggled with both their own acceptance of Lily's sexuality, in addition to the integration of this conflict within their religious life, describing her at one point as 'destroying the family' by coming out. Lily had tried to maintain the three relationships, with her parents, her girlfriend, and her congregation, but found this very stressful, describing it as making her feel as if she was leading a 'double life'. Although initially the family attempted to manage the situation privately, a member of Lily's congregation came across her Twitter account, on which she had shared LGBT+ content, and showed it to her church elders. As a result, Lily had a visit from her church elders to discuss her sexual orientation.

> Lily: So then that person found it and instead of going directly to like my dad spoke to another elder in the congregation who then messaged my dad and said do you know that Lily's been posting like political stuff about LGBT rights and posting about some sort of gay relationship she's in, blah, blah, blah, blah. So I come home and everything like blows up again. I'm crying, I don't know what to do, I make my Twitter private just temporarily, I change like the username – everything kind of blew up again. I stopped going to the meetings, elders came to the house to have a chat with me about… like they obviously understood that I felt torn, like that was good, but it was more the fact I was worried that they were going to sit down and be like, right, have you done this, this, this and this?

Lily found this breakdown in her relationship with her church hugely distressing. In tight-knit religious communities where community members are strongly encouraged to primarily socialise together, it has been suggested that the knowledge that friends and family would no longer be able to socialise with LGBT+ individuals in the same way, can be an additional pressure when deciding to come out (Lalich and Mclaren, 2010). This isolation was reflected by Lily; firstly, because it caused conflict in two of her key relationships: her family and her congregation; secondly however, Lily found it quite difficult to make friends which she put down to her shy and introverted nature, where her church had provided a sense of community and a social life. Being unable to attend congregation meetings therefore meant that she was further isolated. She lost her connection to her congregation and the friends that she had within it, whilst also reducing the social activities she could participate in with her family with whom she lived and usually attended church meetings and socials. Furthermore, she also experienced the pressure of knowing that her family experienced stigma and shame in their congregation for being unable to get her to end her relationship and stop being gay. Finally, Lily also commented that her mother had started to heavily hint about Lily moving out of the family home to live independently, which she did not feel financially able to do. As a result of the breakdown in her relationship with her church, I interpreted Lily as, at times, both losing her sense of belonging with her religious community, and perceiving herself to be a burden to her family as they struggled to accept her sexuality, both of which are associated with the development of suicide behaviours (Van Orden *et al.*, 2010).

Even for participants who did not consider themselves religious, religious settings could provide yet another context in which they were rejected.

> Andrew: Definitely the trying to talk to any of any family member about it [his mental health], apart from maybe my gran; especially like my dad, my step-mum, my mum, and my aunt, are all people that I've went to for things like that; and they just don't really get it. As far as I'm aware they've not really been affected by mental health in their own lives, they're all straight and cisgender and they're all just normal people; which sounds so dramatic, but it is, it's true, they've not went through that same kind of rejection from your parents, rejection from school, friends. Rejection from school, I was in Catholic schools as well; they've not went through anything like that. So, like I think a lot of it is just they don't really understand why I'm upset or why I'm depressed; because in their eyes, you know…

In this quote (similar to Sophie's quote on page 162), Andrew describes the manner in which rejection across all the contexts of his life added up, which he saw as a primary contributor to his depression. Furthermore, he describes the unintelligibility of his distress to his family, explaining that they tended to conceptualise wellness through a materialistic lens, assuming that because they had financially provided for Andrew that he would be well. Andrew, however, understood his distress as arising from repeated rejections across multiple areas of his life, and felt that this social disconnection was a more important influencer to his sense of wellbeing. Thus, whilst religion provided some participants with a support network and a setting in which they could belong, for others it could further amplify existing senses of rejection, detrimentally impacting on their mental health.

5.5 Education

5.5.1 Pressure to do well

As discussed in section 5.3, school was a challenging environment for many participants due to school bullying. However, for others it had provided structure, a sense of purpose and achievement, and a place to escape when home life was more difficult (either because of adverse childhood experiences or because of familial non-acceptance of sexual orientation or trans identity). This was the case for Amber, who described school as a ‘safe haven’ for her away from the difficulties that she faced at home. However, school was largely stressful for many participants and, consistent with existing research literature (Hawton, Saunders and O’Connor, 2012; Rodway *et al.*, 2016), was cited as both worsening suicidal distress and for two participants had acted as a catalyst for a suicide attempt.

Archer, Lynsey, Yasmin, Sophie, Stuart, Damian and Isabel all reported difficulties attending school due to their mental health or bullying experiences. Educational success at school was seen by pupils as essential for a prosperous future, and thus failure at school was interpreted as having catastrophic consequences for young people by participants, schools, and participants’ care-givers. Some participants who were achieving highly at school put themselves under tremendous amounts of pressure to maintain academic performance.

> Meryem: I hold myself to high standards. But it was so, it was really, really hard, because on one end, I was like, holy shit, like, got to get into, like, fucking Harvard, or whatever. Like, maybe not there, but you know, like a really good uni, in terms of, you know, Ivy League, Russell Group, that kind of thing. And so I was like panicking, but at the same time, I was so depressed, that like, it was an offset, my anxiety was like, you’ve got to be the best, and my depression was like, nothing fucking matters, I want to die.
>
> Tam: I **was** the over-achieving queer TM[44]. ‘Cause I applied to Ivy League unis, I did the SATs and I put way too much pressure on myself, because I have this awful habit of like, if I can do it, I should do it, even if I start breaking down, but like, I really need to do this, to prove to myself that I can.

Both Meryem and Tam had achieved highly at school and were now studying at university, but had experienced stress related to a pressure to achieve highly. Meryem had suffered massive anxiety related to her educational attainment accompanied by suicidal thoughts from the age of nine. She received treatment for her poor mental health in a residential centre for a year in her teens after finding herself unable to leave her bed even to use the toilet because of her

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[44] TM is the abbreviation used for trademark.

anxieties. She found that her mental health improved significantly after she had received an unconditional offer to university in her last year at school. She then dropped all non-mandatory classes and began to socialise more, describing this period of her life as having ‘no stress’.

Fiona had also experienced feeling trapped in her life circumstances when she lived at home in the North of Scotland. She felt that educational success was the key to her being able to get away, live more freely, and most importantly, being able to access mental health support without her family finding out. She described feeling like if she did not manage to get into university there would be ‘no point’. Similarly Stromberge, who had felt intensely trapped in conflict with his mother over his trans identity (as discussed in section 5.4), had at the suggestion of his school, explored going to university a year early in order to escape his, at times, unbearable home life. As discussed in 5.2.1, for many participants moving away from either a local area, a home situation, or an educational setting was viewed as the only way to escape queerphobia, and within this sample, it was only those participants going to university who spoke about moving away. Consequently, this leaves questions unanswered about how living conditions can improve over time for those who do not see university as an option for them.

5.5.2 Educational failure as personal failing

In a study of the deaths of young people aged 10-19 in England between 2014 and 2015, Rodway *et al* (2016) found that academic pressures, and in particular exam pressures, were prevalent amongst the deceased in the lead up to their death. I interpreted participants’ difficulties in education, whether with a single assessment, a course, or more broadly in their educational achievements, as experiencing a defeat considered to be important in the IMV model (O’Connor and Kirtley, 2018). Furthermore, as discussed throughout this chapter, because for many education was constructed as a gateway to participants’ futures, they expressed a link between educational failure and an imagined failed future and failed self. Continuing the use of the IMV model here, being able to think positively about the future is an important motivational moderator influencing people’s transition from feelings of entrapment to thinking about suicide. In this population, this may be exacerbated where young people see the transition to higher education being their only possible option for escaping queerphobic environments, and therefore an educational setback can trigger profound feelings of hopelessness.

> Yasmin: I think school put far too much pressure on your exams and like, you know, what you will be able to do with your life after you leave, like if you fail your exam that's it, it's over, you know. I know now since I've left that's not the case at all. There's a real, like I felt this and I think a lot of people do, there is a real like sense of your worth is in it.
>
> Leo: especially where I was from 'cause it was very middle class. Everyone's like…you go to...you do GCSEs, you do A Levels and then you go to university, then you get a job and that's it. That's all you do. And that was expected of everyone and if you didn't do that then you were, sort of, a failure, yeah. So it was, sort of…that was ingrained into me from, like, very young. So then having to be one of those people that went to college and had all this, like, pre-notions about college and what that meant if you went was, sort of, very difficult to come to terms with.

Leo and Yasmin both struggled with rigid life-course trajectories that were expected by those around them (parents, teachers, peers), and it had taken them time to come to terms with this when they had struggled academically. However, in addition to stress caused by educational problems, some participants were very anxious about possible future failures even where these were not likely. For example, Harley was achieving very highly at school and was set to apply for elite universities, but for her even the consideration that she might be struggling academically was hugely over-whelming.

> Harley: I hadn't actually finished [a test]. She [her teacher] said you can stay in if you haven't finished yet, my teacher said you can stay in if you haven't finished yet, and I had a study period next period so I was like, oh, I can stay in here. And I was expecting a few more people to be kind of staying behind and everyone got up and left when the bell went, it was just me and I was like I'm a failure, I'm such a failure, why can't I finish this, I don't understand anything.

Many participants cited that experiences and expectations of educational failure worsened their mental health and contributed to suicidal distress. However, for Ayla and Euan, educational difficulties contributed directly to a suicidal crisis: Ayla whilst at school, and Euan after failing his first year at university. Euan described his feelings of failure when he received an email to inform him that he had not passed his first year at university. He had read online about what he described as a ‘suicide bag’ which he believed would give him a ‘painless’ death. He went ahead and purchased the necessary equipment, but after reflecting more on this, he became concerned about the person who might find him and stated that it would be more of a punishment to stay alive.

> Euan: It’s still not a positive thing of me stopping myself, how pathetic, how absolutely pathetic, imagine the person who’s going to find you [description of methods redacted].
>
> Hazel: Okay, and that was what decided that you weren’t going to do it?
>
> Euan: Yes, I felt like it was more of a punishment to go home. It was more…satisfying to see myself suffer rather than just ending it.

Euan’s account in the quote above positions suicide as a punishment for failing his assessments at university, to which he then conceptualised a greater punishment: having to tell his parents about this failure, which perhaps somewhat counterintuitively, kept him safe from suicide. I interpreted Euan’s account of his aborted suicide plan as characteristic of the development of suicidal thinking detailed in the IMV model. However, although Euan began to feel trapped with suicide as his only option, with time he found and availed of another option, going home to his parents, where he lived and worked for a year before returning to education, which he conceptualised as a punishment.

Ayla on the other hand described a moment of crisis when she was informed by email of a problem with some of her schoolwork:

> Ayla: I just like looked at the screen and then it kind of went blank after that […] after that it was like I literally kind of left my body and I started to watch myself from the third person […] I suppose like after I had watched it I just like didn’t give any reaction for a few seconds, like it took me a few seconds to understand what was going on and then like after that I just like remembered just like kind of built and built and built, like it was accumulated for so long and then it was like boom.

It was at this point that Ayla attempted suicide; however the attempt was interrupted, and therefore prevented by her mother. It is important to note however, that whilst Ayla cited the educational challenge that she faced and the associated fear of failure as the catalyst for this suicide attempt, the attempt was situated within a context of many other contributory factors. At the time of the attempt, Ayla was struggling to cope with the illness and hospitalisation of a close family member, anxieties around life transitions, body image concerns (as discussed in detail in section 5.3), in addition to educational challenges which acted ultimately as the catalyst for the attempt. This emphasises that whilst a critical incident like the one Ayla describes can act as a catalyst, it must always be considered within a broader, much more complicated, landscape of contributory factors.

5.6 Abuse

5.6.1 Emotional and Physical Abuse and Neglect

Existing research has well established an association between adverse childhood experiences (ACEs), in particular abuse, and suicide behaviours (Dube *et al.*, 2001; Miller *et al.*, 2013; Fuller-Thomson *et al.*, 2016; Merrick *et al.*, 2017). It has been suggested that LGBT+ young people may face disproportionately high rates of ACEs (Schneeberger et al., 2014; Blosnich and Andersen, 2015; Zou and Andersen, 2015; Clements-Nolle et al., 2018; Schnarrs et al., 2019), however it is unclear if this is due to experiences of queerphobia in the home (as discussed in 5.4). Alex, Lynsey, Bun, Yasmin, Euan, Meryem and Amber all experienced parental abuse, neglect, mental health problems or problematic substance use in childhood, with some of these participants specifically attributing a deterioration during their mental health in childhood to these difficulties.

Lynsey felt that her depression had been triggered by the abuse she had experienced from her dad. Although she had cut off contact with him aged 14, she said that in doing so, she began a process, supported by CAMHS, to deal with the emotional and physical abuse she had faced. Although she had received support, she noticed the same pattern in the romantic relationship she had aged 18, describing herself as deprioritising her own needs in order to appease the men (both her boyfriend and father) who did not wish to emotionally process the difficulties in their relationships with her. She described engaging in abusive and emotionally demanding relationships as taking a huge mental toll on her.

> Lynsey: it was me putting other people first but to a sort of catastrophic extent both times was what kind of got me into a place where both times I was, like, suicide is what I'm going to do now.

Yasmin had experienced emotional abuse in early childhood from her step-father, who had also abused her mum, when she was young. She felt that this experience of abuse had contributed directly to her low self-worth and thus her suicidal thoughts.

> Yasmin: I thought if something, you know, so terrible happened to me so early and it sort of ruined things and set me off to a bad start in terms of life, then like, you know, maybe that means I wasn't meant to be happy, it wasn't meant for me, type of thing. So, that really contributed to suicidal thoughts. So, I remember thinking that when I was a bit like, you know, in this time period. I think, you know, later on when I was like 15, 16, it was the worst. I thought there is no point, it wasn't meant for me so, you know.

Yasmin's experiences of abuse had impacted on her self-worth and self-compassion and described herself as at points in the past, 'really hating herself'. Yasmin had, for a long time, experienced intense shame about her experiences of abuse. It had taken what she felt was a long time to gain a PTSD diagnosis from her childhood abuse which allowed her to begin to access services to process her experiences of abuse and move on from them.

Bun had spent significant time in kinship care: first with his great-grandmother and latterly with his half-brother's grandparents; and in both these situations, described feeling abandoned. Regarding his first move, Bun described his mother saying,

> Bun: 'I'm moving, see you in a couple of months and I'll phone you at the weekend', and I was very confused by it all, and I felt abandoned.

Subsequently he moved to the area in which his mother was living, but lived separately from her in his step-grandparents' home.

> Bun: I lived with my step-grandparents, so they were my brother's family. And they made me aware of it [...] I'd stay with my mum occasionally on the weekend, but my mum was also very mentally…she was very mentally unstable at the time, trying new medication, going through her lot, so when I lived with her, she was

> very abusive. She was traumatisingly abusive, she screamed at me, I was dead to her most of the time.

He reported that his mother, father, and one of his mother's boyfriends were involved in taking and selling drugs during his childhood. As a small child, he was kidnapped by his father during a visitation resulting in police involvement with the family, and he had been made homeless by his mother multiple times. He attributed his self-harming behaviours throughout childhood and adolescence to the abuse that he experienced and expressed a sense of rejection from family, in particular from his mother. For example, he described being physically punished for crying as a child, and as a result, stated that he had started to harm himself with head banging and self-bruising as a management tool rather than expressing emotions verbally. However, he also explained that when his mother noticed his self-injuries, she also physically punished him for this.

Throughout Bun's interview, he consistently expressed a strong sense of rejection whether through the 'abandonment' he described from his mother, or through his perceived lack of support from CAMHS and the GP (to be discussed in Chapter Six). After the death of his great-grandmother, he seemed to experience a significant lack of mutually caring relationships in his life, both within his family and his peer group; it appeared that he had only more recently begun to form positive friendships. Across participants' accounts, abuse was framed not as a reductionist 'risk factor' for suicidal distress, but rather abuse appeared to enact a deeply felt social disconnection through the breaking down of what should have been caring relationships, detrimentally impacting on their self-esteem and self-worth. Although, for these participants, abuse was not cited as a catalyst, it was positioned more broadly as a contributory factor for suicidal distress.

5.6.2 Sexual abuse and assault

Whilst all ACEs are recognised as increasing the likelihood of experiencing suicide behaviours (Dube *et al.*, 2001; Fuller-Thomson *et al.*, 2016; Merrick *et al.*, 2017), sexual abuse has been identified as having a particularly significant impact (Miller *et al.*, 2013; Serafini *et al.*, 2015). Alex, Bun, Tam, Euan, Lynsey, Meryem and Andrew all reported experiencing sexual abuse or assault: all, bar Alex and Lynsey, in childhood. Euan was sexually assaulted aged 10 years old.

After the attack, he returned home, showered, and went to bed and had not disclosed the attack to anyone in his life, feeling they would not have been able to provide support; the assault, however, had a huge emotional impact on him.

> Euan: it's always just been me against the world. It's always really kind of just put everything in perspective for me, kind of like life is always going to be unfair, it's never going to be a fairy tale, it's never going to be just perfect, nothing's going to click for you, Euan, you've got to fight for every moment, and it's just like…

He also discussed how it had made him question whether this early childhood experience of sexual assault had influenced his sexuality and had, at times, 'blamed that for being gay'. There were two themes running through the quote from Euan. Firstly, there is a sense of hopelessness that hints at the challenges he had asking for help from others when he stated 'it's always just been me against the world'. As a child, Euan had taken on caring responsibilities for both his parents and younger siblings. He described feeling that he had not wanted to seek help from others. In part this was due to perceiving others as incapable of helping him, but in part because he felt that he should be able to help himself, which has previously been associated with poor mental health outcomes (Seidler *et al.*, 2016), and finally because he felt that he wasn't worth helping (barriers to help seeking are discussed in detail in Chapter Six).

Secondly however, as Euan had situated his suicidal distress so centrally within his internal conflict about whether to come out, describing a sense that he would eventually either find a way to come out or end his life seemed particularly pertinent. Whilst Euan did not point to the sexual assault he experienced in childhood as directly contributing to his suicidal distress, I questioned whether this contributed to the ideas he expressed around wishing he was able to change his sexuality (discussed in 5.4.2), and to some of the internalised stigma that he felt both around coming out and around intimacy with other men. For example, he described the similarities between sexual assault and potential future intimacy he might experience with other men:

> Euan: I'm quite scared of sex, I think it's probably something to do with trauma but, you know, every time a conversation gets towards something a little more flirty, it's like I don't like this anymore, I'm going to stop doing this, and it's like…always ruins it for me[…] And it's always, you know…something I wish I could experience, you know?

> But…who knows? I always just think about an experience I had in the past and it's like why would I want to do that to myself again? And it's weird because I can't think of it in any other way other than hurtful.

As a teenager, Andrew described having found it very difficult to make friends offline and had struggled to maintain the friendships he had made, which he attributed to his autism. Instead, he had found it easier to socialise through online gaming platforms as it took away the stresses of having to read others' faces and tones. However, it was through online gaming that Andrew had been groomed, which was discovered by his mum and reported to the police who intervened. Andrew, however, both at the time of the incident and at the time of the interview, described the situation as 'really nothing' and the response as 'a really big over-reaction'.

> Andrew: I was kind of pushed towards the internet looking for people to engage with and to connect to and talk to; then I felt it just kind of built me up a bit; so when that was torn down it was even worse.

Andrew had experienced quite intense isolation before he had begun to socialise online and, after his mother and the police's intervention in this grooming, he described feeling further isolated, experiencing a sense that there had been 'serious damage' done to his familial relationships too, and as a result felt that his mental health had deteriorated. Both at the time and in retrospect as an adult having reviewed the messages he had been sent online, he felt that the reaction had been disproportionate.

Following the intervention, aged 14 Andrew recounted his first experience of depression, describing feelings of helplessness, confusion, and intensified isolation. It was also around this time that he began self-cutting, which, as described in Chapter Four, Andrew had found useful in allowing him to express and process emotions in what felt like a more controlled manner. Both Euan and Andrew had struggled as adults with sexual relationships, whilst Tam who was sexually assaulted in childhood, reported on-going struggles with anxieties about being sexually assaulted in adulthood by one of the men in her life. It is well-established that young people who have experienced ACEs, and in particular sexual abuse or assault, are more likely to think about and attempt suicide (Miller *et al.*, 2013; Serafini *et al.*, 2015). In my study's sample, participants affected by sexual abuse or assault lived in contexts in which they were often already isolated and in which their experiences of abuse or assault frequently serviced to further this isolation, whilst also negatively impacting their self-esteem.

5.7 Discussion

Cutting across the themes explored in this chapter was a strong sense, expressed by the participants, of social disconnection both through rejection and isolation, which appeared to have a negative impact on participants' self-esteem and self-worth. The relationship between social disconnection and suicide has been documented since Durkheim and plays a key role in both the IPTS and IMV models (Van Orden *et al.*, 2010; O'Connor and Kirtley, 2018). At the most distal level in this study, participants felt that they experienced a cis-heteronormative cultural climate. In previous work, ideas about a sense of safety and belonging where one lives have been identified as important to the development of suicide behaviours (Hatzenbuehler, 2011; Rimes *et al.*, 2018; Meyer *et al.*, 2019).

To further unpack this, in this study I discussed what made participants feel un/safe and as if they did/not belong. Drawing upon both experiences within their local areas and broader societal narratives about LGBT+ people, they identified a number of factors: local knowledge that they had picked up over the years that had cemented their local area in their minds as narrow-minded; hate incidents they had experienced; microaggressions around gender non-conformity; as well as more broad identifiers of public opinion they picked up from media representations, particularly of trans people. Arising from a cis-heteronormative community climate, young people experienced bullying and social isolation, parental non-acceptance, and anticipated or actualised challenges around coming out in Abrahamic religious settings, all as expected parts of growing up as LGBT+ youths. Throughout participants' accounts, experiences of queerphobia were presented not as shocking, but as expected within a cis-heteronromative community climate that produced cisgender, heterosexual lives as desirable and valuable, whilst othering LGBT+ lives. This was further compounded where participants' experienced additional forms of stigma, such as ableism or classism.

Furthermore, alongside experiences of queerphobia and cis-heteronormativity, existed participants' experiences of ACEs, particularly physical, emotional, and sexual abuse: all of which have been found to be associated with increased suicide risk (Dube *et al.*, 2001; Miller *et al.*, 2013; Fuller-Thomson *et al.*, 2016; Merrick *et al.*, 2017). Some previous research has argued that LGBT+ people have reported higher instances of ACEs due to queerphobia present within the home environment (Schnarrs et al., 2019). However, in this study, some participants experienced childhood emotional, physical and sexual abuse as well as neglect, parental substance use, and parental mental health problems independent of the queerphobia they experienced during adolescence.

In the immediate face of these challenges, young people could begin to feel as if they had no safe place to exist as LGBT+ young people, and as a result could experience a sense of entrapment that has been associated with the development of suicidal thoughts in the IMV model (O'Connor and Kirtley, 2018). Although often increasing the pressure to achieve highly at school, some participants envisaged the transition to higher education as an opportunity to move away from difficulties they associated with life at home. For some, however, educational pressure was very intense, and a failure, whether of a qualification or a single assessment could be perceived as a profound defeat, which again has been hypothesised as key to the development of suicidal thoughts by the IMV model (O'Connor and Kirtley, 2018). Many participants who had made the transition to university reported an improvement in their mental health since their moves. However, as noted by McDermott and Roen (2016), this raises questions about how things might get better for participants who were not able to access higher education. For participants in this study who were not able to transition to higher education there appeared to be few options for independent living visible to them.

Although all participants in this study had survived the challenges they faced, for many the cumulative weight of these difficulties had been sufficient to result in either suicidal thoughts or a suicide attempt. In this chapter and, more broadly, this research, I was keen to avoid overly focussing on LGBT+ specific factors contributing to LGBT+ youths' suicidal distress, which has been critiqued in previous LGBT+ youth research (Bryan and Mayock, 2017). As discussed in

Chapter Two of this thesis, researchers have argued that by focussing on LGBT+ specific factors contributing to LGBT+ youth suicidal distress without also sufficiently considering those contributory factors affecting the general population and youth population, we risk re-pathologising LGBT+ young people by providing an unnuanced and unquestioning view of the connection between being LGBT+ and being suicidal. In asking a more open question about what had made participants' suicidal distress worse, I aimed to create an opportunity for participants to raise all factors that they felt were pertinent. In doing so, I hope that I have demonstrated that there were a range of factors, both LGBT+ specific and not, contributing to suicidal distress.

Minority stress theory proposed that LGBT+ people experience stresses specific to their LGBT+ identity, that are *additional* to the everyday stresses that all people face (Meyer, 2003). In this study, participants identified a range of factors contributing to a sense of defeat, entrapment and acute social isolation, the cumulative effect of which appeared to manifest in their suicidal distress. Experiences of ACEs and educational difficulties were not specific to participants' LGBT+ identities, and indeed have been widely demonstrated to increase young people's suicide risk (Miller *et al.*, 2013; Moore *et al.*, 2017). However, for many participants these factors existed alongside pervasive queerphobia and cis-heteronormativity, which seemed to be experienced not as spatially and temporally specific incidents and circumstances, but instead as more fundamental attacks on participants' central senses of self. Thus, although some participants reported both anticipating and experiencing improvements to their mental health once they had moved away to university, for some the detrimental effects of the difficulties experienced in childhood and adolescence remained. Furthermore, for participants for whom university education was either undesirable or inaccessible, there was a lack of clearly visible paths for their living conditions to get better.

Although the LGBT+ specific and youth specific factors were analysed in the Youth Chances Study (Rimes *et al.*, 2018), these were treated as somewhat separate and separable. However, in this study, I have explored how it is possible that factors interact with one another: with queerphobia so pervasive in most young people's lives, it appeared to create an infusion of stigma into the areas of their lives considered more general, such as education. Whilst in this chapter I have focussed on the contributory factors to suicidal distress, without reflecting upon protective factors or those promoting recovery; it is here that Chapter Six will focus.

Chapter 6 Protective factors and future improvements

6.1 Introduction

Research into LGBT+ youth suicide has been criticised for focussing on contributory factors without paying sufficient attention to protective factors or those promoting recovery (Savin-Williams, 2001; Hatchel, Merrin and Espelage, 2019). In this final findings chapter therefore, I will focus on what helped participants in this study to manage suicidal distress and what they saw as being important for a future in which fewer LGBT+ young people think about, attempt and die by suicide. This chapter will address my third and fourth research questions. For context, I will begin by discussing participants' help seeking attempts and the barriers they reported to accessing support. I will then move on to explore what participants stated had helped them to feel better, including the tools they found helped promote wellbeing. Finally, I will close the chapter by discussing what participants in this study suggested would help to reduce LGBT+ youth suicide in the future.

6.2 Barriers to accessing help

In recent years public suicide prevention campaigns have focussed both on reducing stigmatising attitudes towards suicide in the general population, whilst encouraging everyone to talk more openly about mental health and suicidal distress and seek help where necessary (Calear, Batterham and Christensen, 2014; Pirkis *et al.*, 2019). Help-seeking is identified as crucial for mental health recovery, however as discussed in Chapter Two, it has been suggested that there is a reticence amongst young people to seek out and use professional mental health support (Gould and Kramer, 2001; Wilson *et al.*, 2010; LeCloux *et al.*, 2017; Hughes, Rawlings and McDermott, 2018). In contrast, the participants in this study reported proactive help-seeking behaviours, accompanied by a range of difficulties accessing support, which I will now discuss.

6.2.1 Gender Identity Clinics

Feelings of entrapment have been identified as a key stage in the development of suicide behaviours (O’Connor and Kirtley, 2018). Feeling stuck or trapped was discussed by many participants in this study for a range of different reasons (as discussed in Chapter Five). However, amongst trans participants there appeared to be a feeling of entrapment specifically experienced in relation to social and medical transitions. Research indicates that trying to access gender-affirming medical treatments can be frustrating for trans people, with the processes involved at times negatively affecting people’s mental health, whereas accessing treatment may have a positive effect (Bailey *et al.*, 2014; Ellis, Bailey and McNeil, 2014; Dhejne *et al.*, 2016; Carlile, 2019). This was reflected in my study’s sample where accessing trans healthcare had been particularly difficult for Alex, Archer, Lewis, Damian, and Leo.

> Lewis: transitioning felt like a different dimension, like it wasn’t possible, like I would never be able to be free as such, kind of felt as if it was a cage that I couldn’t get out of. So, kind of the last resort was…the only way to escape it was to die.
>
> Alex: I'm the last in my [friendship] group to be on hormones, and so there's a lot of times where I sit there and I'm, like, I'm never going to get on hormones and therefore my life is entirely pointless.

There was a sense expressed by participants who experienced difficulties accessing gender-affirming medical treatment that they could begin to feel trapped, become less able to envisage their future, and as a result seemed to express a sense of hopelessness; all of which have been found to be key stages in the development of suicide behaviours (Van Orden *et al.*, 2010; O’Connor and Kirtley, 2018; Hunt, Morrow and McGuire, 2020).

Furthermore, some participants reported difficulties accessing healthcare due to problems with coordination of care between the Gender Identity Clinic (GIC) or Gender Identity Development Service (GIDS) and Child and Adolescent Mental Health Services (CAMHS). Alex reported being told he needed to lose weight before he could be prescribed testosterone by his Gender Identity Clinic (GIC), which is common practice across the National Health Service for people deemed overweight (NHS, 2020). However, he found it difficult to lose weight healthily and reached out to his GIC for weight-loss support, which they were unable to provide. He reported being referred to a psychologist instead for support with emotional distress that he was feeling around difficulties with weight loss and thus the delays to his medical transition.

Although there are options for supported weight loss within NHS Scotland (through both self-referred and GP referred routes) (NHS Inform, 2020), Alex did not recall having been signposted towards them and felt that this would have been extremely helpful. At the time of the interview he was on the waiting list for psychological services at his GIC, but reported finding the treatment he was offered frustrating, expressing a strong preference to receive support for weight loss instead. However, Alex also felt that he could not articulate his frustration to the GIC. It has been argued in existing research that young people can feel pressure to prove that they are both stable enough to consent to care, but distressed enough to need gender-affirming medical treatment whilst at the GIC (McDermott and Roen, 2016). This was reflected upon by Alex who described being very conscious of how he acted within services, worried that if he came across as an ‘angry trans person’ he could be denied treatment.

In addition to this, Alex had also tried to access mental health support as he was experiencing suicidal thoughts, had attempted suicide, and felt he was experiencing depression. He went to his GP who referred him to mental health services, however after a period on the waiting list he was assessed and told that his mental distress was because he was trans and that he should be seen by the GIC instead.

> Alex: one of them was telling me, you're too trans for that. And the other one was…and the other people are saying, you're too mentally ill to get the help you need. And there are…and it's, like, one of you has to give, I can't give any more, I can't do any more, I need you to accept that.

Similar difficulties were also experienced by Archer, who had been supported by and discharged from CAMHS for anxiety and depression. However, after experiencing a deterioration in his mental health, reported being re-referred by their GP who suggested anti-depressants would be helpful but needed to be prescribed through CAMHS as he was under 16. He described being told by

CAMHS that they felt unable to treat Archer because they attributed his mental health problems to his trans identity and therefore felt it should be treated within the specialist GIC service. Subsequently, their mental health declined and he reported being seen in A&E after expressing his intent to kill himself to a youth work professional. When seen in A&E, Archer described feeling concerned about their own safety and explained to me that he wanted to either be prescribed something or kept in to help keep him safe. However, after being checked over, they reported being sent home and an emergency outreach team visiting him on three occasions before ending his engagement with CAMHS. He described this interaction as making him feel ‘abandoned again by them’ and ‘thrown to the side’.

> Archer: I also did get in to CAHMS and they didn’t support me either. They turned to me and said, you’re only having mental health issues because you’re trans. And I was like, well not everything revolves around me being trans. I’ve struggled with mental health before.

Although both young people experienced emotional distress related to their gender dysphoria, they also felt that they had more generalised emotional and suicidal distress which they wanted mental health support for. Unfortunately, neither participant felt that they had been able to access their desired support, attributing this to difficulties in the organisation and coordination of care for trans people.

Leo also reported feeling that his gender-affirming medical treatment was caught in confusion about whether he should be assessed and treated within CAMHS or the GIC and as a result, spent years waiting for treatment. However, in contrast to Alex and Archer, Leo did not want mental health support. He felt confident that his emotional distress stemmed from his gender dysphoria and the difficulties he had accessing gender-affirming medical treatment. Leo described his initial referral to CAMHS by his GP, which he reported being later informed had not followed the correct pathway and he was then referred from CAMHS to the GIC. Unfortunately, given the time he had spent waiting for CAMHS treatment, when he was referred to the GIC he was told that he would be too old by the time he reached the end of the waiting list and therefore that his referral needed to be transferred to the adult service. However, after months of waiting Leo reported becoming concerned and therefore checking up on the referral; on doing so he was informed the referral had not been made, causing further delays. Eventually when he was seen at the GIC and prescribed hormones for his GP to administer, he explained that his GP had refused to do so. During this time again Leo felt a strong sense of entrapment which he expressed as ‘I think it was just a lot of feeling stuck. Like, it felt like my life was on pause’.

The World Professional Association for Transgender Health (WPATH) Standards of Care used in Scotland make it clear that there should be robust opportunities for young people to explore their feelings about their gender with mental health professionals before making decisions about medical transitions. However, in this sample it appeared that a lack of joined up care between CAMHS and the GIC seem to result in neither service feeling that they were in a position to support these young people, which ultimately resulted in the young people not receiving the care they needed. It appears likely that the tensions and confusion between services are a result of clinicians wanting to ensure that young people receive specialised and appropriate care. However, clearer communication of care pathways for young trans people who experience mental health problems seems necessary to ensure that young people are provided with timely, co-ordinated care. It may therefore be useful to have more explicit guidelines on the coordination of care between CAMHS and the GIC for young trans people who also experience mental health problems, particularly given the high rates of mental ill health amongst trans people (Clar*k et al*, 2014; Surace *et al*, 2020). In addition to this, if access to gender-affirming medical treatments is dependent on meeting weight loss requirements, it might be helpful if young people could be signposted towards weight loss support.

6.2.2 Access to mental health services

GPs often act as gate-keepers to accessing mental health services within the NHS (NHS, 2019). However, consistent with other studies on the topic, at times participants felt that their GP demonstrated a lack of awareness about mental health and a feeling they did not take participants’ care preferences into account (Plaistow *et al.*, 2014). After Lynsey had taken a paracetamol overdose, she was taken to A&E by her partner and treated. At discharge she reported being told she had to go and discuss what had happened with her GP, which she did.

> Lynsey: So like I hadn’t really thought about what I was taking, I was just sort of, like, right, if I like take a ton of paracetamol that will do it. I hadn’t really thought it through further than that, I was, like, fine, and then I remember I went to my GP, because I was on antidepressants and also on beta blockers and my doctor said to me ‘why didn’t you take these other beta blockers because they would have done more damage?’ Obviously, her thinking, like, I knew. I had no idea, so of course I filed that information away for next time, so next time I attempted suicide I then used the beta blockers because I knew that would do more harm because she sort of like told me they would. So that was actively detrimental.

Lynsey reported feeling that her GP was not taking her seriously and she described how the interaction had made her feel like she was a nuisance. Although Lynsey’s GP may have been expressing albeit inappropriate intrigue about Lynsey’s chosen method, Bridge, Goldstein and Brent (2006) have discussed how sometimes low lethality in suicide attempts amongst young people is interpreted as a lack of desire to die, but may instead be reflective of an inability to accurately calculate the lethality of their attempt. In the end, Lynsey took the decision to change GP and has found her new doctor more helpful and empathetic.

The relationship between practitioner and participant was incredibly important. Many participants reported that they had been unable to forge a successful therapeutic partnership with their mental health professionals, particularly when they had access to a very limited number of sessions in which to build a working relationship. For participants in this study the destruction of a therapeutic alliance could hinge on a single incidence, for example:

> Damian: One day I was feeling really shit, you know, I said, I'm feeling really terrible today, like, just so miserable, I think I might be going to kill myself, definitely, this time, it’s… everything is really awful. I just feel so, like there's nowhere I can go where I'm respected, there's no one I can meet that seems to be the kind of person I want to talk to. There's just, there's nowhere I can really go, I feel, but then it also feels like I'm acting in life. And I can't really remember what else I said, but it ended in me saying something like, I just feel like I've got too many tawdry quirks. And at the end of this big spiel that I'd given, she laughed and said, oh that’s not what tawdry means.

Reflecting on the incident in the interview, Damian discussed that for him, it didn’t really matter whether he had used ‘tawdry’ in the right way; feeling that instead the pertinent factor was that he was expressing the intent to attempt suicide. He therefore reported interpreting this incident as a signal that he and his professional had not connected. Similarly, Amber was referred to a specialist trauma clinic to help her to process her experiences of childhood abuse from her father. She described her therapist’s response when she had felt comfortable enough to open up about the self-esteem issues she experienced in relation to her abuse and depression.

> Amber: I said, I feel like a lot of the times I do feel ugly, and she was like, well do you wear makeup, and I'm like, yeah, and she's like, well put your makeup, look in the mirror and go, ‘I'm still ugly but I still look better’ […]I had to wait, like, seven months for the trauma therapy, and that turned out to be shite. So, I wasted seven months of hope.

Amber reported that this comment completely broke down the relationship for her and she felt that this demonstrated the therapeutic alliance was no longer working for her. Whilst this example provided by Amber again highlights the importance of sensitivity at all times in the therapeutic alliance, it also demonstrates how the scarcity of services and the length waiting times can impact participants’ evaluation of mental health care. For some, waiting lists were simply too long and instead they turned to private mental health providers. However, for those who did wait for NHS treatment, if they then did not receive their expected standard of care or the expected improvement to their mental health, they could experience an enormous sense of disappointment. Under-cutting these difficulties seemed to be the well-established challenge of how influences over care preferences are shared between clinician and service user (Plaistow *et al.*, 2014). Participants in this study appeared to feel their care needs were not being sufficiently taken into account, despite a commitment within NHS mental health services to involve patients in decisions about their care (NHS Scotland National Service Specification, 2020).

6.2.3 Emotional and familial barriers to mental health care

Some participants reported facing barriers when trying to access mental health care, including their parents refusing or discouraging treatment. Ayla described her mother being extremely resistant to her accessing medication when she was offered a tranquiliser by their doctor aged 12. Ayla felt that her mother had not believed that she needed medication, whilst Ayla herself welcomed the help offered. However, she reported that over time, with the deterioration of Ayla's mental health and her mother's increasing awareness of her self-harm and suicide attempts, her mother learned to accept her need for professional help, including medication.

Similarly, Lily reported her mum had trouble accepting that Lily had at times felt suicidal, and was keen to reframe this as her 'feeling low' and Harley described being told by her parents that she shouldn't feel suicidal.

> Harley: Every time I've gone or I've talked to my mum about it it's always been like 'I don't understand how you could feel this way. You have everything'.

Harley explained that she believed her mother felt this way as she herself had experienced a difficult up-bringing and on comparing their situations felt that Harley should be content. However, I was intrigued by the framing Harley reported which seemed to hint at a belief in a relationship between good mental health and 'hav[ing] everything', which was also echoed in an account given by Andrew. These accounts made me question whether some participants' parents might perhaps have interpreted their child's poor mental health as resulting from a lack of material provision. As their care givers, they might therefore have felt a sense of guilt and responsibility about their child's mental health.

Harley's mum had intervened to prevent her accessing Childline and re-accessing her GP, although she had been allowed to attend a CBT course. As a consequence of the parental reactions Harley had witnessed, she described feeling guilty:

> Harley: I think I've spoken to them once or twice in the past few years and I've gone I kind of want to die, they're always like don't do that, it would make us sad. Then it makes them visibly upset, which makes me feel worse. So, I'm like, oh no, and then it's also I remember there have been like a few times where I've actually gone to bed and I've just cried because I feel so guilty.

Perceived burdensomeness has been identified as a key construct in the development of suicide behaviours (Van Orden *et al.*, 2010). In this quote I interpreted Harley's guilt at upsetting her parents as a concern about burdening them, which was shared by other participants in this study:

> Lynsey: I don't like to feel like a burden on people so I didn't want to tell my mum so that I don't want her to worry, you know?
>
> Ayla: I felt like people already had problems and I didn't want to add on to them. Like I didn't want to be a burden especially like since like I'm already anxious and I already don't like myself much, that would just add on to my like, dislike as in like, oh, you're just being a burden now, kind of.

Ayla explicitly expressed the cyclical nature of her difficulties: that in-part her concerns about being a burden were related to her low self-esteem, but in turn not seeking help may have then worsened her mental health problems. The concern that by help-seeking, whether through social support networks or from professional mental health support would somewhat burden others is troubling. Help-seeking is considered crucial for reducing suicidal distress and improving mental health more broadly, whilst help-negating behaviours are considered consistent with poor mental health outcomes (Wilson *et al.*, 2010). Therefore it may be useful to consider how help-seeking can be promoted amongst young people in a way that addresses concerns about burdensomeness pre-emptively.

Some participants appeared to have learned help-negating behaviours from those around them. In Harley's case, a reduction in help-seeking and an increase in help-negating behaviours seemed to have developed over time. Although as described above, Harley discussed how in the past she had attempted to seek help for mental health problems, including suicidal distress, from both charitable organisations and from her GP, during the interview she offered a series of reasons why she was now not seeking help. For example, she commented that she did not believe that she was 'bad enough' for treatment and was unsure of whether she would ever be able to get better. Instead, she expressed that she was now trying to cope independently with her suicidal distress, saying she was trying to 'grit her teeth and get on with life'.

The narrative about being 'bad enough' to warrant support was reflected in other participants' accounts. Euan reported that when he was younger and experiencing particularly bad periods of mental health, he had tried to force himself to 'snap out of it'. In addition to this, he struggled to see how anyone could help him, which he discussed primarily within a school context as this was most accessible to him in adolescence.

> Euan: it's like I don't think you're qualified enough, it's like judging people before I even know what they're going to say. It's like what are you going to do, Mr [redacted] from Higher Admin, are you going to talk to me about my home life? It's not going to do much.

Although help-negating has been associated with poor mental health outcomes (Wilson *et al.*, 2010), reflecting on section 6.2.1 and 6.2.2 it is clear that the available support was not always found to be helpful by participants in this study. So, whilst seeking help has the potential to improve participants' mental health, it may require more options for care than participants in this study found themselves able to access.

6.2.4 Being young and ageism

For some participants, age seemed to contribute to both how they and others understood their experiences, particularly of mental health and mental health support.

> Andrew: Because it was my first kind of encounter was the kind of serious, like, depression; about 14 as well, so it probably wasn't that serious, let's be honest, but yeah, like, I think confusion, isolation, like, helplessness, not really knowing what to do; I didn't know what to do with myself.
>
> Harley: I'd just cry a lot, which was just something that happened. I don't know if that was just because I was 13 or because of all these other factors, but it was just rough.

I interpreted Harley and Andrew as both somewhat diminishing the seriousness of their distress due to their age. Harley later talked about the possibility that she had experienced such serious distress because of her hormones. Andrew felt the trigger for his depression was the isolation he faced after his online grooming experience was discovered (detailed in Chapter Five), but seemed to dismiss it as less serious due to his age. I questioned whether this dismissiveness could be a product of broader societal messaging that participants experienced about unruly adolescent emotions (McDermott, 2015), as well as scientific literature on difficulties regulating emotions in adolescence (Blakemore and Robbins, 2012; Sawyer *et al.*, 2012; Schweizer, Gotlib and Blakemore, 2020). This was further reported in participants' accounts of interacting with medical healthcare professionals, who they described also appealing to adolescent hormones when accounting for poor mental health in participants' teenage years.

> Lewis: My old GP, when I was registered at home, I was like, I am depressed, and they're like, you're just a hormonal teenager and did nothing about it, and I was like, well, no, no, because if it was just hormonal teenager, my sister would feel the same. Yeah, asked to be referred to [GIC], like you need your mum's consent, I was like, no, I don't. Yeah, so just poor healthcare professionals.

Whilst some of the comments participants reported from professionals explicitly addressed age, maturity and hormones, many of the barriers to accessing help hinged upon the notion that participants' distress was not taken seriously.

The maturation process encompasses different types of development: ageing is one part, as is the development of emotional regulation (Casey, Duhoux and Cohen, 2010; Ahmed, Bittencourt-Hewitt and Sebastian, 2015) and the development of sexuality and gender identity (Saewyc, 2011; McDermott, 2015). It has been argued that LGBT+ young people who experience mental health problems can be viewed as 'failing' this maturation process by both expressing emotional distress and therefore not being seen to have matured into rationality and away from emotionality, as well as being viewed as failing to mature by heterosexual and gender conforming norms (McDermott, 2015; McDermott and Roen, 2016). It is further possible that this dismissal was affected by mental health stigma, dismissing emotional distress as not serious (Schulze, 2007; Heflinger and Hinshaw, 2010). Consequently, participants in this study may have experienced the dismissal of their help-seeking behaviours at the intersection of queerphobic, ageist and mental health stigma.

It is well established that the interaction between a range of social, psychological and biological factors can negatively impact upon emotional regulation throughout adolescence, but for the majority this is thought to be part of 'normal' development and settles in adulthood (Blakemore and Robbins, 2012; Sawyer *et al.*, 2012; Schweizer, Gotlib and Blakemore, 2020). However, what is less clear in light of this, is how treatment (either through medication or talking therapies) should proceed for adolescents who seek help for emotional distress that they are finding unmanageable. One of the challenges for clinicians working with the participants within this study was communication. Many of the participants described help-seeking for depression, but few participants seemed to have explicitly disclosed suicidal distress to their GPs despite all having felt suicidal at times. For example,

> Ayla: When I went to that doctor he asked me, well, the thing was my mum was also sitting there with me, he asked me, like after listening to me, has there ever been a point where you've thought, I've wished like…or have you ever like…has there ever been a point where you considered suicide or like just…and just be…? I don't know how to translate it, sorry, like just be saved from it all in a way […] Like just want to get rid of it in a way, have you ever considered self-harm or suicide? I'm next to my mum, I'm 12 and I'm like, no….

In Ayla's account of her younger self she made it clear that in saying 'no' to this question from the doctor she had been lying. This quote exemplifies how difficult it could be for participants to be both to be honest with a clinician but particularly whilst a parent, who as discussed in 6.2.3 young people could be trying to protect from concern, is present. There is clearly a fine line to be navigated for clinicians between avoiding pathologising challenges in emotional regulation experienced by young people, and identifying and treating adolescent mental health problems in a timely manner so as to reduce the risk of future suicide attempts into adulthood (Cash and Bridge, 2009). However, for participants in this study, using an approach which encouraged participants to wait for an improvement without medical or therapeutic support, often resulted in them reporting feeling dismissed, not taken serious, and continuing to experience poor (and for some worsening) mental health.

6.3 What helped?

In order to address the gap in existing research relating to protective factors against LGBT+ youth suicide, I asked what helped make suicidal distress better.

6.3.1 Social Connection

As discussed in Chapter Five, social isolation and rejection were identified by participants as key contributory factors to the deterioration of their mental health. In order to navigate this, participants talked about the importance of connecting with other LGBT+ people either offline or online, to help them to develop senses of belonging and community, a connection to broader LGBT+

culture and communities, and gain affirmation of LGBT+ identities. It has been argued that this is a key benefit of experiencing a sense of LGBT+ community cohesion, encouraging the development of shared values and experiences that LGBT+ people can draw upon, which has been termed ‘minority coping’ (Meyer, 2003). Caution must be exercised not to idealise LGBT+ communities, over-looking the many possible structural barriers to accessing minority coping resources (for example, ableism, classism and racism), as discussed in Chapter Two. However, in this study, it must be noted that the majority of participants had found an LGBT+ community in which they described a sense of belonging.

Some participants described a process through which they had organically developed offline friendships, describing a kind of LGBT+ gravity in which young people, especially those who had struggled to connect with their peers, had gravitated towards each other at school. After the friendship group was established, each of the individuals had then slowly, over time, been able to come out as having an LGBT+ identity. For those that had not found LGBT+ friends organically, it seemed to be important for them to actively seek those connections out either online (using social media sites like Tumblr, Twitter, Facebook, YouTube and Instagram) or in-person. There were two main ways that participants found community online: through shared interests (which often happened to include LGBT+ or mental health elements, but did not necessarily) and by directly seeking out spaces that related either to LGBT+ identities or mental health support.

6.3.1.1 LGBT+ online spaces

Participants, and in particular trans participants, found it helpful to look at the coming out and transition stories of others online. As discussed in Chapter Five, coming out was often a huge source of stress to participants, with them expecting and experiencing negative reactions from those around them. Related to this, many participants in this study discussed having periods of time in which they were unable to imagine a future, which has been identified as a motivational moderator in the development of suicidal thoughts (O’Connor and Kirtley, 2018). I interpreted participants’ online identity exploration as a platform through which participants were able to experiment with types of future thinking, either by bearing witness to other people living the kinds of lives that they wanted to live, or by trying out the identities that they wanted to have anonymously through their online interactions.

> Stromberge: I did end up, sort of managing to get into some groups on Facebook, and things. And I don't know if it necessarily helped with suicidal thoughts, but it helped with the sort of, general, there's a future thing, you know.
>
> Euan: I'm that flamboyant person that I really want to be, and it's like, it feels good, it feels good to be… It's dumb because it's like I try to work its [being gay] way into everything I say, but that's just me trying to have fun and it's just like it feels good to do that, it feels good to shove it into people's faces. It feels good to like…I don't care what you think, this is what I'm going to do and even if they don't like it. I know some people do get really annoyed at it, that makes it even better.

Whereas Stromberge used online spaces to look at the transition stories of others in a unidirectional manner to gather information, Euan had used online spaces to explore his identity in dialogue with others, which as discussed in Chapter Five, he felt unable to do offline. Euan was only out to his brother and me as his interviewer, and felt unable to have relationships or be affectionate with others. He was extremely concerned that if people knew that he was gay in his offline life they would view him differently, but found there was a freedom to being out online where he could explore his identity, allowing him to be out in a measured and controlled manner.

Craig and McInroy (2014) have discussed how online spaces offer young people places to grow, develop and experiment with their lesbian, gay, bi, trans and queer (LGBTQ) identities, as well as rehearsing how to come out without having the same consequences that were possible in their offline lives. In part, they argue this is supported through the sharing of information and stories by and for LGBTQ people within these spaces, offering more realistic role models than can be offered through celebrities, TV or books. This was not without challenges however, as some participants remarked that whilst enjoying their online life, found it highlighted the contrast with the difficulties they faced offline.

> Lewis: [I] kind of felt like I was living two lives, because like my online life, I was just me, whereas at school I was like…it felt as if I was impersonating someone.

In addition to identity exploration, participants in this study also used online spaces to ameliorate feelings of loneliness and isolation, and gain a sense of belonging. Sophie described looking for books in the library that had LGBT+ content and searching the internet using questions such as ‘don't like boys, I'm a girl’ and searching for #gay #Scotland on social media in order to make friends. These friendships, whilst instigated online, subsequently migrated offline, and she continued to maintain many of them at the time of the interview.

> Sophie: it was just having common, something in common to discuss, even though it's that one thing, it wasn’t much. You know, I would travel all the way to [large city in Scotland], at 14, 15, to see these people that I don't know, all based on the fact that we all, were all gay, or trans, or do you know what I mean. It's quite scary, actually, that it happened, but at the time, it's not what I was thinking of. I was like, clinging to the fact that, likeminded people, there is someone else like me.

Like Stromberge, Sophie used online spaces to locate people with whom she could identify a likeness around LGBT+ identity. However, unlike Stromberge, Sophie used these spaces to make friendships which then moved offline and were maintained throughout her teenage years. This can perhaps in part be explained by differences in their offline friendships. Stromberge had a strong sense of belonging, having established close friendships at school and maintained a stable romantic relationship throughout his adolescence, in the rural North of Scotland, that was still on-going at the time of our interview. On the other hand, Sophie, growing up in the rural East of Scotland, had lost her ex-girlfriend to suicide, and had experienced homophobia from her friends when she had come out and as a result had lost friendships and felt very isolated. Sophie had therefore used online spaces explicitly to seek out friendships with other LGBT+ people which she lacked in her offline life, whereas Stromberge used the Facebook groups he described more for information gathering and to gain insight into possible trans futures that he might one day have.

Whilst online spaces played many different support roles - alleviating isolation, facilitating future thinking and offering opportunities to explore LGBT+ identities in participants’ lives; there were also risks associated with online spaces that meant that whilst sometimes a support, they could also act as a stressor. Some participants spoke with nostalgia about a time when these spaces were ‘safe spaces' away from queerphobia, suggesting that whilst they had in the past been safe, they were not necessarily anymore.

> Stuart: I follow a lot of really cool people on Twitter, a lot of cool trans people saying a lot of cool stuff. But as a result of that, they're responding to not cool stuff, and then I see the not cool stuff, which I don't know, I'm conflicted about seeing.

As discussed in Chapter Five, participants commented on online transphobia as contributing to a queerphobic, cis-heteronormative community climate. As a result, it was difficult for people to avoid witnessing this conflict, even when they were actively avoiding it, if their friends or people they followed were engaging with it. Therefore, even when the engagement they witnessed was a rebuttal, it could have a detrimental emotional impact on those witnessing it, making them feel less safe and more anxious. Thus, whilst for many, online spaces offered an opportunity for participants to connect with LGBT+ people and content, this was not without risk.

6.3.1.2 LGBT+ Offline Spaces

Some participants in the study had organically found LGBT+ friends within their existing school friends, whereas other participants actively sought out LGBT+ offline spaces. Alex talked about how important it was for his mental health to create a bubble in which he felt that he could live safely, but how terrifying it could be to leave that bubble. Bursting the bubble could be in significant ways such as gaining a job in a non-LGBT+ organisation, or as temporal as using the toilets in the student union building where the LGBTQ+ society[45] met weekly. In particular he, like many other trans participants in this study, highlighted that safety for them included not being misgendered, having their correct name and pronouns used, and not being subject to intrusive questioning related to trans identity. Alex's bubble had been created through his involvement with his university LGBTQ+ society, which connected him with friends, partners, and his chosen area of academic study. Alex explained that his bubble acted as a safety net against suicide. His connection to this community group had increased his awareness of suicide amongst trans communities, and through this connection, he had developed a sense of responsibility to his trans peers. He described a

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[45] The 'LGBTQ+ society' was a student group.

desire not to be ‘another suicide statistic’ and an awareness that many of his friends were also struggling with suicidal thoughts. Consequently, he expressed a concern that his own suicide could start a ‘domino effect’ of suicide amongst his friends, which he was very conscious he did not want to do.

Lynsey explained that before university she had not considered her sexuality a central part of her identity. Having witnessed some of her peers at school come out and experience queerphobia, she felt that between the ages of 12 and 18 she had repressed her sexuality. However, while at university Lynsey attempted suicide twice, and following the breakdown of her relationship, felt incredibly isolated. It was through the LGBTQ+ society that she had been able to connect with other people experiencing mental health problems, which she believed had aided her recovery, describing it as ‘life changing’ and ‘lifesaving’.

> Lynsey: I just had not really thought it was a big part of me and then actually when I joined, I’m really proud of it now and it was something I genuinely feel is an important part of me but it’s because I joined that community and that really did… it provided me with a lot of that where I’ve got friends who’ve gone through mental illness themselves, who are more understanding, that definitely helped a lot, so like after… so like the second year of having these two suicide attempts and things, finding that community of friends and people who had similar experience to me helped a lot and I think that’s kind of what’s helped me get over it almost is having these people around me who get it, and this definitely helped.

For Lynsey, getting involved in her university LGBTQ+ society had allowed her to connect with and explore her own sexuality, whilst also providing a sense of community, helping her develop supportive and nurturing friendships. Many of these new friends also had lived experience of mental health problems, and as a result, could signpost her toward services that had been found to be particularly effective and accepting of LGBT+ people. This exemplifies a core part of ‘minority coping’ described by Meyer (2003), in which an LGBT+ person may be able to draw on community-level resources to help support them in times of difficulty. Although Meyer primarily described this in response to queerphobia, Lynsey spoke about being able to experience a sense of LGBT+ community, but additionally due to the high levels of mental illness amongst her friends made at the LGBTQ+ society, she was also able to draw upon shared mental health resources and wisdom.

Connection to LGBT+ community was not limited to university settings. Jamcake accessed her local LGBT+ youth work service first through one-to-one appointments with a youth worker, and now had built up sufficient confidence to combine individual appointments with attending a youth group.

> Jamcake: It [the youth work service] gives me something to do each week. And whenever it was like a small goal I had reached, like, going out to get, even if it was something really small, like getting, like a female t-shirt, like one for girls, made for women specifically, or a pair of trousers, and I would always tell him, and [youth worker name redacted] was like well done, well done, and I'm like yeah! [...] it was also very nice for someone, like even if it was just like in an hour a week, just to use my name as well.

For Jamcake this youth space was not only affirming her identity (something that was largely absent in other areas of their life) but also provided her with some structure and routine, helped set goals, and built her confidence around their gender expression.

The majority of trans participants in this study had accessed LGBT+ specific youth work services which combined both individual and group-based youth work, and consistent with findings from other research, they found this support very useful (McDermott, Hughes and Rawlings, 2016). Whereas cis LGB+ participants in this study tended to rely more on individual LGBT+ friends they had made or peer-organised collectives such as LGBT+ university societies, that did not provide professional support. Whilst this difference was noticeable it was not clear what motivated it. The majority of participants had experienced at least one negative reaction to the disclosure of their sexuality or gender identity either from peers, colleagues or family, so it did not appear to stem from a difference in experiences of queerphobia.

Although for many participants involvement in LGBT+ groups played a support function for them, this was largely as part of a reciprocal relationship in which they either also provided support to their peers or were more broadly involved in activism to further LGBT+ rights. For example, Lewis volunteered in schools, sharing his story with pupils, whilst Stromberge had taken on a kind of mentorship role to younger members of the LGBT+ youth group he was involved in:

> Lewis: Just reaffirming that they're not wrong, they're safe, they're not alone and that there's people that want to help them, not just because they have to. It's easier now to find other young LGBT people or people that are older, but not much older. Like I talk to so many young, young LGBT people, like 12, 13, about like my experiences, hopefully so they don't feel the same, things like that.

> Stromberge: that was something that, actually, did end up helping, but in a weird sort of secondary way. And like, actually, helping these people feels good, you know, and nice.

As discussed in the introduction to this thesis, the relationship between activism and social connectedness has a long legacy in LGBT+ organisations, with early LGBT+ groups forming in order to lobby for increased rights and social change (Davidson and Davis, 2006; Cook, 2007). Even though today there are many different reasons that LGBT+ organisations and spaces exist (Spade, 2008; Browne and Bakshi, 2013; Formby, 2017), it is likely that young people involved with LGBT+ organisations will participate in some activism. In this study, being involved in this activism connected participants with other LGBT+ people, whilst also facilitating mutually caring relationships that has been found to have a protective function against suicide (Van Orden *et al.*, 2010). Through activism and providing support, participants both gained purpose and forged social connection, thus alleviating the isolation, building senses of self-worth and ultimately improving their mental health.

For all participants there was a sense that LGBT+ organisations, whether self-organised like university LGBT+ societies, or professionally run like LGBT+ youth work organisations, fostered minority coping. They provided an accepting space where those around them understood their identities, accepted them, and shared a sense of culture or community. It was within these spaces that young people were able to share in their experiences of marginalisation and create a sense of safety, but also learn from each other about shared LGBT+ history, and about ways of making their lives liveable.

However, whilst LGBT+ specific groups were whole-heartedly endorsed by participants as helpful, there were barriers to accessing them. Firstly, in some rural areas, transport links to places in which LGBT+ groups were held were a barrier to access, as travel was expensive. Further to this, Stuart explained that whilst an LGBT+ group had been established in his local community, due to the bullying he had faced during his school education, he was nervous about his visibility and chose instead to attend a group in a city nearby. Secondly, for participants who did not have supportive families and still lived at home, they either had to battle with their families to be allowed to attend the group, or lie about the group, pretending that it was a youth group with no specific focus. This could then create an additional stress about getting 'caught out' and exacerbate feelings of living double lives.

6.3.2 Accessing Support

6.3.2.1 Professional Support

The majority of participants had been professionally supported with their mental health at some point, through GPs, specialist mental health services, or counsellors. Participants reported that primarily they had been offered cognitive behavioural therapy (CBT), and where the therapeutic alliance was satisfactory, had found this effective in the short-term for relieving distress. The effectiveness of CBT hinges on its ability to create a sustained change in an individual's mind-set, internalising therapeutic methods and equipping them with the tools to independently challenge and disrupt their own negative thoughts (Fenn and Byrne, 2013). Participants in this study found that longer term these effects did not always remain, and as a result once discharged, they reported that over time they could experience a deterioration in their mental health.

> Andrew: The therapy would probably help me feel a little bit better, and more elated, and then I would be discharged, and I'd be like, what, like is this going to come back; and every time it came back, like, within a month everything was back. And the techniques weren't really techniques […] But I think it was actually talking to a stranger that was probably getting me out of that place. But that's probably why I went right back, because there was no stranger to talk to after that.

In interpreting Andrew's explanation of why therapy hadn't worked for him in the long-term, I considered the broader context in which he had described experiencing the deterioration of his mental health. As discussed in Chapter Five, Andrew had been homophobically bullied at school; his father (who was his primary carer) had reacted badly to him coming out; he had been groomed online in the one space that he reported he had been able to establish peer relationships, which when discovered, had also negatively affected his relationship with his family. For him, as for many participants in this study, there were very few places they felt safe to communicate their thoughts and feelings openly and be understood. Although not explicitly stated, it is possible that for some participants, contact with a therapist was one of the only, if not *the* only, place in which this was possible. I considered therefore whether where participants had few positive social connections, the cessation of their allotted therapy sessions might represent a further rejection for them in a life which, as discussed in Chapter Five, was already quite full of rejection.

Similar to Andrew, Isabel felt that the benefits of therapy were having regular contact with a person with whom she could talk about her feelings. Isabel had an effective course of CBT, which she strongly wanted to continue. However, she reported that when she asked her GP if she could be re-referred, they had said that her only option would be group therapy, which she described feeling uncomfortable with. After further suicide attempts and a change of GP, Isabel was assigned a Mental Health Nurse at her local practice, which she had found very effective.

> Isabel: now that I see my Mental Health Nurse, I feel so much better these days. And it’s good to know that there’s somebody there. And I wish people… I wish everybody could get something like that and it was available for everybody. Because it’s a lot of help.

As exemplified by Isabel and Andrew, for some participants it appeared that the effective part of therapy was having stable, regular contact with a professional with whom they felt comfortable and could trust. The British Association of Counsellors and Psychotherapists guidelines decree that counsellors and therapists affiliated to this professional organisation should respect diversity and seek to form an empathetic understanding of clients’ experiences (BACP, no date). It is possible therefore that therapy for these young people perhaps had the unintended consequence of easing social isolation, whilst also affirming participants’ identities in a manner that, as discussed in the previous chapter, was absent across many areas of their life.

6.3.2.2 Immediately accessible support and distraction

Existing literature suggests that young people are more likely to reach out for mental health support from their peers than from professionals (Gould and Kramer, 2001; McDermott, Hughes and Rawlings, 2016). Although in this sample many young people had reached out for professional support, often multiple times, participants also relied heavily on friends for everyday support both in terms of everyday mental health support and support at times of crisis.

> Leo: I think I was just tired of it. I think I was telling everyone that I was going to…or was hinting at it. And then I…the only reason I didn't 'cause I got in an argument with my American friend about biscuits and gravy 'cause what they call gravy is not gravy. It's disgusting. It looks like baby vomit.
>
> Hazel: Okay. And so how did that argument help? I'm really interested by that.
>
> Leo: I don't know…. And I think just, sort of…it was just completely different from how I was feeling. They didn't know how I was feeling either so it was, sort of like, distracting me for long enough for to me, like, get out of the immediate sort of feelings.

Distraction is a core part of safety planning for the management of suicidal distress (Stanley and Brown, 2012; Oxford Health NHS Foundation Trust, 2018), which many participants had engaged with. Some participants had also used established support organisations such as the Samaritans and Childline, and to a lesser extent LGBT Youth Scotland's digital support service.

> Fiona: What stopped me from like going over that fence into actually attempting was actually like calling the Samaritans and being like…like I'm… I'm like I don't know what to do here.
>
> Lynsey: I spoke to a guy for about two hours, and that definitely helped… it was just nice to have someone who was like, impartial, to speak to but was also there in that moment of crisis. It wasn't like… I didn't have to wait for a year to speak to him. I just phoned up and they were there.

Others looked up distraction and self-care activities online, including on social media sites such as Tumblr, or had them recommended by medical professionals. Amber had looked up distraction activities online. She used these alongside an 'emergency pack' that her doctor had suggested making, with items that could be used for both self-care and distraction (including a movie, slippers, and chocolate), whenever she felt herself ‘spiralling’ and becoming suicidal. Sophie described feeling physically ‘burny’ and ‘scratchy’ when her mental health was deteriorating. To manage this, she would try and move away from this feeling by getting up to do something, contacting a friend or doing a chore. As discussed in Chapter Four, the internal struggle hypothesis suggests that there can be a level of ambivalence about living and dying experienced by those who think about suicide (Kovacs and Beck, 1977). This appeared to be present amongst this sample, where participants often spoke about actively engaging coping strategies (either individual or with others), when experiencing worsening suicidal distress, which I interpreted as exemplifying an internal struggle between wanting to live and wanting to die.

For other participants friends were involved in on-going mental health care. For example, helping to identify triggers and warning signs of deteriorating mental health and acting as the primary supporters of participants at times of distress, both listening to their difficulties and advising when to seek help from others.

> Jamcake: just being open with friends, being able to tell them how I feel, can kind of… like, I feel like this, and they’re like, ‘well that’s, I’m sorry you feel that way, is there anything I can do to help?’, and normally just letting me rant on, can make me feel better, and that someone does care.
>
> Hazel: So that kind of acknowledgement?
>
> Jamcake: Yeah, the acknowledgement that what I feel isn’t, like, it doesn’t make me a complete freak and that my feelings are valid, and that someone does care I guess.

Whilst support was highly appreciated, Leo acknowledged the draining impact of supporting friends’ mental health, explaining that over time it had left him burned out. Furthermore, Lynsey remarked that young people often did not have the tools to provide effective support.

> Lynsey: I had friends around me which were supportive, which was good. They were good, I guess, but also they’re not, I don’t know how to like say this… they’re not like… they obviously weren’t trained to deal with things and they were trying their best but they weren’t always a positive influence. Sometimes they would say things that would make me feel worse or the way they treated me or sometimes

> you felt like it was they didn't want to deal with it, and I had to deal with it because it was happening to me and they would be, like… it was very… relying exclusively on friends is very challenging because it depends on how much they're willing to do for you.

As it is recognised that young people often feel most comfortable seeking support from their friends (Gould and Kramer, 2001; McDermott, Hughes and Rawlings, 2016), it is perhaps necessary to consider whether there is sufficient, accessible support offered to young people who provide peer mental health support. It has been argued that youth peer support often recommends disclosing young people's suicidal thoughts and feelings to a trusted adult (Gould and Kramer, 2001). However, given the challenges, discussed in 6.2, to participants accessing professional support, it may also be useful to provide some advice about how to provide peer support beyond referring on. In addition to this, Leo further suggested that it might be useful for education around mental health to focus on equipping young people to identify symptoms of a decline in mental health both in yourself and others, and ways to open up and talk about this comfortably.

6.4 How can we reduce LGBT+ Youth Suicide in the future?

To close the interview, I asked participants for their suggestions of what would reduce LGBT+ youth suicide in the future. Participants' reports of what helped relieve suicidal distress tended to neatly dovetail with their suggestions for reducing LGBT+ youth suicide in the future, primarily focussing on ways of reducing stigma and increasing access to mental health support.

6.4.1 Challenging queerphobic stigma

Queerphobia was a cross-cutting undercurrent to the majority of participants' experiences, and for many this happened at school. Perhaps in response to this, and as a way to safeguard future generations, schools were seen as an effective way to educate against queerphobic attitudes. In recent years a working group of the Scottish Government, after successful campaigning from a range of LGBTI organisations across Scotland, have constructed a comprehensive set of recommendations for LGBTI inclusion across the curriculum, which seeks to address the types of issues raised by participants in this study (Scottish

Government LGBTI Inclusive Education Working Group, 2018). Within these recommendations, members of the Scottish Government's LGBTI Inclusive Education Working Group have recommended that LGBTI inclusion is both worked into the curriculum in schools, but also into the teacher education curriculum, to allow future educators to be better equipped to teach LGBTI content and address queerphobia in the school environment.

These suggested enhancements to the Scottish curriculum seem to fit with those improvements that participants stated they would like to see. Recommended in 2018, some participants in this study were unable to benefit from the proposed curriculum enhancements, as they had already left school at the time of their recommendation. However, for some, they were in place for the latter part of their schooling. Indeed, whether before or after the recommendations of the working group, many participants had experienced the inclusion of LGBT+ people in their schooling in some way, however some had found this representation quite difficult. As a result, participants' experiences were able to provide some lessons learned from the perspectives of LGBT+ young people who had experienced attempts to include LGBTI content in the classroom.

> Fiona: The way that LGBT issues were taught about it, kind of, in the same place… like it was, kind of, in the same way that we talked about drugs and alcohol.

Although the LGBTI Inclusive Education Working Group specifically mentions the inclusion of LGBTI content on the Relationships, Sexual Health and Parenthood Education in schools, it is unclear the ways in which they envisage the embedding of LGBTI content across other areas of the curriculum. For some participants, the positioning of LGBTI content as part of Personal and Social Education (PSE) meant that for some people it felt as if it was tokenistically included in the curriculum, rather than embedding the inclusion LGBT+ lives throughout the curriculum alongside cisgender, heterosexual lives.

Additionally, one trans participant, Archer commented that when LGBT content had been included in his curriculum it had predominantly covered lesbian and gay content, to the exclusion of bi and trans content. Finally, Harley discussed how, although teachers wanted to include LGBT content, they were not necessarily equipped to have challenging conversations around this content if they were needed.

> Harley: [at school] we watched my favourite film ever, Pride, I do actually really like this film, watched it in our PSE class and, ooh [pained tones] …
>
> Hazel: Not a good experience?
>
> Harley: It was interesting, because we basically sat down and we were like we're going to be watching a film and everyone's like, hell, yeah, film time. And then it was like it's called Pride and everyone's like this is going to be gay, isn't it, this is probably Harley's doing. I was like please don't target me, I like this film but I didn't have anything to do with this […] So we watched it, and I remember there is a part in the film where two guys kiss and I remember the people sitting in the front of the classroom going ewwwww, like a group of boys at the front being like really grossed out. It was unpleasant.

Harley's account positioned her classmates' reaction to the film as homophobic, perhaps in part because of the biphobic bullying that she had routinely experienced at school (as discussed in Chapter Five). However, for a teacher who did not fully understand this broader context, this could be interpreted as a one-off incident that could be homophobic, but also could have been the result of discomfort with physical affection. I argue, that given the prevalence of queerphobic bullying amongst this sample, there is a clear need to provide professional development opportunities for teachers to upskill in challenging queerphobia in productive ways, to help pupils question their values and reflect on their thoughts and behaviours. This need may be further evidenced in the future if the recommendations of specifically recording queerphobic instances of bullying at school are taken up (Scottish Government LGBTI Inclusive Education Working Group, 2018).

The inclusion of LGBT+ content on the curriculum was often framed by participants as a way to combat peers' stigma. However, Leo suggested that it was not only for the purposes of cisgender, heterosexual people in the classrooms learning *about* LGBT+ people, but also to help LGBT+ people recognise themselves at what was often a crucial time for coming to understand their own identity.

> Leo: I think just education on LGBT stuff in school could help, ‘cause then that could help get rid of stigma from other students and it could help some people figure stuff out a lot faster.
>
> Hazel: Ok, and you’re doing a face that suggests perhaps you were one of those people?
>
> Leo: Yes, maybe some people wouldn’t have to go through several years of feeling miserable and not knowing why.

As discussed in Chapter Five, many participants had struggled extensively with coming out, internalising queerphobic stigma that they witnessed around them. For most, positive representations of LGBT+ people were largely absent from their everyday lives and therefore many had turned to books, pop culture, and the internet for information, easing the process through witnessing other people coming out or transitioning. Lewis discussed how because of the acute isolation he felt he had turned to Tumblr to gain information about transitioning,

> Lewis: Just like allowing me to feel like I wasn’t alone, if I wasn’t the only person in the whole world experiencing what I was going through, like other people of similar ages, other people that were older with different experiences, how to like access other support, how to go about starting a medical transition, a social transition, what I needed to do, things like that, ended up just having a big list of who I needed to speak to essentially. Just took a while to get through them all.

Whilst it would undoubtedly be impossible to provide the detailed kinds of information about transitioning that Lewis describes here, it is likely that there is scope to provide greater representations of LGBT+ people through the curriculum. In doing so, this could help to work towards a school environment that was both less transphobic and less cis-heteronormative, and could serve to counter some of the broader, negative representations of trans people.

6.4.2 Improving support

As discussed in section 6.2, many participants reported experiencing difficulties accessing support whether that be through their GP, from mental health providers, or from support services within educational settings. Furthermore, due to long waiting times, some participants had turned instead to private mental health provision, but recognised that this was not accessible to all. It was therefore unsurprising that they felt support services needed to be improved.

> Harley: More access to targeted support, I think. Because a lot of the time I've found when a queer person specifically attempts or is thinking about suicide it's either got to do a lot with sexual and gender identity or at least in part got to do with sexual and gender identity. And I think if I had had more available access to the sort of targeted supported that I think there probably is out there it would have made a lot of things easier.

In particular, participants seemed to prioritise talking therapies as their preferred method of support, and strongly advocated for the reduction of waiting times for these. Lynsey had proactively reached out for a range of medical and therapeutic supports and described her experience saying, ‘it’s not even where to go, it’s there being resources when you’re there I think’. However, participants were also aware of the limited resources that the NHS was working with, and that the reduction of waiting times would have financial implications, that meant they were not possible within the funding structure of the day.

6.4.2.1 Cultural competence of Support Professionals.

Participants also raised issue with the levels of LGBT+ awareness that those in supporting professions (whether GPs, counsellors, psychologists, or teachers) had. Often this was not related to a negative experience that a participant had, but moreover an expectation or concern that they would be met with a lack of LGBT+ awareness, potentially based upon the cis-heteronormative and queerphobic experiences they had in other areas of their lives. When participants felt a professional lacked LGBT+ awareness, it undermined their confidence that they were the right person to support them. For example, Meryem felt that her therapist demonstrated a lack of cultural competence both in terms of her ethnicity and sexuality. As a consequence, Meryem became anxious that she might further add to the stereotypes that the therapist already held.

> Meryem: for example, there are some negative stereotypes, and sometimes they might be true. But I don't want to, like, perpetuate

> those stereotypes, or like, perpetuate any kind of anti-queer sentiment, even if they are valid to my life.

Participants suggested that more LGBT+ specific training for mental health professionals might be useful to ensure that they understood contemporary LGBT+ issues. Additionally, I queried whether there might also be scope for mental health professionals to further promote where LGBT+ training had been undertaken, and where possible to proactively communicate a positive and accepting attitude toward LGBT+ people, to help pre-empt concerns that participants reported. Further to this, participants emphasised that both mental health and educational professionals did not need to know in detail about LGBT+ issues. Instead, where it was not their specialist subject, participants suggested that it would be useful for them to be able to effectively signpost toward specialised services that would be able to provide this support.

6.4.2.2 Peer Support

Participants suggested that it might be useful to have more formalised peer-to-peer support amongst LGBT+ young people.

> Andrew: almost like an Alcoholics Anonymous style support; I don't know if that would have helped me, I don't know if I would have been too anxious or too autistic to go to that. But I don't know, because definitely the talking to strangers really helps, but when it is that kind of patronising slow voice, and they like to explain all your problems to you; even though, yes, they absolutely know what they're talking about, it's still you don't want to hear that.

There was a sense amongst the participants that this would be useful both to show young people experiencing suicidal distress that they were not alone in feeling this way, but also that it was possible to get better. Participants described the need to acknowledge heightened rates of LGBT+ youth suicide when compared to cisgender, heterosexual peers, whilst also providing recovery narratives and making explicit that this disparity was not **because of** young people's LGBT+ identity, but rather contributed to by a complex range of factors.

It is likely that peer support provisions would require very careful facilitation. Many participants described turning to their friends during times of distress, but as previously discussed, providing peer support required a substantial amount of emotional labour and could become over-whelming. This was not least because it did not appear that there was training or supervision available to, or accessed by, young people providing peer support. In future therefore it might be useful to explore opportunities for training and support.

However, for some young people, particularly those that weren't out, accessing a face-to-face peer support services could be too revealing. For example,

> Euan: Something confidential I think is the most important thing because I would have never went to an LGBT mental health officer if there was one in the school, I would never have done that because it would have just been such a horrific thing for me, you know? It wouldn't even be something I would have thought of doing. I would say as well, like, because back then, it's not that long ago but there wasn't a mobile phone or smartphone or anything, I feel like the best I could have done back then was put a note in a box, I want to speak to you, but even that's still extreme. There's quite a lot of stuff online now, I know there's quite a lot of online help services, I know there's one LGBT Youth Scotland, I've seen that quite a lot, that's really…I think that's amazing. I really wish I had that when I was a bit younger, and I think that's really good. I wish…
>
> Hazel: You wish it had been around?
>
> Euan: Yes, but I find that quite important because I would never have done anything, I would never have said to anyone in person I think I'm gay, I don't know how to cope with it.

As Euan had been unable to come out at school (and indeed was out in very limited contexts as an adult – only to his brother) anonymity within support services was of paramount importance to him. Although Euan was the only participant in this study who was out to so few people, I argue that he therefore gives unique insight into the many young LGBT+ people who remain unable to come out, and therefore might not feel able to participate in a study such as mine. Although Euan felt that support specifically as an LGBT+ young person would have been useful for helping him to accept his sexuality, without the guarantee of anonymity, accessing such support would have been completely impossible.

6.5 Discussion

This chapter sought to address a gap in the existing research about LGBT+ youth suicide by focussing on factors felt to protect against suicidal distress and suggestions to reduce LGBT+ youth suicide in the future. Research to date, in both youth suicide and specifically LGBT+ youth suicide, has suggested that young people can be reluctant to seek help from professionals (Gould and Kramer, 2001; McDermott, Hughes and Rawlings, 2016; LeCloux *et al.*, 2017). However, the young people who participated in this study spoke extensively about their help-seeking efforts and therefore to address this contrast with existing research and to contextualise the positive experiences discussed later in the chapter, I began by discussing the barriers faced.

Participants discussed frequently and proactively reaching out to Gender Identity Clinics (GICs) and specialist mental health services (both accessed through their GPs as gatekeepers). The majority of participants waited on long waiting lists to access these services, due to the scarcity of resources available, in the hope that once accessed they would be effectively supported. It seemed for some that this contributed to a huge sense of expectation attributed to the services and their resources, and to a huge sense of disappointment if the services did not match up to those expectations. In part, perhaps the scarcity of services available to participants, the manner in which a single service was often perceived to be the only way to improve participants' situations, and the length of waiting times, explains the intensity of frustration participants described when the services had not fulfilled their expectations. Furthermore, it is possible that this scarcity contributed to the notions that participants reported feeling themselves, and experiencing from their parents, that they needed to be 'bad enough' to receive mental health support. However, at times of suicidal crisis, support was predominantly provided by helplines (such as the Samaritans, Childline and LGBT Youth Scotland) or from peers.

Consistent with the existing literature (Bailey *et al.*, 2014; Ellis, Bailey and McNeil, 2014; Carlile, 2019), trans participants expressed a sense of entrapment, whilst waiting for access to medical transitions. This appeared, within this study, to specifically contribute to participants' inability to see a future and in turn their suicidal thoughts. There seemed to be particular complexities in coordinating and communicating care for trans young people who experienced suicidal distress. However, many of the participants in this study, both cis and trans, felt they had not been provided with the care they expected or desired in specialist services. It might therefore be useful for both clinicians and young people to find ways to communicate expectations clearly, in an appropriate manner for young patients.

The difficulties communicating went in both directions. Participants spoke about challenges they experienced disclosing the severity of distress they felt to professionals. Therapeutic exchanges appeared to be high-stakes interactions for participants, and were highly emotionally charged. In the context of the social isolation, rejection, and disconnection discussed in Chapter Five, participants discussed how their help-seeking efforts served to either compound or dispel these emotions. For example, in therapeutic relationships in which participants felt they were experiencing further rejection, even a single, short incident, could destroy participants' faith that the relationship could work at all. However, in contrast, participants stated that a stable relationship with an affirming therapist could provide the key to improving their mental health, and for many, it appeared that this could be the only affirming adult relationship they perceived they had. Unfortunately, the opportunities for such a therapeutic alliance were often time-limited. Therefore, despite the hope that therapeutic techniques could be internalised and used independent of the therapist (Fenn and Byrne, 2013), for participants in this study, this was not the case. Instead, they tended to value the interaction with a therapist over the tools they learned, and therefore the positive effects were not sustained long-term once contact with the therapist stopped.

Perhaps in part because of this, access to peer support was considered an essential part of both on-going mental health support and distraction during times of crisis; providing often instant and long-term access to support. However, without support or training for those providing peer support, this may take a significant toll. Therefore, in future, it may be useful to consider ways that young people can be more robustly supported to provide effective and sustainable peer-support.

In Meyer's (2003) work he proposed the concept of 'minority coping' which referred to the process through which LGBT+ people who experience a strong sense of community cohesion may be able to draw on community level resources allowing them to cope with queerphobia. Some participants had been able to connect with other LGBT+ young people in their pre-existing friendship networks. However, other participants proactively sought out other LGBT+ young people either through LGBT+ youth groups, societies, or online. It appeared that through connections with LGBT+ peers, participants were able to draw on community level resources. In doing so, young people reported reduced isolation, drawing on these community level resource to gain a sense of belonging and community, exploring their identities, and sharing information

Perhaps unsurprisingly, when asked what participants believed would help reduce LGBT+ youth suicide in the future, they drew on themes discussed across this chapter: reducing queerphobic stigma and improving mental health support. They were acutely aware that there was a scarcity of mental health support available, which they argued needed addressed, whilst also raising a desire for enhanced LGBT+ awareness amongst mental health professionals. Furthermore, perhaps due to the prevalence of queerphobia in participants' lives, they felt that dismantling queerphobic stigma was essential for reducing LGBT+ youth suicide. Schools were seen as the key site for this, perhaps in part because the majority of participants had been bullied in school, but also because participants felt that this was the most efficient way to change the attitudes of future generations.

Although the focus on reduced queerphobic stigma and improved mental health support offers a seemingly neat solution to the issues raised throughout this chapter, I want to draw attention to some issues raised in this thesis that sit silently unaddressed at the end of this final findings chapter. Rob Cover's (2012) work warned of the possibility that the repeated presentation of connections between being LGBT+, experiencing queerphobia and suicide, may have normalised suicide as a response to queerphobia. Cover argues that this normalisation may not solely be found in societal understandings, but in LGBT+ young people's own understandings too. In this study however, participants painted a far more complex picture, including experiences of abuse, bullying, queerphobia and familial non-acceptance, and educational difficulties. Whilst some of these issues could be addressed through the strategies proposed by participants in this chapter, some would not be.

There are a variety of reasons why some factors may remain unaddressed. Potentially this may be because, as proposed by Cover, dominant narratives have cemented an almost causal relationship between queerphobia and suicide. Alternatively it might be influenced by the participants knowledge of the focus of this study (LGBT+ youth suicide), reinforced through the hypothetical framing of the question asked in the interview, meaning that participants perhaps focused on the factors they imagined would be common across LGBT+ young people who thought about suicide: queerphobia and mental health problems. However, this may also have been a reflection on the factors that participants felt could be most easily addressed. It has been commented that suicide and suicide prevention research often aims to influence a clinical audience and therefore can over-focus on individual, psychological factors that are viewed as modifiable (Button, 2016). Similarly, it is possible that participants in this study perhaps focussed on the factors influencing suicidal distress that felt the most accessibly modifiable: queerphobia and mental health support. Whereas those factors that participants were both not sure would be shared across the LGBT+ youth population - such as abuse or educational difficulties - and that they were less clear how to ameliorate, remained unaddressed. It is these complexities that I will try and draw together in the final discussion chapter of this thesis.

Chapter 7 Discussion

7.1 Introduction

In this final discussion chapter, I will synthesise the findings and discuss the unique contribution that this doctoral project makes to existing research. To begin I will revisit the aims of this study in order to present how my findings answer each of my four research questions. I will then move onto discuss how these findings relate back to the research literature discussed in chapters one and two and how they progress our knowledge about LGBT+ youth suicide. I will pay particular attention to the implications this has for the theories I have drawn on, the development of methodological innovation, as well as suggesting ways that government policy and clinical practice might respond to this and potential directions for future research. To close this thesis, I will give an overview of the strengths and limitations of this study.

7.2 Revisiting the aims of this study

In this study I aimed to address a number of limitations identified in the existing literature. Firstly, despite an established body of research seeking to understand LGBT+ youth suicide internationally, literature focussing on the experiences of LGBT+ young people who think about and attempt suicide in the UK is more limited. Furthermore, I was unable to find any research focussing specifically on the experiences of young people living in Scotland. In section 1.3, I discussed the national variations found within the UK. In previous decades Scotland had lagged behind England & Wales with regard to decriminalisation of homosexuality. However, Scotland led the way abolishing Section 28 before England & Wales and more recently introduced LGBTI inclusive education across all Scottish state schools, with recommendations in place since 2018, and expected delivery by May, 2021 (Scottish Government, 2018c). Thus far, existing literature has positioned stigma as playing a central role in explaining disparities in mental health between LGBT+ and cisgender, heterosexual people, and that stigma is likely to be affected by geographical, socioeconomic and cultural specificities. It seemed there was a key gap left by not including Scotland in studies that seek to understand LGBT+ youth suicide in the UK; and this was a gap that I was keen to fulfil.

Secondly, much of the existing research had focussed on the disparity in the prevalence of suicidal thoughts and attempts LGBT+ young people compared to their heterosexual, cisgender peers (McDermott and Roen, 2016). However, there was less research exploring why these disparities existed, and even less on what protected young people from suicide and how things could be improved (Savin-Williams, 2001; Savin-Williams and Ream, 2003; Hatzenbuehler*, 2009;* Haas *et al.*, 2011; McDermott and Roen, 2016; Bryan and Mayock, 2017; Clements-Nolle *et al.*, 2018; Hatchel, Merrin and Espelage, 2019). In the research that did seek to explain this disparity, it was argued there was an over-reliance on queerphobia as the primary explanation, and therefore a concern that other more general or youth specific factors could be missed as a result (Cover, 2012; McDermott and Roen, 2016; Bryan and Mayock, 2017; Clements-Nolle *et al.*, 2018).

This reliance on societal stigma and discrimination (sometimes termed minority stress) was particularly interesting as, more broadly, suicidology has been criticised for failing to take wider social and structural factors into account when trying to understand suicide, instead focussing on individual, psychological factors (Button, 2016; Rimke, 2016; Mills, 2018; Chandler, 2019; Inckle, 2020). Similarly, although queerphobia was recognised as existing in wider society, there was limited understanding of this as a social process. Instead, an almost automatic assumption was made between experiencing queerphobia and the possibility of suicidal distress; which, it has been argued, can be seen as re-pathologising LGBT+ youths, failing to fully account for the social and structural nature of queerphobia (Cover, 2012; McDermott and Roen, 2016).

Doing this doctoral research therefore, offered an important opportunity to take a multi-disciplinary approach, bringing individual psychological factors into dialogue with broader social and structural factors. I was keen to draw upon more sociologically informed theories of cis-heteronormativity to consider the ways in which acts of queerphobia were extensions of, rather than disruptions to, the community climates in which young LGBT+ people lived. The existence of queerphobia as subtly socially sanctioned and facilitated by cis-heteronormative community climates provided possible insights into the social production of LGBT+ youth's suicidal distress. I then used these more sociologically informed theories to create dialogue with established psychological theories in the development of suicide behaviours, to consider how and why LGBT+ youth might be more likely to experience key constructs associated with the development of suicidal thoughts and attempts, such as entrapment, thwarted belonging, burdensomeness (Van Orden *et al.*, 2010; O'Connor and Kirtley, 2018), that are often completely ignored within LGBT+ youth suicide research.

In sum, whilst this research initially set out to address the geographical gap in understanding the experiences of LGBT+ youths in Scotland, it furthermore has facilitated multi-disciplinary dialogue, drawing together established psychological knowledge with understandings from sociology, to better understand LGBT+ young people's suicidal distress. To facilitate this dialogue, I used a qualitative methodology to explore understandings of LGBT+ young people who had lived experience of suicidal thoughts or a suicide attempt. Qualitative methodologies offer opportunities to explore topics centred around lived experiences, facilitating spaces in which participants can share what they believe to be important (Pope and Mays, 1995). In my study this was further supported by an individual, semi-structured interview design to provide sufficient focus for participants to feel clear and confident of the study's aims, but sufficient freedom to enable them to share the factors they felt had influenced their experiences of suicidal distress (Riessman, 1987; Burgess-Proctor, 2015).

In this research I sought to answer four research questions:

1. How do young LGBT+ people in Scotland make sense of their suicidal thoughts and attempts?

2. What do young LGBT+ people in Scotland believe to be the contributory factors to their suicidal thoughts and attempts?

3. What do young LGBT+ people in Scotland believe to be the pertinent factors that have protected them from suicide?

4. What do LGBT+ young people believe could help reduce young LGBT+ people's suicidal thoughts and attempts in Scotland in the future?

To answer these questions, I conducted 24 semi-structured interviews with LGBT+ young people aged 16-24. All participants had experienced suicidal thoughts, ten had attempted suicide, and fourteen disclosed experiences of self-harm.

7.3 Revisiting the findings

I will revisit each research question individually to highlight my contribution to knowledge in each area.

7.3.1 How do young LGBT+ people in Scotland make sense of their suicidal thoughts and attempts?

In addressing this question I was keen to resist psychologised understandings of emotions and sense-making that have previously been criticised for reducing emotions into quantifiable measures (Burkitt, 2014; Chandler, 2016b). To begin answering this question, I considered the structure of participants' stories of developing suicidal distress, in addition to the content of them. The majority were keen to rewind their narratives to a 'beginning', often an initial difficult incident, which the participant deemed significant in its detrimental impact on their mental health; choosing to focus far more on external factors influencing their lives, than on their feelings responding to them.

As discussed in section 2.5.5.2, in their exploration of how young people think about suicide and self-harm, McDermott, Roen and Scourfield (2008) noted their participants considered having the 'correct' motivations for a suicide attempt was important for having suicidal distress understood as 'genuine'. Therefore in analysing the interviews, I considered whether, in constructing stories of suicidal distress as an almost rational series of events, participants were working to demonstrate their suicidal distress as genuine. Correspondingly, I also considered whether doing so worked to actively resist narratively positioning suicidal distress as overly-emotional. It has been argued that narratives around adolescent emotions have been used to diminish the seriousness of suicidal distress amongst LGBTQ youths and deny them help (McDermott, 2015), with the perception that emotional distress is a ‘normal’ or expected part of adolescence that will, with time, pass (McDermott, 2015; McDermott and Roen, 2016).

Participants in this study made sense of suicide in multiple, over-lapping and interacting ways, which therefore adds to existing understandings of LGBT+ youth suicide that either tends to take meaning-making for granted or else has looked at it primarily in relation to gender and sexual orientation. Many participants told chronological stories identifying incidents that they felt had contributed to the deterioration of their mental health. For some therefore, suicide was constructed as a response to the cumulative weight of the range of contributory factors they had experienced, positioning suicide as an escape from unbearable life circumstances, including normative pressures around sexual orientation and gender identity and the associated challenges with coming out (McDermott and Roen, 2016; Rivers *et al.*, 2018). Related to this, some represented suicide as a way in which they responded to social isolation, rejection and associated feelings of emotional numbness.

Suicide could be positioned as a way of escaping a situation that participants believed was irresolvable or unbearable, in which queerphobia often played a role, and could be conceptualised as requiring strength or bravery to enact. Further to this, I argued that some participants appeared to position suicide as a tool through which to query their value to others. In doing so, participants were somewhat embodying the rejection that they had experienced from those around them and projecting it back, in order to ontologically question the value of their existence *to others*. Additionally, suicide could be positioned as a communicative device through which participants could articulate how bad their emotional distress was and the connected need for mental health support. However, despite the many, varied interpretations of the role they felt suicide played, some participants also described an element of surprise at their own suicide attempts. For some this appeared to be a type of disassociation, in which participants viewed their physical actions as out of their conscious, cognitive control (Orbach, 1994; Levinger, Somer and Holden, 2015), perhaps reflecting the strength of internal conflict about wanting to live or die they experienced. Alternatively however, this may have been a narrative device aiming to create distance between the interviewee as the rational narrator of their story, and their previous, less rational and more emotional, suicidal self.

When initially constructing this research question, I was interested in exploring a concept discussed by Rob Cover (2012): that it was difficult to imagine a queer life untouched by suicide. Cover argues that the repeated connection forged between queer youths and suicide, both in social and research narratives, has meant that suicide may be viewed as a normalised response to queerphobia. Seeking to explore this, I noted in my sample there was an extent to which the connection between being LGBT+ and being suicidal was discussed. Many participants referenced awareness that LGBT+ young people were at heightened risk of suicide, with Harley most explicitly describing 'the tortured gay stereotype' and 'the really depressed trans stereotype'. However, rather than envisaging suicide as a normalised response to queerphobia, participants echoed the concerns of the 'suicide consensus' (Bryan and Mayock, 2017); pointing out the difficulties of continuously hearing repeated narratives that positioned LGBT+ young people as at risk of suicide, and suggesting that it would have been helpful to have recovery narratives simultaneously on offer. Indeed, some participants actively tried to push back against what they saw as a stereotypical perception of a suicidal queer teen, either by trying to create narratives that distanced LGBT+ young people from these stereotypes or, in one instance, by this featuring into one young person's reasons to stay alive. In this case, as described in Chapter Six, Alex described his awareness that his own suicide could impact other young people's suicidal distress, expressing concerns about a potential 'domino effect' that his own suicide could have instigated amongst his trans peers. This is not to entirely divorce suicide from LGBT+ contributory factors, but instead to argue that suicide was not seen as an automatic or normalised response amongst my sample, and that participants understood their suicidal distress through a broader lens.

The majority of participants began to experience suicidal thoughts between 12 and 14 years old, which had then fluctuated throughout adolescence, consistent with the evidence that suicidal distress is often cyclical (O'Connor and Kirtley, 2018). Many participants discussed a lack of 'seriousness' or legitimacy that they attributed to early suicidal thoughts, due to a strong sense that they would not act on them. However, this was often not the case with suicidal thoughts experienced later in their teenage years, as participants felt greater certainty that they intended to act upon them. Fourteen participants also discussed their experiences of self-harm, which is considered an established risk factor for suicide (Gordon *et al.*, 2010; Whitlock *et al.*, 2013; Franklin *et al.*, 2017). This understanding of self-harm as a ‘risk factor’, somewhat positions it as a step on an escalating trajectory of increasing distress, and indeed this was consistent with some participants’ accounts. In my study, some discussed how they had been, and still were, unable to distinguish their self-harm (through poisoning or cutting) from their suicide attempts. However, others provided accounts of self-harm that were more consistent with research that has suggested that self-harm can be used as self-care or a way to manage and de-escalate suicidal distress (Laye-Gindhu and Schonert-Reichl, 2005; Mikolajczak, Petrides and Hurry, 2009; Paul *et al.*, 2015; Chandler and Simopoulou, 2020).

Participants in this study provided complex and nuanced understandings of suicidal thoughts, self-harm, and suicide attempts, which might provide insights into important opportunities for interventions to reduce suicidal distress. Both the Integrated Motivational Volitional (IMV) model and Interpersonal Theory of Suicide (IPTS) propose that an important part of acquiring the capability or developing the volition to attempt suicide hinges on a decreased fear of pain and death (Van Orden *et al.*, 2010; O’Connor and Kirtley, 2018). It has been argued that thoughts and visualisations of suicide may act as a cognitive rehearsal, habituating suicide and decreasing the fear of death (Selby, Anestis and Joiner, 2007; Van Orden *et al.*, 2010; Crane *et al.*, 2014; Kleiman *et al.*, 2018; O’Connor and Kirtley, 2018), whilst self-harm may increase tolerance of pain (Gordon *et al.*, 2010). Therefore, although participants often expressed that early suicidal thoughts were of less concern and self-harm could help to regulate distress, they may, at times, act as early warning signs of escalating suicidal distress, and therefore could signal an opportunity for early intervention.

7.3.2 What do young LGBT+ people in Scotland believe to be the contributory factors to their suicidal thoughts and attempts?

Answering this question must be foregrounded with an understanding that, as discussed in 7.3.1, many participants made sense of their suicidal thoughts and attempts as *responses*, positing an almost causal relationship between social factors and events and suicidal distress. Suicide research more generally has been criticised for over-focussing on the psychological factors influencing suicidal distress, whilst neglecting the role of social factors (Button, 2016; Hjelmeland, 2016; Rimke, 2016; Mills, 2018). In contrast, research specifically seeking to understand LGBT+ youth suicide has been criticised for focussing on societal queerphobic stigma as the key factor explaining the elevated rates of suicidal thoughts and attempts amongst LGBT+ people when compared to cisgender, heterosexual people to the exclusion of all other factors (Cover, 2012; McDermott and Roen, 2016; Bryan and Mayock, 2017).

Although some emerging research, perhaps most notably the Youth Chances project has tried to bring together LGBT+ specific and youth specific factors (Rimes *et al.*, 2018), I have argued that they are often portrayed as separate and separable from one another. This can also be seen in Minority Stress Theory's positioning of expectations, experiences and responses to navigating queerphobia, as *additional* stresses to the day-to-day stresses that everyone experiences (Meyer, 2003). Although I agree in this study, participants' experiences did echo this in part, they also described times at which there were interactions between those factors that were LGBT+ specific and those that were youth specific. In these cases, it appeared that queerphobia somewhat infused experiences considered to be generally applicable to youths who think about or attempt suicide, furthering understandings of the interaction between LGBT+ specific and more general factors contributing to suicidal distress amongst LGBT+ youths.

To begin to understand this interaction, I drew upon a concept that has primarily been used in the North American context, 'community climate' (Hatzenbuehler, 2011; Meyer *et al.*, 2019), although an equivalent concept has been discussed in a British context as 'feeling accepted where you live' (Rimes *et al.*, 2018). The notion of being queer in a heteronormative cultural orientation has been explored in depth in Sara Ahmed's *Queer Phenomenology* (2006). Ahmed argues that repeated exposure to heteronormativity, heterosexuality can be thought of as a societal orientation, and therefore constructing a queer life, she proposes, is almost a process of disorientation. To explain further, the normalisation and naturalisation of living a heterosexual life means that it is treated as neutral, a background to everything else; by contrast therefore, living queerly stands out starkly as different to this expected norm.

As discussed in Chapter Five, I interpretted participants in my study as coming to understand their community climates through a range of everyday cis-heteronormative microagressions and queerphobic instances, occuring at both local and national levels. As was found across studies from England and Wales, within this context, LGBT+ youth were shamed for their transgression of cis-heteronormative norms (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; McDermott, 2015; McDermott and Roen, 2016; McDermott, Hughes and Rawlings, 2018), and it was within this context that all other contributory factors occurred. In drawing attention to the cis-heteronormative community climate, I aimed to complement understandings of queerphoia as a contributory or 'risk' factor for suicide. Joining voices such as Cover (2012) and McDermott and Roen (2016), I argue for a broader lens of analysis, holistically including the cis-heternormative cultural context as fertile ground in which suicidal distress was able to grow, that was additional to, although continuous with, the idea of queerphobia as specific hate incidents.

Bullying is a well-established risk factor for suicide amongst youths (Hinduja and Patchin, 2010; Bauman, Toomey and Walker, 2013; Holt *et al.*, 2015; Rodway *et al.*, 2016; Shain, 2016; Moore *et al.*, 2017). As LGBT+ youths experience high levels of bullying when compared to their cisgender, heterosexual peers (Fedewa and Ahn, 2011; Toomey and Russell, 2016; Myers *et al.*, 2020), it has been argued that bullying may be a particularly important risk factor for LGBT+ youth suicide (Almeida *et al.*, 2009; LeVasseur, Kelvin and Grosskopf, 2013; Mustanski and Liu, 2013; Ybarra *et al.*, 2015; Peter, Taylor and Campbell, 2016; Hatchel, Merrin and Espelage, 2019). In this study it appeared that bullying was seen as consistent with, and somewhat an extension of, the cis-heteronormative context previously described. Bullying often targeted participants' non-conforming gender expressions, which their peers interpreted as evidence of a non-heterosexual sexual orientation, and this could be compounded by other forms of stigma such as ableism or classism. Consequently, any educational difficulties that participants faced were often in environments in which they were already bullied by their peers; for some this meant that they struggled to attend school, for others it meant that attending school was an unpleasant experience. I therefore argue that although educational difficulties and peer victimisation or bullying are established risk factors for suicide (Hawton, Saunders and O'Connor, 2012; Rodway *et al.*, 2016), amongst LGBT+ young people there may be additional pressures on educational achievement where the move to university can be envisaged as a young person's only escape route from 'inherently narrow minded places'.

Further to the peer and educational difficulties participants faced, amongst my sample, participants reported a number of adverse experiences in childhood such as abuse, neglect, parental substance use, and parental mental health problems. This echoes findings from the more general population of young people who think about and attempt suicide (*Miller et al.*, 2013; Serafini *et al.*, 2015). Abuse, assault and neglect was understood by some participants as a form of social disconnection, in which a situation or relationship that was expected by the young person to be safe or supportive broke down. In turn, participants explained that this could have a profound impact on their own self-esteem or self-compassion, as in some instances participants had understood their adverse experiences to have reflected their personal value as a child and had internalised this negative appraisal.

It has been hypothesised that the high levels of childhood abuse reported by LGBT+ young people may be due to queerphobia faced in the home (Schnarrs *et al.*, 2019). However, amongst this study's sample it appeared that the instances of abuse, assault and neglect reported were, on the whole, separate from young people's experiences of queerphobia in the home. However, additionally many participants who had come out, also experienced negative reactions which could range from parents pretending the child had not come out and therefore ignoring their LGBT+ identity, to parents threatening to, or actually asking, a young person to leave the family home. This is consonant with both UK and international research which has found that expected and actualised negative reactions to coming out can produce a pressure point for LGBT+ youths' emotional and suicidal distress (Diamond *et al.*, 2011; Rivers *et al.*, 2018; Hunt, Morrow and McGuire, 2020). In future research it might therefore be useful to consider in what ways parental negative reactions to their child's coming out might be considered a form of abuse or neglect.

In interpreting my data I was keen to consider how the contributory factors identified by my participants could be mapped onto key theories of developing suicidal distress such as the IMV model and IPTS (van Orden *et al.*, 2010; O'Connor and Kirtley 2018), in order to consider how experiences of queerphobia 'get under the skin' and increase suicide risk (Hatzenbuehler, 2009). The social isolation and rejection that participants experienced from peers, friends and families in response to coming out could be thought of as 'thwarted belonging' and burdensomeness, conceptualised as key stages in the development of suicidal thoughts (Van Orden *et al.*, 2010). Experiencing isolation and rejection from both peers and family, where a relationship was desired, meant that many young people did not have a place they felt they belonged as LGBT+ people, with some experiencing a lack of mutually caring relationships. Furthermore, the associated conflict in the home meant that some participants felt a sense of burdensomeness on their families, in some instances because they were explicitly told this was the case.

As a key finding of this research, adding to existing understandings, when participants understood this to be queerphobically motivated, it appeared to have an additional significance over and above other negative experiences. Young people's accounts of both their own beliefs and the beliefs of those around them, suggested that their LGBT+ identity was understood to be a core part of their personhood. Consequently, when a young person experienced a queerphobically motivated rejection, it was experienced as not just a rejection of a single personal characteristic, but moreover an ontological rejection of their existence as a whole. As a result, the cumulative weight of this rejection, in addition to participants' experiences of childhood abuse, educational difficulties, and bullying meant that many participants could begin to feel trapped in what they felt were very challenging circumstances and it was within this context that suicide could be envisioned as the most visible or accessible escape.

7.3.3 What do young LGBT+ people in Scotland believe to be the pertinent factors that have protected them from suicide?

Protective factors existed, in part, as a mirror image of those contributing to suicidal distress. As previously discussed, some participants understood suicidal distress as responding to social isolation and rejection. Consequently, it was unsurprising that the process of undoing feelings of social disconnection and rejection by connecting with other LGBT+ people seemed to be crucial in the reduction of suicidal thoughts. For some, this was a process of developing mutually caring relationships, which have been identified as important when considering the development of suicidal thoughts (Van Orden *et al.*, 2010), with the additional benefit of happening within a context where participants' LGBT+ identity was accepted and queerphobia was not present. For others, involvement in LGBT+ spaces, whether offline or online, allowed them to begin to understand and experience a new sense of 'normal' with regard to their LGBT+ identity. As has been found in existing research, being able to gain affirmation and support *as an LGBT person,* holistically recognising the young person's full identity, was an important protective factor against suicidal distress (Diamond *et al.*, 2011; McDermott, 2015; Peter, Taylor and Campbell, 2016; Hunt, Morrow and McGuire, 2020).

The experience of connecting with other LGBT+ people, and the associated sense of community belonging and cohesion, has been termed 'minority coping' by Meyer (2003). Meyer conceptualised that through minority coping, LGBT+ people would be able to access resources for support, and tools to help negotiate the challenges they faced, by drawing upon community level resources for problem solving. Within this study's sample, the majority of participants had found a part of an LGBT+ community in which they had been able to belong, with many finding this central to the reduction of isolation and improvements in their mental health. However, for many it had taken time and energy to find these communities, and therefore in future, it might be useful for services working with young people to be able to signpost to LGBT+ specific spaces and services, where possible establishing working relationships across services for joined-up provisions.

Although existing research suggests that young people, and particularly LGBT+ young people, find it difficult to seek help from professionals (Gould and Kramer, 2001; Wilson *et al.*, 2010; LeCloux *et al.*, 2017; Hughes, Rawlings and McDermott, 2018), this did not seem to be the case for my participants. This leaves a gap for future research to explore the experiences of young LGBT+ people who experience suicidal distress, but do not seek help. In this study, despite seeking help participants described multiple barriers to accessing support, whether through parental resistance to treatment, long waiting lists, or because they felt that their distress was being dismissed or minimised by the professionals they interacted with. I interpreted these reactions, whether from professionals or parents, as furthering the sense of rejection that participants reported; adding dismissal of their emotional distress to a context which they already experienced as strongly rejecting their personal identities more broadly. Consequently, some participants described how they had felt the need to disclose suicidal distress in a manner they were not comfortable with, in order to demonstrate the severity of their mental health problems. In contrast, when support relationships worked well, they served in part to dismantle the social rejection and isolation that participants felt. In fact, some participants said having regular contact with a professional that they could talk to, and gain acceptance and affirmation from, was the primary value of therapy to them.

It was often LGBT+ networks that supported participants to monitor their mental health and identify when external, professional help was required, signposting to services that were considered LGBT+ friendly. It was also through these networks that participants were able to immediately access support and distraction at times of a mental health crisis, which is highlighted as an important part of crisis support (Stanley and Brown, 2012; Oxford Health NHS Foundation Trust, 2018). However, it must be acknowledged that whilst peer-support was considered hugely valuable, it often required a large investment of time and emotional labour from young people who, for the most part, did not have any formal training or support for the care they were providing. Understanding whether there may be scope to set-up and nurture more formalised peer support schemes that are tailored for LGBT+ young people living with mental health problems, could be a future avenue for research.

7.3.4 What do LGBT+ young people believe could help reduce young LGBT+ people's suicidal thoughts and attempts in Scotland in the future?

Participants in this study were explicitly asked what they believed would reduce LGBT+ young people's suicide in the future. As discussed in Chapter Six, participants focussed on two key suggestions: reducing queerphobic stigma and increasing and improving mental health support. It is perhaps understandable, given the prevalence of queerphobic experiences across the sample, that participants believed reducing queerphobic stigma would help to reduce LGBT+ youth suicide in the future. Participants focussed on the potential of education in school to reduce queerphobia and improve the lives of LGBT+ young people. This may also have been influenced by the recent high-profile guidance aiming to introduce LGBTI inclusive education across Scotland, which advocates for the transformative potential of school-based education to include LGBTI people and reduce queerphobia (Scottish Government LGBTI Inclusive Education Working Group, 2018). Further to this, participants suggested that there needed to be an increase in the mental health support provisions available to young people and an improvement in the LGBT+ awareness demonstrated by staff. Participants offered fewer suggestions about how address other factors they identified as contributing to suicidal distress, perhaps because they were unclear about whether these factors were shared across the LGBT+ population, and therefore whether they would be of interest to this research project. However, this also may have been motivated by an uncertainty about a clear way to improve these factors.

7.4 What this means

7.4.1 Clinical implications

Some participants in this study stated that their interactions with clinicians had been undesirable at best and unprofessional at worst. Interactions with clinical services were often shaped by scarcity, with long waiting lists and restricted treatment options meaning some participants waited a long time for care they believed did not fulfil their needs. Research has highlighted large variations in waiting time to access Child and Adolescent Mental Health Services, but has stated that there are the shortest waiting times for young people who disclose self-harm (Smith *et al.*, 2018; Edbrooke-Childs and Deighton, 2020). However, within this study's sample, as discussed in Chapter Six, some participants did not wish to disclose their self-harm and suicidal distress in early discussions with medical professionals, and therefore may not have been viewed as urgent.

Furthermore, although likely to be motivated by a desire to provide trans young people with high-quality, specialist care, there appeared to be significant confusion about the navigation of care between mental health and gender identity specialists. Given the estimated heightened prevalence of suicidal thoughts and attempts amongst young trans people, it seems that this could indicate a need for clearer care pathways to be defined for trans young people who also experience suicidal distress. This could perhaps be accompanied by a greater roll-out of embedded psychological services within Gender Identity Clinics, as is present in some clinics. Whether in specialist gender identity or mental health services, it appeared that participants would benefit from clearer information, accessible to young people, to manage their expectations. This could be achieved by working closely with a wide range of young people when designing patient information.

In addition, it was suggested by participants that greater LGBT+ awareness would be useful amongst professionals that they had interacted with (GPs, mental health professionals, school staff, social workers, etc). Although participants did not explicitly state what they wanted professionals to be aware of, given the levels of queerphobia and cis-heteronormativity participants faced across multiple areas of their lives, it is possible that they needed reassurance that this was not going to similarly be present in their healthcare interactions. However, further research is needed to identify specific gaps in healthcare professionals LGBT+ awareness, from the perspectives of patients and professionals, to assess future training needs.

Some participants discussed how they had found therapy helpful because it had provided someone to listen to them, over and above the benefits of learning techniques and tools for self-managing suicidal distress. Others had been put off accessing counselling due to long waiting lists or had experienced the ending of care from mental health services as a further rejection. Due to the scarcity of free-at-the-point-of-access mental health care reported by participants, they discussed relying on peer support. However, they were also mindful of the limitations of the support their friends could provide due to both limited skills and the risk of burnout. The possibility of formally provided and supported peer support was proposed by some participants. At the time of writing, there did not appear to be any formal peer support interventions for LGBT+ youths who experience mental health problems, including suicidal distress, in Scotland. However, since existing evidence suggests that young people are most likely to reach out to peers for support with suicidal distress (Gould and Kramer, 2001; McDermott, Hughes and Rawlings, 2016; LeCloux *et al.*, 2017), it may be useful to consider whether there is scope to develop interventions to train LGBT+ youths to support one another. It must be noted that it is unlikely that young people who were not out would feel comfortable accessing peer support services, due to the risks associated with disclosure, and therefore this strategy is not appropriate for all.

7.4.2 Policy implications

Every Life Matters is Scotland's suicide prevention action plan (Scottish Government, 2018b), and specifically mentions LGBT adults and young people as a group considered at higher risk of suicide. In order to address this, the Scottish Government has offered mental health and suicide prevention training to NHS Scotland staff, and it is through this training that issues such as LGBT+ awareness could be raised. However, the depth of this training and the extent to which broader LGBT+ awareness may be provided are unclear. Throughout this study it was clear that participants learned the acceptability of their existence as an LGBT+ person from a wide range of social cues and to some extent had come to expect queerphobia. Undoubtedly LGBT+ awareness and a sensitivity to LGBT+ issues are necessary in suicide prevention efforts. It would perhaps be useful to take a wider perspective and consider how the broader culture of health care environments could proactively work to dispel perceptions of cis-heteronormativity and queerphobia, to facilitate successful working relationships in which young LGBT+ people feel comfortable to disclose suicidal distress. For example, considering ways that they can proactively communicate a service's pro LGBT+ attitude and any LGBT+ specific training professionals within a service might have undertaken, either through online or in-person information provided about their service.

The second area of policy clearly implicated is the introduction and implementation of LGBTI Inclusive Education (Scottish Government LGBTI Inclusive Education Working Group, 2018). Many participants in this study suggested that further inclusion of LGBT+ subject matter on their school curriculum could have helped to change their peers' perceptions of LGBT+ people more generally, and in turn reduce the queerphobia they had faced. However, participants who had experienced attempts by schools to include LGBT+ content raised warnings that teachers needed to be prepared for how pupils might negatively interact with this content. The recommendations of the LGBTI Inclusive Education Working Group, suggest that there is a need to embed LGBTI inclusion in the Scottish school and teacher education curriculum and to specifically monitor instances of queerphobic bullying in schools. In doing so it would perhaps be more possible to gain a clearer picture of the prevalence of queerphobic bullying and monitor the extent to which this is ameliorated by LGBTI inclusion in the curriculum. In turn, this could help the education sector to better understand the support needs of LGBT+ young people, and begin to address a central component in participants in this study's suicidal distress.

7.4.3 Research implications

The findings of this thesis present a number of opportunities for future research. Firstly, as youth suicide is a major public health concern (Hawton, Saunders and O'Connor, 2012; Bilsen, 2018), both because of the immediate detrimental effects on young people experiencing suicidal distress and because suicidal thoughts in adolescence have been argued to be significant predictors of mental health problems in adulthood (Cash and Bridge, 2009). For LGBT+ young people, the difficulties of adolescence can be amplified as they simultaneously negotiate coming to terms with their LGBT+ identity, and coming out to themselves and others (Diamond *et al.*, 2011; Rivers *et al.*, 2018). However, the majority of research on youth suicide, is undertaken with those aged over-16 on the assumption that the findings can be applied to those under-16 (Irish *et al.*, 2018). Most participants in this study stated that they had begun to think about suicide between the age of 12 and 14, often a similar time at which they had begun to consider their LGBT+ identity. I therefore propose there is an opportunity for future research to work with LGBT+ people who have lived experience of suicidal distress aged under-16, in order to address this gap in understanding. However, as discussed in Chapter Three there are a number of complex ethical issues associated with this, particularly around the negotiation of informed consent, which would need to be taken into account.

Secondly, building on the themes constructed across this thesis, it would be useful to consider methods that would allow engagement with participants that both had and had not engaged in help-seeking, to explore avenues for future suicide prevention. In this research the majority of people were out to at least one parent, with only one participant considering himself to not be out. It would be useful therefore in future research to consider ways that young people who are not yet out, or who would feel uncomfortable engaging with research in face-to-face settings, could have their voices heard. One way to address this, could be to consider the use of anonymous methods such as surveying (whether using qualitative, quantitative or mixed methods). This would be particularly useful when gathering data around the kinds of mental health and suicide prevention work that would be helpful amongst a wide range of LGBT+ youth. Additionally, it would be useful to conduct quantitative research to gain a clearer understanding of the prevalence of suicidal thoughts and attempts amongst young people (including those aged under 16) in Scotland. This would be particularly useful for gaining insight into whether particular groups within LGBT+ communities are disproportionately affected by suicidal distress, comparing within group differences to enable more focussed work with those most severely impacted.

7.4.4 COVID-19

This thesis was written up, almost in its entirety, during the COVID-19 pandemic, therefore it would seem remiss not to make any mention of the changing state of the world and the potential consequences for LGBT+ young people. As part of the UK wide ‘lockdown’ to prevent the spread of COVID-19, UK schools were shut from March 2019 to the end of the academic year (Crawley *et al.*, 2020). For those young people at transition points, either into higher education or the work place, COVID-19 may have interrupted or disrupted opportunities (Power *et al.*, 2020). There have been specific concerns expressed about young people experiencing abuse and neglect; outwith the global pandemic, it is expected that schools might notice signs of abuse and neglect and be able to intervene. More broadly schools can also provide respite outside of the home environment for the young people affected. However, with very limited contact outside of the home during lockdown this was not possible, although for young people already identified as 'vulnerable', provisions were put in place (Crawley *et al.*, 2020). For young people with pre-existing mental health conditions, the structured routine of school can be an important part of managing their mental health (Lee, 2020). However, it is also worth noting that whilst many young people may have been detrimentally affected by school closure, for those who struggled in school environments with pressures around attendance or achievement, or who have been bullied at school, this could have a had a positive effect (Danese and Smith, 2020).

It is recognised that the negative mental health effects that are a consequence of the pandemic are unevenly distributed amongst people who already experienced disadvantage (Power *et al.*, 2020), and within this the risk to LGBTQ+ youth has been identified as an area in need of further investigation (Gorczynski and Fasoli, 2020; Smith *et al.*, 2020). Furthermore, early findings from the Queerantine Study of adult LGBTQ+ mental health during the pandemic, suggest higher rates of stress and depressive symptoms are observed amongst LGBTQ+ populations. This is also thought to have had greater impact on trans, gender-diverse, and young sections of this population (Kneale and Bécares, 2020).

As discussed, experiences of queerphobia both at home and at school, meant neither context was perceived as entirely safe. As a result, for many, finding LGBT+ communities whether offline or online had been crucial to improving and supporting mental wellbeing (McDermott, 2015). During the COVID-19 pandemic, young people may have been unable to access in-person LGBT+ spaces and further, whilst often whole families were spending sustained periods of time together, could mean young people's online activities are submitted to increased familial surveillance. Thus, further research in this area will be necessary to fully understand the impact of COVID-19 on young LGBT+ people's mental health.

7.5 Strengths and limitations

My research is the first qualitative study that sought to specifically understand LGBT+ young people's suicidal thoughts and attempts in Scotland. My findings are broadly consistent with the findings of the small number of projects from England & Wales, as well as international qualitative research on LGBT+ youth's suicidal distress (Diamond *et al.*, 2011; McDermott and Roen, 2016; McDermott, Hughes and Rawlings, 2016; Peter, Taylor and Campbell, 2016; Oginni *et al.*, 2018; Rimes *et al.*, 2018; Rivers *et al.*, 2018; Hunt, Morrow and McGuire, 2020). Furthermore, although this study focussed on LGBT+ young people, currently living in Scotland, who had thought about or attempted suicide, some participants had migrated, having grown up at least in part in other parts of the UK, or indeed the world. Therefore, whilst the findings of this research were designed to be specific to Scotland, they may have broader application internationally.

In this research, I built on this growing body of research to argue that whilst queerphobia played an important role in some elements of LGBT+ youth suicide, it was part of a far more complex picture. To begin to explore these complexities, I built on McDermott and Roen's (2016) work on the ways in which suicide can be seen as responding to normative societal standards, arguing that cis-heteronormativity can be seen as the backdrop against which all other experiences occur. As a result, cis-heteronormativity cannot be considered a separate but additional stressor in young LGBT+ people's lives, but instead must be considered an active and integrated structure that infuses and interacts with all other experiences. In doing so, I attempted to construct dialogue between more sociologically focussed theories of cisnormativity and heteronormativity, with psychological theories in the development of suicidal distress. This enabled me to consider the material consequences of cis-heteronormativity and the ways in which models of suicide behaviours can more fully account for social factors impacting upon LGBT+ young people's suicidal thoughts and attempts.

Given the sensitivities of the topic, I was aware from the outset that there might be difficulties both in recruiting sufficient participants to this study, and facilitating representation of some of the diversity of LGBT+ youths. Therefore, I meticulously planned a range of in-person and online recruitment efforts (both individual and through a range of Third Sector organisations). Consequently, I recruited 24 young LGBT+ people with lived experiences of suicidal thoughts and attempts. This sample included people with a range of suicide experiences, from those that had experienced suicidal thoughts sporadically to those who had experienced long periods of hospitalisation, and a wide range of LGBT+ identities. Twenty-two participants disclosed a physical health condition, chronic illness, sensory impairment, Autistic Spectrum Disorder, learning difficulty, neurodevelopmental disorder, speech disorder or mental health condition (either current or prior). Participants came from both rural and urban areas of Scotland, with all deciles of the Scottish Index of Multiple Deprivation represented within my sample, and had a range of work and educational experiences.

Previous research on this topic has suggested that bi and trans young people might be at heightened risk of suicide when compared to lesbian, gay and cis young people (IOM, 2011; Marshal *et al.*, 2011; Rimes *et al.*, 2018). However, there is a lack of research exploring trans young people's experiences of suicidal thoughts and attempts (Toomey, Syvertsen and Shramko, 2018; Rimes *et al.*, 2019), with the majority coming from clinical settings (Surace *et al.*, 2020; Connolly *et al.*, 2016). Therefore, I was keen to ensure that bi and trans young people were well represented in this study. In recognition of the expansion of terminology used by young LGBT+ people, I asked people explicitly which terms they used to refer to themselves. Ten participants were trans and a further one described themselves as having a non-binary gender identity but did not consider themselves as a trans person. Furthermore, eighteen participants described having a non-monosexual sexual orientation such as bi, queer, or pansexual meaning that this research was able to capture the experiences of a range of LGBT+ people with a range of LGBT+ identities. The diversity of this sample is a strength of this research, enabling me to consider whether and how a range of factors impacted upon participants' suicide experiences.

One challenge I experienced was the gender split of the sample. In this study, the gender split of the sample was fairly even with seven participants describing themselves as men or male; eleven as women or female; two as non-binary; and four describing themselves as a combination of binary and non-binary gender terms such as ‘non-binary trans woman’ (discussed in Chapter Three). However, when broken down further there was a lack of representation of cisgender gay, bi or queer (GBQ) men and trans women. Although I attempted to address this through more targeted recruitment, these two groups remain under-represented. Given the disproportionate effect of suicide on men in Scotland (Mok *et al.*, 2012, 2013), the under-representation of cisgender GBQ men must be acknowledged as a limitation of this research, whilst the engagement with trans men can be recognised as a strength. Secondly, whilst there were three Black, Asian, or Minority Ethnic participants, this study predominantly included white participants. In future, I would work more specifically with trans women, cis GBQ men and BAME LGBT+ organisations from the outset of designing this study, to discuss how to make my research more accessible.

The limitations to the diversity of my sample were exacerbated by the large interest I received from potential participants at the opening of recruitment. Although I did, to a small extent manage to pause, revisit and revise my recruitment strategy, in part my own reluctance to turn people away limited my ability to recruit a more diverse range of participants. In future, I might begin recruitment concentrating specifically on organisations working with the groups under-represented within this study’s sample, to try to engage with those least engaged with first. Alternatively I could set myself quotas for sub-groups that I want to engage with, which could then inform more targeted recruitment.

A strength of this work was its explorative nature, seeking to capture the depth of experiences rather than breadth, which I believe was achieved. However, in focussing on young LGBT+ people who had thought about or attempted suicide there were gaps left in our understanding. Firstly, although this study identified a range of factors contributing to young LGBT+ people’s suicidal distress, I did not include LGBT+ young people in this study who had not thought about or attempted suicide. Without this comparison group it is impossible to say whether these factors affect all young LGBT+ people or to assess whether there are critical differences that might mean that the young people included within this study went onto think about or attempt suicide, and others facing similar contributory factors did not.

Secondly, when considering future interventions to reduce LGBT+ youth suicide, it would have been useful to also gather views on feasibility from those whose job it would be to implement suggestions; for example, teachers, clinicians, and youth workers to name a few. Without these perspectives it is impossible to know what work might be on-going or planned in the near future. It would therefore be useful in future research to discuss with professionals working with LGBT+ young people what they believe are the opportunities for enhancements to provisions and practices, as well as the barriers that they foresee to implementation. Facilitation of a dialogue between young people and the professionals that work with them might further offer insights into points of misunderstanding and illuminate ways to address this.

7.6 Methodological reflections

7.6.1 Design

There is growing interest in conducting qualitative suicide research (Hjelmeland and Knizek, 2010), however due to the infancy of qualitative suicidology there was a limited pool of research to draw upon when designing this study. Although I read a large amount of qualitative research methods literature, in particular focussing on interview-based methods and methodologies to help prepare for this study, I felt quite nervous before I undertook the research that the structure of the interview wouldn’t work. I had been keen to use a very loose structure in my interview schedule to allow my participants to guide me towards what they felt had been important in their own experiences of suicidal distress. However, I was also conscious that when insufficient structure is provided, participants can sometimes experience ‘the interpretative problem’ (Silverman, 2001a), where they try to infer what the researcher is asking for and answer that question.

Although, as discussed in Chapter Three, I carefully considered a range of methods, I believe interviewing was the right choice for this project. On reflection participants seemed, for the most part, to have a clear idea of the elements of their stories they wanted to tell me about, with some even having prepared notes in advance so that they didn't miss parts of their stories that they found important. This openness to sharing ideas about the interview schedule and the paper-based resources appeared to help facilitate participants' comfort, with some positively referencing this management of expectations, and only one participant saying that she had asked a friend who had already participated in an interview in order to further clarify what was going to happen.

Interviews provided a private space, which meant that participants could explore their experiences in a way that I am unsure they would have, using another method. Interviews as an individual method allowed me to reflect and honour the pace of participants' accounts, as well as allowing us to pause interviews wherever participants wanted. The majority of participants stated that they had chosen to volunteer for the study for altruistic reasons, describing a desire to help out future young people who were like them. As a result, the interviews often had a level of personal and emotional value to them. A combination of these motivations and, as discussed throughout my findings chapters, the high levels of rejection and dismissal reported, meant that participants seemed very keen to share their stories with someone who wanted to listen. Consequently, interviews were often very long, which led me to consider whether it might have been helpful to have had two interviews with participants, both to break up the dialogue and to give them, and me, more time to reflect on their experiences in relation to this research.

Despite the relative strengths of an interview-based design, there were a number of limitations that I must reflect upon. Firstly, participants reflected on the contributory factors to suicidal distress for longer than they reflected on the factors protecting them from suicide and promoting wellness. Participants often had clear ideas of the factors and events that had a detrimental impact on their mental health, whereas it appeared that factors keeping them safe from suicide were often more gradual and subtle. Therefore, whilst participants often articulated a sense that suicidal distress was less present than it had been at a previous time, they seemed to articulate a less clear pathway to this point. As a result, in future research I believe that careful consultation and piloting would help to further refine more positively focussed interview questions, in order to facilitate more in-depth reflections on factors promoting wellness and preventing suicide.

Secondly, I was keen to avoid an overly narrow focus of the interview schedule. I wanted to offer participants space to explore their own priorities, providing the interview schedule in advance with the hope of relaxing participants, managing their expectations and allowing them to consider their answers in advance of the live interview setting. Participants also articulated appreciating being provided with the interview structure in advance in order to manage their expectations. However, on reflection I considered the possibility that these stories were not shaped in accordance with the elements that participants felt were important, but instead the elements that they felt would either be interesting to the research project and myself as a researcher, or that would be shared with other participants in the study. For example, although participants did sometimes mention experiences of stigma that were not specific to their LGBT+ identity, such as classism or ableism, these were presented in less detail than participants' explorations of queerphobia and cis-heteronormativity. Racism however was almost invisible within participants' narratives. Furthermore, as reflected in Chapter Six, participants chose to reflect primarily upon ways that queerphobia could be disrupted as a method of reducing LGBT+ youth suicide in future. Although this focus may in part have reflected the widespread experiences of queerphobia and cis-heteronromativity participants had, this focus may also have been shaped by the focus of this study. Participants were recruited as young LGBT+ people with lived experience of suicidal thoughts or attempts, and therefore may have assumed that the relationship between LGBT+ specific experiences and suicidal distress would be of primary importance to the study. As a result they may have limited their discussion of other elements of their identity to reflect this perceived focus, in fact reproducing the exact narrow focus that this study aimed to disrupt.

7.6.2 Researcher Identity

This study required me to carefully balance my identity as a researcher, a member of the queer community, and as a youth worker. I have worked as a youth worker for over five years and have always worked specifically supporting LGBT+ young people. At times in this study I was not only conducting research with young people in my work demographic, I was also conducting research in my work space, using the same room I use for one-to-one youth work for my research interviews, meaning that there was physically no separation between my research and youth work spaces. However, the experience of conducting research was very different to being a youth worker, and therefore I had to be extremely mindful of navigating this balance, internally monitoring my practice, throughout my interviews. When I ask questions as a youth worker, the purpose of doing so is both to understand a young person's experiences, but also to try to gather sufficient information to consider what types of signposting and further support might be helpful. In doing so I can work with a young person toward a desired outcome, as part of an on-going working relationship. In contrast, the process of conducting research to me felt somewhat more transactional. It was ethically essential that I enacted careful boundaries to ensure that participants' expectations were not mismanaged, and that they knew that I could not provide future support. However, as a result, I continuously questioned myself, asking whether I had asked a question for the right reasons or whether I was slipping into the familiar comfort of a youth work role, reflectively listening without focus on the research questions and interview schedule in mind. Perhaps as a consequence of this constant internal monologue, I felt far less comfortable than I would in other interactions (including those I have as a youth worker), affected by a fear that I might be crossing a research:support boundary.

I do not think that this was helped by the solitary nature of doctoral work. In a youth work environment, I work as part of a small, specialist team, for the most part we work together in a very immediate sense (for example, if I experience a problem I can nearly always immediately call on a colleague to help and vice versa), and we are further supported by senior colleagues to whom we can defer to or ask advice from wherever necessary. Whilst the presence of senior colleagues to whom I could defer and ask advice was available in the form of my supervisors, the sense of team-working which I was used to was not. To try and address this I set up a reflective practice group of my fellow doctoral students with whom I discussed my research practice, from which I arranged after each interview a debriefing conversation by phone or by text of how I was feeling. This served to replicate, in part, the team-working environment that I was used to and enabled me to reflect on the strengths and challenges of my practice. However, the other members of the reflective practice group and I, were not working on similar projects. Thus whilst they were able to lend a listening ear, they were not able to discuss the specific details of the research project in-depth or provide advice, as whilst deeply valuing each other and the support we provided, we were not part of the same research project or team. I believe that this in part contributed to a sense I felt of not really gaining confidence in my research practice. In future it might be useful to consider ways in which doctoral researchers could become embedded in pairs or teams working on similar topics to facilitate mutual support relationships; this may be of particular interest whilst many researchers work remotely during the global pandemic.

7.6.3 Venues and logistics

It was very important to me that interviews were held in locations that were comfortable to participants. The interview location was also very important to participants, as this was often one of the few questions that they asked me during the initial phone call. Whilst I did not want to pass the burden of finding a location onto a young person, I also didn’t want to hold interviews in places they felt uncomfortable. For example, one of the locations I was recommended by a colleague was a church. Whilst the church was very happy to rent its room to me, one of my participants queried whether the church would be happy to have us, reflecting tensions perceived between Christianity and the LGBT+ community. Similarly, two participants who lived in small towns asked to meet in a nearby large city due to concerns about being identified. To try and navigate this I had to find and locate venues that were affordable and conveniently accessed by public transport; this was time consuming and often difficult to organise. I then wrote to the participant with a suggested location caveated by saying I did not know the area well and was very happy to take suggestions.

There are however challenges of working with hired, public venues. For example, in one hired venue a member of staff was extremely helpful, however despite my best efforts she did not quite understand the need for privacy and popped in part way through the interview to see if everything was alright with the room (despite me already having let her know it was great). Furthermore, even in venues I knew well, interviewing in them was a process of making the familiar somewhat strange. For example, as discussed, I conducted some interviews in my own youth work centre, in which our meeting room contains a range of resources for both sexual and mental health including a huge display of safer-sex products. Due to my familiarity with the room I had neglected to notice the possibility that a large display of safer-sex products might be strange to a participant who anticipated coming for an interview about suicide, until one participant clearly looked confused at the display.

A final challenge has been a central under-current to this thesis: cis-heteronormativity and queerphobia. As a general rule I tried to meet participants at the entrance to any building to ensure a warm greeting. However, one of my participants was exceptionally early and found their way into a building's reception before I got there, where the receptionist loudly misgendered them to me. A second participant unfortunately had to walk directly past a preacher with homophobic signs shouting homophobic views on her way to meet me (who I then walked past after the interview) and described in our meeting how she and another passer-by had tried to challenge him. Whilst these kinds of interactions are unavoidable and often expected by LGBT+ young people, it is an important consideration anywhere where there are front of house staff that can be pre-warned and an important consideration for any researcher working with LGBT+ people.

7.7 Conclusion

This study is the first piece of research specifically seeking to understand young LGBT+ people's suicidal thoughts and attempts in Scotland. However, despite national variations in legislation across the UK, and the 2017 claim that Scotland was the most inclusive country in Europe for LGBTI people (Scottish Government, 2017), these findings were consonant with an emerging body of research from England and Wales. Although some participants pointed toward the size, location or rurality of where they lived as responsible for the cis-heteronormative community climate and felt that other locations might be more accepting of LGBT+ young people, it did not appear that there was an actual location that was demonstrably better. Instead there appeared to be a range of factors, both LGBT+ specific and related to the wider youth population, that contributed to young LGBT+ people's suicidal distress (McDermott and Roen, 2016; Rimes *et al.*, 2018; Rivers *et al.*, 2018). Building on existing research, in this thesis I have argued that LGBT+ specific and more general factors contributing to LGBT+ young people's suicidal distress can be thought of both as separate contributors, but also as interacting and mutually reinforcing.

In this study, participants described experiencing adverse childhood experiences such as abuse and neglect and educational difficulties within a cis-heteronormative community climate. Consonant with the findings of work from England and Wales (McDermott, Roen and Scourfield, 2008; Scourfield, Roen and McDermott, 2008; McDermott and Roen, 2016; McDermott, Hughes and Rawlings, 2018), cis-heteronormativity was validated and reinforced through everyday practices, and those who transgressed these norms were shamed, communicating the lack of acceptance of LGBT+ people to them and those around them. It was in this context that participants expected and experienced queerphobia in the home and from bullies at school. Consequently this queerphobia can be understood as continuous with, and an extension of, the cis-heteronormative community climate established, rather than as unexpected, one-off events.

Adding to existing understandings, in this study I have argued that these experiences of queerphobic isolation or rejection and the associated lack of belonging appeared for some to hold particular weight. I interpreted that this was because participants viewed their LGBT+ identity as inextricably linked to their senses of selves. Therefore when people around the participant rejected this part of their identity, it was not simply understood as a rejection of a personal characteristic, but moreover a rejection of their core sense of self. This ontological rejection of participants' existence as LGBT+ people was therefore understood as a fundamental rejection of them as human beings. Consequently, for some young people in this study, there was simply no part of their life in which they felt that they could exist safely as LGBT+ people, and it was in response to the cumulative weight of this range of contributory factors in their life that they began to think about suicide.

Suicidal thoughts began for many between the ages of 12 and 14, around the same time that several participants began to consider their LGBT+ identity. For some these early suicidal thoughts were represented as less ‘serious’, than those experienced in later adolescence, over which participants reported an intention to act. I have raised the possibility that early thoughts could have a pernicious effect over time, with their onset perhaps offering us an opportunity for early intervention to reduce LGBT+ youth suicide in the future. Similarly, whilst for some a suicide attempt was seen as an escalation of long-term suicidal thoughts, for others a suicide attempt was seen as disconnected from participants’ suicidal thoughts, often experiencing them as a loss of control or an act of impulse, for some articulated as a type of disassociation.

Whether participants had experienced suicidal thoughts or additionally suicide attempts, they articulated multiple, over-lapping and interacting ways in which they made sense of the role of suicide in their lives. For most suicide was understood as a response, either to participants’ own feelings or to external, contributory factors. For some a suicide attempt was presented as a show of strength, perhaps reflecting wider societal under-appreciation of how hard it was for some young people to stay alive. Whilst for others suicide played a communicative role, demonstrating how over-whelming suicidal distress had become and the need for support. Some participants expressed an acute sense of entrapment, often in external life circumstances, within which they had become unable to see a way for things to improve and therefore had begun to see suicide as their only way to escape. Whilst others described experiencing a sense of numbness in response to unbearable life circumstances and emotional pain. For these young people suicide was both represented as a way of seeking existential confirmation, through sensation seeking, and an embodied querying of whether their existence mattered to others in their lives.

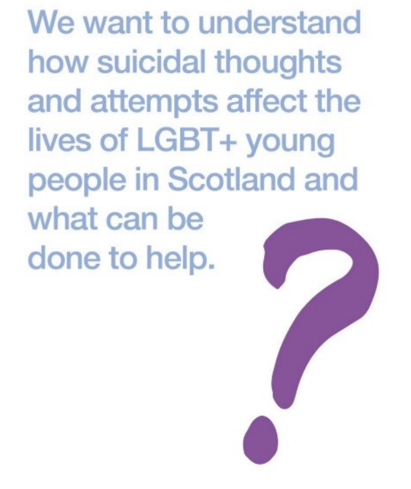
The senses of isolation, rejection and lack of belonging that underpinned participants’ suicidal distress were also addressed in participants’ accounts of protective factors. In contrast to the experiences participants identified as contributing to suicidal distress, consonant with existing research (Diamond *et al.*, 2011; Rivers *et al.*, 2018), where opportunities were identified to connect with others in ways that accepted and affirmed their LGBT+ identity, to some extent treating it as a single element of participants' whole person, participants in this study felt a sense of getting better. This therefore suggests that it was this sense of being able to forge connection with others, and feel one's value within those connections, that allowed participants to feel their lives were liveable. It was also through these connections that many participants were able to establish support networks, who often provided both crisis and long-term mental health support.

To end this thesis I want to reflect on participants' suggestions for reducing LGBT+ youth suicide in the future. Given the prevalence of queerphobia experienced in this sample, education was viewed as a possible effective way to reduce queerphobia both immediately for young people in schools, but also for future generations to come. In Scotland, the introduction of LGBTI inclusive education offers an opportunity to monitor the effectiveness of this suggestion in the near future. Furthermore, scarcity had appeared to shape the experiences of many participants who tried to access mental health care, alongside concerns that they might be met with cis-heteronormative or queerphobic professionals when they accessed services. Consequently expansion of mental health services that operated explicitly in a LGBT+ inclusive manner was considered essential for future reduction of suicide amongst LGBT+ youths.

In this study I have used a multi-disciplinary approach when seeking to understand LGBT+ young people's suicidal thoughts and attempts in Scotland. In doing so I attempted to address criticisms levied about LGBT+ youth and suicide research. Suicide research has been criticised for failing to take into account social factors contributing to suicide and over focussing on individual factors (Button, 2016; Hjelmeland and Knizek, 2016; Rimke, 2016; Mills, 2018). In contrast, LGBT+ youth suicide research has been criticised for focussing on stigma, discrimination and harassment without paying sufficient attention to those factors influencing suicide and youth suicide more broadly (Cover, 2012; McDermott and Roen, 2016; Bryan and Mayock, 2017; Clements-Nolle *et al.*, 2018). In this research, I have sought to articulate how the interactions between individual psychological states such as numbness, thwarted belonging, burdensomeness, defeat and entrapment are influenced by broader social and structural factors such as cis-heteronormativity, normative expectations of maturation, and queerphobia, thus contributing to suicidal distress.

In doing so I have attempted to navigate a complicated boundary. Whilst I was cautious that I did not want to centre queerphobia in a manner that served to re-pathologise LGBT+ young people, I also wanted to sufficiently take into account the ways in which cis-heteronormativity and queerphobia served to isolate LGBT+ young people and position them as a burden. To conclude therefore, I wish to argue that it is necessary to consider both the psychological and the social in plans for future LGBT+ youth suicide prevention. In keeping with participants' suggestions, it is necessary to both consider individual, LGBT+ informed support for young LGBT+ people experiencing suicidal distress, whilst also more broadly considering interventions to reduce queerphobia and cis-heteronormativity in wider society; for example, through education and cultural representations of LGBT+ people. In short, in order to reduce LGBT+ youth suicide, interventions must tackle queerphobia and cis-heteronormativity at its roots.

Appendix 1 – Social Media Advertising



We want to understand how suicidal thoughts and attempts affect the lives of LGBT+ young people in Scotland and what can be done to help.

Who can take part?

- LGBT+ young people
- Aged 16-24
- Based in Scotland
- Who have experienced suicidal thoughts or have attempted suicide

What will it involve from me?

An interview at a time and location convenient for you.

You will receive a £20 voucher.

How do I take part?

h.marzetti.1@research.gla.ac.uk

@hazelmarzetti

07989161022

gla.ac.uk/lgbtyouth

Don't want to take part in this research but would like support?

Childline – 24 hour listening service for children and young people, call 0800 1111

Samaritans – 24 hour listening service, call 116 123

Switchboard LGBT+ helpline open every day from 10am to 10pm, call 0300 330 063

Understanding LGBT+ Youth Suicide

We are looking for...

- LGBT+ people
- Aged 16-24
- Based in Scotland
- Who have previous experience of suicidal thoughts or who have attempted suicide

To participate in a confidential interview aiming to understand factors that contributed to suicidal thoughts and feelings, support that was useful during these times, and suggestions for future support.

Participants will be given a £20 voucher in exchange for their participation.

For more info see www.gla.ac.uk/lgbtyouth, contact Hazel via email h.marzetti.1@research.gla.ac.uk, phone 07989161022 or on Twitter @hazelmarzetti.

MRC/CSO Social and Public Health Sciences Unit

Appendix 2 – Demographic Monitoring Form

We are using this form to ensure that we include a diverse range of individuals in our research, and so that we know where we may need to improve and tailor recruitment. You are not obliged to answer any questions that you may not wish to, and can skip any question you would feel uncomfortable answering or that simply are not relevant to you.

How do you describe your gender identity?

How do you describe your sexual orientation?

Do you consider yourself to be a trans person?

Yes ☐ No ☐

How do you describe your ethnicity?

Do you consider yourself disabled?

Yes ☐ No ☐

Please tell us more about your disability if you would like.

Do you think of yourself as being religious?

Yes ☐ No ☐

If so, which religion?

Have you ever been or are you currently homeless?

Yes ☐ No ☐

Have you ever been or are you currently looked after?

Yes ☐ No ☐

Are you currently:

At school ☐

At college ☐

At university ☐

Working full-time ☐

Working part-time ☐

Unemployed ☐

Other (please provide details if you would like) ☐

If you would like to, please tell us what you are working as or studying.

What do you see yourself doing in the future?

What is your postcode where you are ordinarily resident?

(For example, if you are currently at university, this would be the address of where you were living before university. This information will be used to ensure that we have a good spread of postcodes, and not to physically locate you as an individual).

What did/do your parent/s or carer/s do for work?

Appendix 3 – Updated Recruitment Materials

Understanding LGBT+ Youth Suicide

We are looking for...

- Queer and trans people of colour
- Trans women
- Cis (not trans) gay and bi men

- Aged 16-24
- Based in Scotland
- Who have previous experience of suicidal thoughts or who have attempted suicide

To participate in a confidential interview aiming to understand factors that contributed to suicidal thoughts and feelings, support that was useful during these times, and suggestions for future support.

Participants will be given a £20 voucher in exchange for their participation.

For more info see www.gla.ac.uk/lgbtyouth, contact Hazel via email
h.marzetti.1@research.gla.ac.uk,
phone 07989161022 or on Twitter @hazelmarzetti.

MRC/CSO Social and Public Health Sciences Unit

Appendix 4 – Participant Information Sheet

University of Glasgow
College of Social Sciences

Improving health and reducing inequalities through the study of social influences on health and wellbeing.
MRC/CSO Social and Public Health Sciences Unit
MRC Medical Research Council
CHIEF SCIENTIST OFFICE
University of Glasgow

Participant Information Sheet

Understanding suicidal thoughts and behaviours of LGBT+ young people in Scotland.

Research Team: Hazel Marzetti, Lisa McDaid, Richard Mitchell, and Rory O'Connor.

Introduction.

You are invited to take part in this PhD research study, which aims to understand how suicide (which we use to encompass thoughts about suicide, suicide behaviours, and suicide attempts) affects the lives of young LGBT+ people in Scotland, and what can be done to improve this.

Before you decide whether you want to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information (h.marzetti.1@research.gla.ac.uk).

Who can take part in interviews?

We are interested in talking to anyone aged 16-24 in Scotland, who identifies as LGBT+, and who has previously experienced suicidal thoughts or has attempted suicide.

Do I have to take part?

No, taking part in this study is voluntary – you don't have to take part. If you decide to take part, but for any reason change your mind, you can stop or withdraw your permission at any time without giving a reason.

What will the study involve?

Taking part in this research will involve a conversational interview with me in which we will discuss your personal experiences of suicide; the actions, activities, environments, and relationships that you found worked to support you, and those that you found unhelpful; and what you think could help young LGBT+ people in the future.

Interviews will be around one hour long, but may be longer or shorter, depending on how long you would like to talk for. You can choose the location for the interview, or alternatively I can try to find a confidential location convenient to you.

As part of the interview we will use the reflection activity (which is attached at the end of this participant information sheet) to guide a discussion of what you found helped, what you found did not help, and what made things worse during times where you feel you have been affected by suicidal thoughts or by a suicide attempt. You may want to have a think about these questions before the interview. Please feel free to make notes on the reflection chart included if this would be helpful, but we will discuss it during the interview and you have the opportunity to add to it.

In exchange for your participation in this project we will provide a £20 voucher to thank you.

What are the benefits of taking part and are there any risks?
Some people may find it valuable sharing their experiences and their suggestions for improved future support for people who have had similar experiences as themselves. But some people may find talking about their experiences upsetting or uncomfortable. If at any point you find talking about your experiences upsetting or uncomfortable, or for any reason wish to stop participating, you should tell me, and we can either take a break or end the interview, whichever you prefer.

Will people who read your work know who I am?
Everything you say will be made anonymous. Anything released into the public domain from this project (for example my thesis, talks I may give about my research, articles I may write about this project) will not include your name. If you would like, you can choose an alternative name to be used, or I can pick one for you.

A document which keeps a record of which new names have been assigned to or chosen by participants will be stored in a password-protected computer file, and not shared with anyone except the researcher.

Will anyone know what I have said?

Confidentiality will be respected at all times, unless there are compelling and legitimate reasons for this to be breached.

Examples of compelling and legitimate reasons for breaching confidentiality:
you have told me that you feel your life or someone else's life is in immediate danger
you tell me about someone who is hurting a child or a vulnerable adult
you have asked me to contact a third party on your behalf

If I believe that I needed to pass information on, I will try wherever possible to talk to you about this, and try and work out who we can tell and how we can tell them together in a way that you are comfortable with.

What will happen to the information collected?
With your permission, these interviews will be audio recorded and photographs taken of your completed reflection chart (attached to this participant information sheet). The audio recording will then be typed up by a professional transcription service to allow me to accurately remember and analyse the interview.

Any record of this project will be securely stored on password-protected computers and in locked cabinets for at least 10 years.

The research will form the basis of a PhD thesis, and may also be written up in publications such as articles, conference papers or blog posts. Summaries of this anonymous research may be provided for interested organisations either in writing or through presentations. If you would like to see my writing about this project please let me know and I will be happy to share it with you.

Can I withdraw my data?
If after the interview you decide for any reason that you do not wish to have your data included in the study, I will remove it from my analysis and completely destroy the data. If your data has already anonymously been included in a submitted version of my PhD, published in articles, or presented verbally it may not be possible to remove it from these works, however it can be destroyed and therefore not included in any future work.

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This project has been considered and approved by the University of Glasgow's College of Social Sciences Research Ethics Committee.

To find out more about the research please contact:
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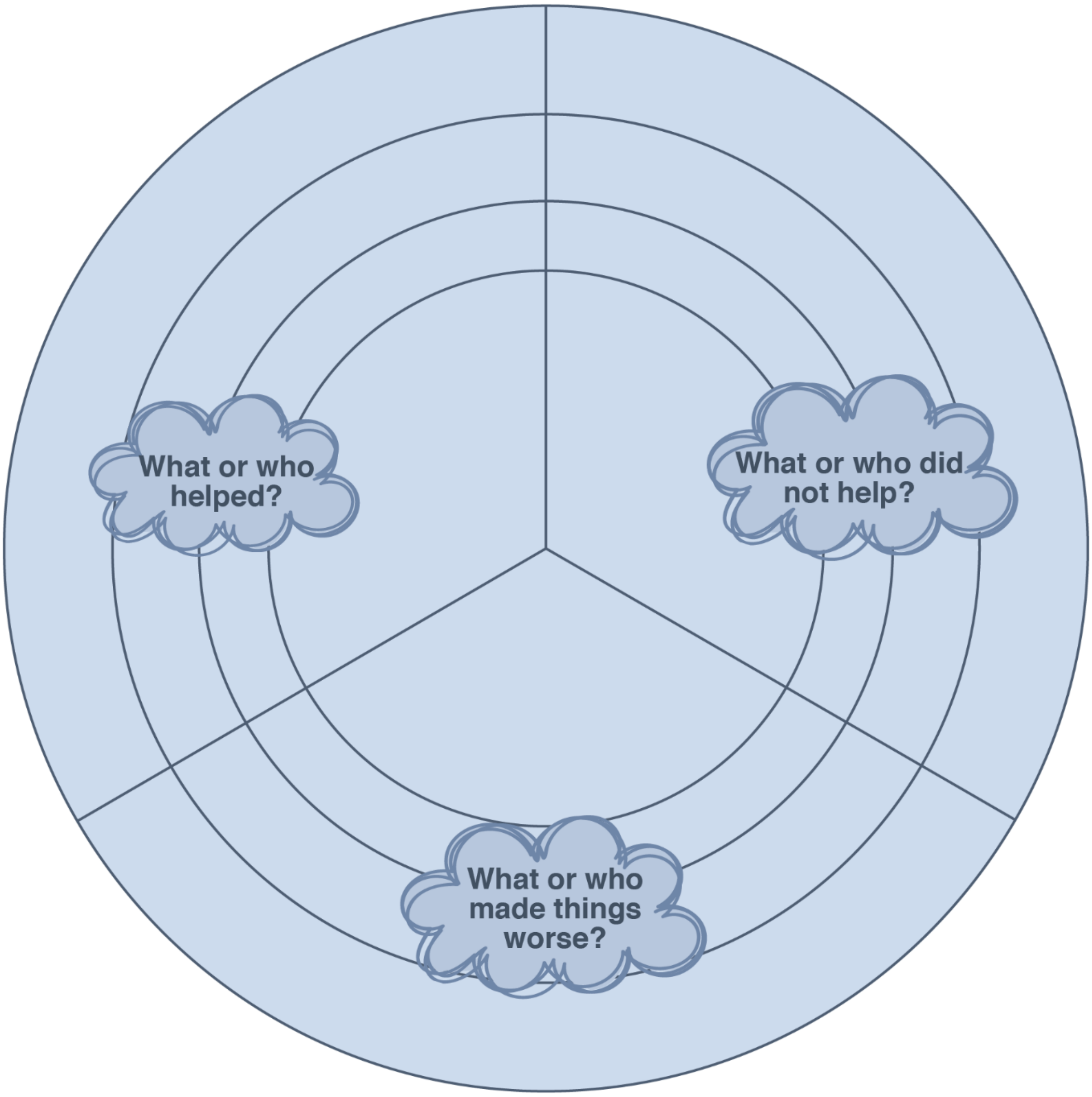
If you would like to speak to someone else not involved with this research or pursue any complaint, you can contact: the College of Social Sciences Ethics Officer, Dr Muir Houston, email: **Muir.Houston@glasgow.ac.uk**

Reflection Activity

During the interview I am going to ask you to reflect on what helped, what did not help, and what made things worse during times where you feel you have been affected by suicidal thoughts or by a suicide attempt.

You may want to have a think about these questions before the interview. Please feel free to make notes on the reflection chart below if this would be helpful, but we will discuss it during the interview and you have the opportunity add to it.



Appendix 5 - Participant Bios

Alex (he/him) is a 20-year-old bisexual trans-man, studying full-time at university. He had experienced suicidal thoughts and had attempted suicide multiple times.

Yasmin (she/her) is a 19-year-old, pansexual, non-binary, trans person who was currently in employment. Yasmin had suicidal thoughts mostly intensely between ages 14 and 16.

Isabel (she/her) is a 24-year-old pansexual, cis-female who was, at the time of interview, studying at college. Isabel experienced suicidal thoughts, had self-injured, and had attempted suicide multiple times.

Laura (she/her) is an 18-year-old, bisexual cis-female. At the time of the interview, she was studying at university. Laura had self-injured (self-cutting and self-poisoning) since the age of 14 and had experienced suicidal thoughts since around the same time.

Amber (she/her) is a 22-year-old bisexual, cisgender, female who, at the time of the interview, was studying at university. Amber had attempted suicide and had a history of self-harm, primarily through scratching.

Sophie (she/her) is an 18-year-old cisgender lesbian who, at the time of the interview, was working part-time. Sophie had attempted suicide during her teenage years and had also self-injured.

Andrew (he/him) is a 20-year-old non-binary, gay person who, at the time of the interview, was working full-time and studying at university. He had experienced suicidal thoughts and had self-harmed during his teenage years.

Eilidh (she/her) is a 21-year-old cisgender lesbian. At the time of the interview, she was studying full-time at university whilst also working part-time. Eilidh first experienced suicidal thoughts aged thirteen and had also self-harmed.

Stuart (he/him) is a 22-year old asexual, aromantic, trans male who works part-time. Stuart had experienced suicidal thoughts since his teenage years.

Lily (she/her) is 24 years old and works part-time. She described her sexual orientation as gay/queer/lesbian and her gender as cisgender female/tomboy. Lily had experience of suicidal thoughts.

Jamcake (she/they) is an 18-year old, pansexual, non-binary, trans woman. At the time of the interview, she was about to start studying at college. Jamcake had experienced suicidal thoughts, and had self-injured through burning.

Lewis (he/him) is a 21-year old queer, trans man, who studies full-time and works part-time. He had thoughts of suicide between ages 13 and 17 and had previously self-injured.

Leo (he/him) is a 22-year old gay, trans male who was, at the time of the interview, unemployed. Leo described a deterioration in his mental health aged 13, and had experience of suicidal thoughts and self-injured.

Archer (he/him/they/them) is a 17-year old pansexual, trans nonbinary person who, at the time of the interview, was studying at college. They had thought about and attempted suicide multiple times, beginning aged 13, and had self-harmed primarily through self-cutting.

Lynsey (she/her) is a 21-year-old cisgender, bisexual woman studying at university. Lynsey had attempted suicide twice whilst at university.

Damian (he/him) is a 17-year-old pansexual trans male, who was attending college. Damian had thought about suicide since early childhood and had attempted suicide multiple times during his adolescence.

Stromberge (he/him) is a 19-year-old bisexual, trans male who was studying at university. Stromberge experienced suicidal thoughts between the ages of 14 and 17.

Bun (he/him) is a 16-year-old pansexual, transgender demiboi. At the time of the interview, he was studying at college. Bun had begun to experience suicidal thoughts in late childhood around the age of 11, had self-injured (in particular through self-hitting), and had attempted suicide multiple times.

Ayla (she/her) is an 18-year-old pansexual/queer, cisgender woman, who was studying at university. She had self-injured, had thoughts of suicide, and had attempted suicide twice.

Fiona (she/her) is a 20-year old bi, cisgender female who was studying at university and working part-time. Fiona has experienced suicidal thoughts from her teenage years, but her suicidal thoughts felt at their worst during her first year at university.

Tam (she/her) is a 19-year-old biromantic, asexual cisgender woman, studying at university. Tam had experienced suicidal thoughts between the ages of 13/14 and 16.

Harley (she/her) is a 16-year-old cisgender, bisexual female, who was studying at school. She had self-injured (self-cutting) and experienced suicidal thoughts.

Euan (he/him) is a 21-year-old cis, male homosexual who, at the time of the interview, was studying at university. He had experienced suicidal thoughts, and had planned a suicide attempt during his first year at university.

Meryem (she/her) is a 19-year-old cisgender, bisexual female, who was studying at university, and working part-time. Meryem started thinking about suicide in late childhood, had self-harmed, and had attempted suicide multiple times.

Appendix 6 – Minimising Distress and Harm Protocol

Scenarios I would want to be prepared for:

A. A participant or prospective participant is distressed and reaches out to me for support.
B. A participant or prospective participant discloses information that I deem needs to be passed on e.g. terrorist activity, child abuse, abuse of a vulnerable adult.
C. A participant or prospective participant discloses another person has an active suicide plan
D. A participant or prospective participant discloses that they have an active suicide plan
E. A participant or prospective participant discloses that they are in the process of making a suicide attempt

Stages of the research where this could happen:

1. Email/message in reply to the recruitment advert
2. Phone call to follow up an expression of interest
3. During a research interview
4. After the research interview is over, by phone or email/message

At all stages of the research it is possible that an individual might email me when I am not available on email (e.g. I am away from the office on annual leave, it is outside of office hours, I am conducting research with another participant). From the point of the first advertisement being sent out until the completion of the research, when away from my email for any significant period of time, I will switch on an auto-reply sign-posting to 24/7 listening services Childline and the Samaritans, and Switchboard LGBT, and advising that anyone who requires emergency support to contact emergency services.

Whilst I acknowledge that all circumstances detailed here are highly unlikely, and hope that none will arise throughout the undertaking of my research, this protocol has helped pre-emptively think through steps to follow in response in the instance that they did occur.

Section 1 – by email or message

Young people will email or message in response to my recruitment advert, therefore it is highly possible that I will not have any information about them, with the exception of the profile or email address that they message me from. As a result I intend for any support that I recommend in this section to be able to be accessed digitally as I am unlikely to know their physical location, but by virtue of their emailing or messaging I will know for certain that they are able to access the internet.

Scenario A.1. a participant (whom I have had no other contact with) expresses by email or message that they are currently distressed and reaches out to request support (whether triggered or not by seeing the advert for recruitment).

- ⇒ If out of the office, the individual will receive an automated reply signposting to the Samaritans, Childline, and Switchboard LGBT.
- ⇒ Once back in the office, I will reply to their email or message engaging with what they have expressed, and sharing with them the full, detailed signposting to support debriefing resource I have designed, and suggesting that they could contact these support services if they feel they would find some support helpful.
- ⇒ I will notify my supervisors by email if someone has engaged with the project for support or to share distress, and will share with them if I have any concerns.
- ⇒ In the instance that someone has reached out for support to me, or if they felt that their distress was triggered by the research advert or thoughts relating to it, the individual would not be deemed suitable for participation in this research project. This is because participation in the research project could be distressing and we want participants to have support that they can access should they require it after an interview. In the instance that they have reached out to the project for support, it would be deemed that the individual did not have sufficient established support mechanisms at that time.

Scenario B.1. a participant (whom I have had no other contact with) expresses by email or message information that I deem needs to be passed on e.g. terrorist activity or bomb threat, abuse of a child or a vulnerable adult, or the participant has asked me to contact emergency services.

- ⇒ Assess the urgency of the situation (and where possible and appropriate discuss this with one or both supervisors), in particular the emphasis will be on whether the individual is safe in the immediate moment or not, or whether an activity is imminent/on-going. If I/we deem it an emergency contact the police with the information I have.
- ⇒ If supervisors were not able to be contacted beforehand, they will be notified afterwards.

- ⇒ I will send a follow up message to the young person and include the 'signposting to support' debriefing resource and encourage them to reach out to support services if they need support.
- ⇒ In the instance that it is not urgent, for example a person has made a passing reference to for example historic abuse as part of a much broader story shared, I will discuss with supervisors a proposed course of action.
- ⇒ In all cases I will debrief with my supervisors.

Scenario C.1. a participant discloses by email or message that another person has an active suicide plan.

- ⇒ I will assess the urgency of the situation where possible with one or both supervisors, and whether I have sufficient information to pass on. Where it is deemed that the situation is urgent, I will do so.
- ⇒ If the situation is deemed non-, I will attempt to discuss whether or not they believe that the third party is safe in the immediate future and whether there are individuals in the third party's life that know about their feelings and are supporting them.
- ⇒ Should the individual state that the third party is safe at the moment, or is being supported by adults in their life, but that they are worried about the other person's future actions, I will encourage them to identify someone in their life that they would feel happy and comfortable talking to about the situation and if the third party does not have support, to encourage the third party to do the same.
- ⇒ Should the young person state that they are unsure about the third party's safety or that they do not believe that the third party is able to keep themselves safe in the immediate future attempt, I will try and get them to identify someone that can take action to keep the third party safe. If they do not feel able to talk to someone in their life, I will offer to contact someone for them. In the instance that there is nobody they feel comfortable identifying, I will attempt to find out the third party's name, age and location, and any known details of their plan, and will explain that due to the nature of the information disclosed I am obliged to pass it on if the individual is unwilling to. I will then pass this information on.
- ⇒ In all instances I will send a follow up message to the individual and include the 'signposting to support' debriefing resource and encourage them to reach out to support services.
- ⇒ I will debrief with my supervisors and in the instance that the young person wishes to continue to participate in the research project will discuss on a case by case basis whether this is appropriate.

Scenario D.1. a participant discloses by email or message that they have an active suicide plan.

- ⇒ I will assess the urgency of the situation where possible with one or both supervisors, and whether I have sufficient information to pass on to police/social work/NHS as appropriate. Where it is deemed that the situation is urgent (the individual has a clear, specific plan, i.e. has made decisions about when and how to attempt suicide which they have disclosed to me) and we have sufficient information to pass on I will do so.
- ⇒ If the situation is deemed non-urgent or I do not have sufficient information, I will attempt make phone contact, or where not possible I will email/message. I will attempt to find out pertinent details such as name, age, location and whether the young person feels able to keep safe for now and has support or whether they require urgent assistance.
- ⇒ If they require urgent assistance I will ask them whether they would like me to contact the emergency services or someone close to them who can provide assistance, to try and maintain their control over the situation. However, if they decline I will make it clear to them that whilst I am happy to continue talking to them (whether via email, phone or message) but that I also have to at that time pass on their details to the emergency services.
- ⇒ If they do not require emergency assistance I will discuss with them their options for gaining support: if there are any adults in their life they would feel comfortable disclosing how they were feeling to and whether they would feel comfortable access a support service for example a chat or help line. I will also discuss with them whether there is a way that they would feel comfortable to disable their suicide plan and how we can keep them safe for now using Applied Suicide Intervention Skills.
- ⇒ If they do not want to construct a safety plan, or if they stop engaging before a point where I was sure that they are safe, I will pass on their details to the police (emergency or non-emergency depending on the situation).
- ⇒ In all instances I will send a follow up message to the young person thanking them for getting in touch, wishing them well and including the ‘signposting to support’ debriefing resource encouraging them to reach out to support services whenever they feel it is helpful.
- ⇒ I will debrief with my supervisors and this individual would not be deemed suitable for participation in the study, as it would be too soon after a recent active suicide plan (and we would roughly want to leave at least three months).

Scenario E.1. a participant discloses by email or message that they are in the process of making a suicide attempt.

- ⇒ I will contact emergency services immediately with the information that I have. Check with them whether there is more information they need if possible.

⇒ By reply follow up on advice of emergency services and signpost the individual to the range of chat or help line services available.

⇒ I will debrief with my supervisors and this individual would not be deemed suitable for participation in the study, as it would be too soon after a recent suicide attempt (and we would roughly want to leave at least three months).

Section 2 – by phone call.

Scenario A.2. a participant expresses (directly or indirectly) in the initial phone call that they are very distressed (whether triggered or not by our conversation).

- ⇒ I will stop talking about the research project and actively listen and engage with what they are saying.
- ⇒ I will ask directly whether they are thinking about suicide at an appropriate moment if the answer is yes go to D.2 or E.2 whichever is appropriate.
- ⇒ If they are not thinking about suicide, ensure that the boundaries of support that you can offer are clear, e.g. I am really pleased that you're telling me about this now, but before we have a proper chat about this I just wanted to make sure you know that I need to go at [time], now I'm really happy to chat to you about this until then, but I am keen that we find you some support for after we've finished chatting – is there anyone in your life that you think you could share this with?
- ⇒ If there isn't anyone that they can identify to support them, I will explore with them how they would feel about contacting a support service – I will suggest services they could contact using my own signposting to support sheet.
- ⇒ I will continue to talk with participant, but 10 minutes before the conversation needs to end give the participant a five minute warning (to give me a moment to gather myself and take a few brief notes on the call) and begin to wrap up. I will explain to the participant that I will send them the support resource to their email address and make sure that is ok or whether they want to give you another email address (for privacy etc).
- ⇒ After call is finished, I will alert supervisors immediately, and find time to debrief with them.
- ⇒ In the instance that someone has reached out for support to me, or if they felt that their distress was triggered by the research advert or thoughts relating to it, the individual would not be deemed suitable for participation in this research project. This is because participation in the research project could be distressing and we want participants to have support that they can access should they require it after an interview. In the instance that they have reached out to the project for support, it would be deemed that the individual did not have sufficient established support mechanisms at that time.

Scenario B.2. a participant expresses in the initial phone call information that I deem needs to be passed on e.g. terrorist activity, child abuse, abuse of a vulnerable adult.

- ⇒ I will assess the urgency of the situation, if it is deemed urgent then I will explain to the caller that I will need to break confidentiality and disclose information to the relevant agency; then I will do so.
- ⇒ In the instance that a person has made a passing reference to for example historic abuse, I will note it down and discuss with supervisors a proposed course of action.
- ⇒ In all instances I will send a follow up message to the young person and include the ‘signposting to support’ debriefing resource and encourage them to reach out to support services.
- ⇒ I will debrief with my supervisors and in the instance that the young person wishes to continue to participate in the research project will discuss with them on a case by case basis whether this is appropriate.

Scenario C.2. a participant discloses over the phone that another person has an active suicide plan.

- ⇒ I will assess the urgency of the situation (in this instance it will be of particular importance to consider the timescale of the plan and the participant’s age), and whether I have sufficient information to pass on. Where it is deemed that the situation is urgent and I have sufficient information to pass on I will let the caller know that I need to pass the information on and will then do so.
- ⇒ If the situation is deemed non-urgent or I do not have sufficient information about the situation I will attempt to discuss whether they believe that the third party is safe or not in the immediate future.
- ⇒ I will ask the participant if there are others in the third party’s life (either friends, family or medical health care professionals) that are supporting that person and whether they know that they are feeling actively suicidal.
- ⇒ Should the caller state that the third party is safe at the moment, or is being supported by others in their life, but that they are worried about the other person’s future actions, I will encourage them to identify an adult in their life that they would feel happy and comfortable talking to about the situation and to encourage the third party to do the same if they are currently unsupported.
- ⇒ Should the young person state that they are unsure about the third party’s safety or that they do not believe that the third party is able to keep themselves safe in the immediate future I will encourage them to tell an adult they feel comfortable with, or to contact a support or emergency service where appropriate.

- ⇒ If the caller discloses that the third party would be deemed a child or protected adult I will explain to them that I will need to pass this information on, and will do so after our conversation.
- ⇒ In all instances I will send a follow up message to the young person and include the ‘signposting to support’ resource and encourage them to reach out to support services.
- ⇒ I will debrief with my supervisors and in the instance that the young person wishes to continue to participate in the research project will discuss with them on a case by case basis whether this is appropriate.

Scenario D.2. a participant discloses over the phone that they have an active suicide plan.

- ⇒ I will assess the urgency of the situation, and whether I have sufficient information to pass on. Where it is deemed that the situation is urgent and I have sufficient information to pass on I will let the participant know that I will have to pass the information on, and then will do so.
- ⇒ If the situation is deemed non-urgent I will attempt to find out pertinent details such as name, age, location, and an emergency contact for the caller, I will also ask whether the individual feels able to keep safe for now or whether they require urgent assistance.
- ⇒ I will make use of my ASIST training to try and help to reach a point where they feel safer. I will discuss with them their options for gaining support: if there is anyone in their life they would feel comfortable disclosing how they were feeling to and whether they would feel comfortable accessing a support service for example a chat or help line. I will also discuss with them whether there is a way that they would feel comfortable to disable their suicide plan and how we can keep them safe for now.
- ⇒ If they are unwilling to construct a safety plan, or if they stop engaging before a point where I was sure that they are safe, I will pass on their details to the police (emergency or non-emergency depending on the situation).
- ⇒ In all instances I will send a follow up message to the young person thanking them for getting in touch, wishing them well and including the ‘signposting to support’ debriefing resource encouraging them to reach out to support services whenever they feel it is helpful.
- ⇒ I will debrief with my supervisors and this individual would not be deemed suitable for participation in the study, as it would be too soon after a recent suicide attempt (and we would roughly want to leave at least three months).

Scenario E.2. a participant discloses over the phone that they are in the process of making a suicide attempt.

- ⇒ I will explain to the caller that I have to phone the emergency services in this situation but that they can stay on the line whilst you do so and continue to talk to me afterwards, but advise that they may want to contact a suicide prevention help or chat line for more help. I will gather any details that I can.
- ⇒ I will contact emergency services immediately with the information that I have.
- ⇒ If the caller has chosen to stay on the line, I will continue to actively listen and engage with them. I will also try to gather any further details that you can about name, location, or method of attempt.
- ⇒ I will follow ASIST guidance and try to find a turning point wherever possible to introduce disabling their attempt and constructing a safety plan.
- ⇒ I will debrief with my supervisors and this individual would not be deemed suitable for participation in the study, as it would be too soon after a recent suicide attempt (and we would roughly want to leave at least three months).

Section 3 – in the interview.
Scenario A.3. a participant expresses (directly or indirectly) in the interview that they are experiencing distress (whether triggered or not by our conversation).

- ⇒ I will acknowledge the participant’s distress, and offer water/tissues as appropriate. I will ask them if they would like to stop the interview (reassuring them that it is fine to do so). If they do not want to stop the interview, I will suggest that we can take a break if that would be helpful. If they do not wish to, I will respect their choice, but will also be ready to revisit this if they maintain levels of distress or if they are becoming more distressed. I will also ask them if there is anything I can do to support them at this time.
- ⇒ Whether the participant decides to end the interview early, or continue to completion, before they leave I will discuss with them the support they have. I will suggest to them that they might wish to contact someone they have identified as being a support to them (either during the interview, or as identified in our initial contact call), and will also remind them that there are a range of support services available that they can access (providing them with a copy of the signposting to support debriefing resource).
- ⇒ If the participant has opted into a debriefing phone call later in the week I will remind them of this, or alternatively I will ensure that participants know that this is an option and will check if they would like a debriefing phone call. I will remind them that if they want to talk about the interview they can get in touch with me on social media or by email, and that at any point they can remove their data from the study.

- ⇒ I will debrief with supervisors.

Scenario B.3. during the course of an interview a participant discloses information that I deem needs to be passed on e.g. terrorist activity, child abuse, abuse of a vulnerable adult.

- ⇒ I will assess the urgency of the situation and my own safety within it.
- ⇒ If it is urgent and safe to do so, explain to the individual that the information needs passed onto the relevant agency and ask them if they would be comfortable to do so and suggest that you phone them together. If they are not comfortable to do so, explain that you need to pass the information on urgently and so will phone the relevant agency immediately.
- ⇒ If the situation feels unsafe, I will follow the lone-worker protocol using Communicare, try to gain safety as soon as possible and then contact the police.
- ⇒ If the situation is safe and non-urgent, I will work with the individual to find a way for them to report the incident themselves, or explain to them that I can report it for them. However I will be clear that somehow, someone has to report the incident.
- ⇒ In all instances I will send a follow up message to the individual and include the 'signposting to support' debriefing resource and encourage them to reach out to support services.
- ⇒ I will debrief with my supervisors

Scenario C.3. a participant discloses in the interview that another person has an active suicide plan.

- ⇒ I will discuss with the participant whether they feel that the third party is safe at the moment, or whether they are worried that the young person is at risk of making a suicide attempt in the near future and what the third party's age is.
- ⇒ I will ask the participant if there are others in the third party's life (either friends, family or medical health care professionals) that are supporting that person and whether they know that they are feeling actively suicidal.
- ⇒ If they answer yes but are still concerned about that person I will ask the participant if there is someone that they feel that they could talk to about the situation, who might be able to provide advice and support. I will also suggest the range of support services that are available to support those supporting others with suicidal thoughts and behaviours.
- ⇒ I will then reconfirm whether they can encourage the third party to reach out to any of their supporters if they have not already done so.
- ⇒ If the participant believes that the third party is at imminent risk of making a suicide attempt I would encourage them to contact the emergency services to disclose their concerns with sufficient details that

an intervention can be made, or alternatively that they can pass those details onto me and I will do so for them. If they maintain that this person is at imminent risk of suicide but do not want to contact anyone, I will explain that because they have disclosed it to me I will need to pass on the information to the relevant emergency service to ensure that the third party can be kept safe.

- ⇒ I will ask the participant if they wish to end the interview and will be guided by them.
- ⇒ In all instances I will send a follow up message to the young person and include the 'signposting to support' debriefing resource and encourage them to reach out to support services.
- ⇒ I will debrief with my supervisors.

Scenario D.3. a participant discloses over the course of an interview that they have an active suicide plan.

- ⇒ I will stop any attempt at interviewing, actively listen and engage with what the participant is saying.
- ⇒ I will ask them whether they have a plan, and if they do, discuss it with them following ASIST framework.
- ⇒ I will try and find a turning point where it would be possible to introduce the idea of constructing a safety plan (disabling the plan and engaging in support).
- ⇒ Once we have discussed disabling the plan, I will discuss with them their options for gaining support, exploring if there is anyone in their life they would feel safe and comfortable disclosing how they are feeling to (for example the emergency contact identified). We would also discuss the availability of chat or help line services for 24/7 support where needed.
- ⇒ If they are unwilling to construct a safety plan then I will discuss with them the need to gain emergency support either through their emergency contact or through crisis health services. For every interview I will identify wherever possible emergency face-to-face support available locally and will suggest this in the extreme situation that a participant remains feeling unsafe.
- ⇒ Once the individual is safe, I will send a follow up message to them thanking them for participating and including the 'signposting to support' debriefing resource encouraging them to reach out to support services whenever they feel it is helpful. I will also offer to debrief with them in a phone call later in the week.
- ⇒ I will debrief with my supervisors.

Scenario E.3. a participant discloses during the interview that they are in the process of making a suicide attempt.

- ⇒ If a participant arrives at an interview and has attempted suicide (for example has taken an overdose or harmed themselves in a serious manner so as to cause me concern for their safety and health) I will immediately contact emergency services.

- ⇒ Once safe I would send a follow up message to the young person including a ‘signposting to support’ debriefing resource encouraging them to reach out to support services whenever they feel it is helpful.
- ⇒ I will debrief with my supervisors.

Section 4: after the interview by phone, email or message
Scenario A.4. a participant expresses by phone, email or message that they are currently experiencing distress and reaches out for support.

- ⇒ If by email they will receive an automated reply signposting to the Samaritans, Childline, and Switchboard LGBT.
- ⇒ Once in a place to reply, or over the phone I will engage with the distress that they have expressed, asking whether they are currently feeling suicidal (if the answer is yes see D.4. or E.4. whichever is relevant), encouraging them to share their feelings with someone in their life that they feel comfortable talking to, and reminding them of the 'signposting to support' debriefing resource and suggesting that they might wish to contact one of the services if they are struggling right now.
- ⇒ If over the phone remember to give the participant clear boundaries of communication and a five minute warning ten minutes before the call needs to end.
- ⇒ If by email or message check in with supervisors and ensure clarity of boundaries (that as a researcher I cannot provide support but can signpost to those that can).
- ⇒ Debrief with supervisors.

Scenario B.4. after an interview a participant discloses by email or message information that I deem needs to be passed on e.g. terrorist activity or bomb threat, abuse of a child or a vulnerable adult, or the participant has asked me to contact emergency services.

- ⇒ Assess the urgency of the situation (and where possible discuss this with one or both supervisors), in particular the emphasis will be on whether the individual is safe in the immediate moment or not, or whether an activity is imminent/on-going. If I deem it an emergency, I will contact the police with the information I have.
- ⇒ If I deem that the information needs to be passed on but that the situation is not an emergency, I will contact the sender (by phone if possible or by reply otherwise) and will attempt to ascertain whether anyone is at imminent risk. I will try and explore as many details of the situation as possible and ask them whether they would feel comfortable reporting this.
- ⇒ If I cannot get the individual to report this themselves, I will remind them of the boundaries of my confidentiality and will explain that I will need to pass this information onto the relevant agency.
- ⇒ I will discuss with the participant support they can access, discussing if there is anyone that they feel could offer them support and reminding them again of the support services detailed on the 'signposting to support' debriefing sheet.
- ⇒ I will debrief with my supervisors.

Scenario C.4. after interview a participant discloses by email, message or phone that another person has an active suicide plan.

⇒ I will assess the urgency of the situation where possible with one or both supervisors, and whether I have sufficient information to pass on. Where it is deemed that the situation is urgent and we have sufficient information to pass on I will do so.

⇒ If the situation is deemed non-urgent or I do not have sufficient information about the situation I will attempt to discuss whether or not they believe that the third party is safe in the immediate future.

⇒ Should the participant state that the third party is safe at the moment, or is currently being supported by someone in their life, but that they are worried about their future actions, I will encourage them to identify an adult in their life that they would feel happy and comfortable talking to about the situation and to encourage the third party to do the same if they have not already done so.

⇒ If they do not feel able to talk to someone in their life and the third party is not being supported, I will offer to contact someone for them, will remind them of the boundaries of my confidentiality, and where necessary I will then pass this information onto the relevant agencies as appropriate.

⇒ I will debrief with my supervisors.

Scenario D.4. after an interview a participant discloses by email, message or phone that they have an active suicide plan.

⇒ In an emergency situation I will contact the emergency services immediately.

⇒ In a non-emergency situation, I will engage my ASIST training to try and disable their suicide plan and construct a safety plan with the individual.

⇒ I will discuss with them their options for gaining support: if there is anyone in their life they would feel comfortable disclosing how they were feeling to and whether they would feel comfortable access a support service for example a chat or help line.

⇒ If they are unwilling to construct a safety plan, or if they stop engaging before a point where I was sure that they are safe, I will pass on their details to the appropriate service.

⇒ I will debrief with my supervisors.

Scenario E.1. after an interview a participant discloses by email, message or phone that they are in the process of making a suicide attempt.

⇒ Contact emergency services immediately with the information that you have.

⇒ By reply follow up on advice of emergency services and signpost the individual to the range of chat or help line services available.

⇒ I will debrief with my supervisors.

Appendix 7 – Consent Form

MRC/CSO Social and Public Health Sciences Unit

MRC Medical Research Council

CHIEF SCIENTIST OFFICE

University of Glasgow

Understanding suicidal thoughts and behaviours of LGBT+ young people in Scotland.

Consent form – Participant copy

Please read the following statements, tick each box you agree with and sign below. You do not need to tick all boxes in order to participate in the study. Please only tick those that you agree to, and if you have any questions or concerns please let me know and we can discuss them.

1	I confirm that I have read and understood the Participant Information Sheet for this study and have had the opportunity to ask questions.	
2	I understand that it is my choice to take part in the study, and that I can withdraw at any time without giving a reason.	
3	I agree to take part in an interview for this study.	
4	I understand that I do not need to answer any question if I do not wish to.	
5	I consent to the interview being audio-recorded.	
6	I consent to the researcher taking photographs of my completed reflection activity.	
7	I understand that material (e.g. audio recordings, transcripts, photos) will be treated as confidential, kept in secure storage at all times, and destroyed in line with University of Glasgow policy, which is currently 10 years after the study ends.	
8	I understand that any personal information (name, contact details) will be treated as confidential, kept in secure storage at all times, and destroyed after my involvement in the study is complete (this will either be after my interview or once I have been sent a summary of findings, if I have requested one).	
9	I agree that what I say in the interview can be used for research purposes (including in the researcher's PhD thesis, reports, and presentations) and understand that my name will not be used at any time.	

10	I consent that the researcher may reproduce anonymised versions of my reflection activity for research purposes (including in the researcher's PhD thesis, reports, and presentations), but that all identifying features will be anonymised.	

Participant name (printed):

Participant signature:

Date:

Researcher name (printed):

Researcher signature:

Date:

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