LGBTQ+ suicide – A call to action for researchers and governments on the politics, practices, and possibilities of LGBTQ+ suicide prevention

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Authors:

***Hazel Marzetti,** University of Edinburgh. CRediT: Conceptualisation; Writing – Original Draft; Writing – Review and Editing.

Charlie Cooper, Orygen, Centre for Youth Mental Health, University of Melbourne, Australia; and School of Educational Psychology and Counselling, Monash University, Melbourne, Australia. CRediT: Writing – Original Draft; Writing – Review and Editing.

Andre Mason, Department of Psychological Medicine, University of Otago, New Zeland. CRediT: Writing – Original Draft; Writing – Review and Editing

Nikki L. van Eijk, 113 Suicide Prevention, the Netherlands. CRediT: Writing - Original Draft; Writing - Review and Editing

John Gunn III, Gwynedd Mercy University, USA. CRediT: Writing - Original Draft; Writing - Review and Editing

Katerina Kavalidou, National Suicide Research Foundation, WHO Collaborating Centre for Surveillance and Research in Suicide Prevention, University College Cork, Ireland. CRediT: Writing – Original Draft; Writing – Review and Editing.

Tiago C. Zortea, The Oxford Institute of Clinical Psychology Training and Research, University of Oxford, United Kingdom. CRediT: Writing – Original Draft; Writing – Review and Editing.

Emma Nielsen, University of Nottingham. CRediT: Writing – Original Draft; Writing – Review and Editing.

*Corresponding author.

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Lesbian, gay, bisexual, trans and queer (LGBTQ+) people have consistently been estimated to be disproportionately affected by suicidal ideation and suicide attempts when compared to their cisgender (non-trans), heterosexual counterparts (di Giacomo et al., 2018; Marchi et al., 2022; Marshal et al., 2011; Surace et al., 2021). However, less is known about why this devastating health inequality exists, how it impacts on distinct communities within LGBTQ+ populations, and how it can be prevented. We call for research, policy and practice networks to address these questions as a priority, within the context of a changing legislative landscape that has seen countries that previously hosted progressive legislation protecting LGBTQ+ rights, slipping into the regressive habits of history. We write this editorial as LGBTQ+ early career researchers and their allies concerned that

inaction at this time could further compound existing health inequalities with tragic consequences. In the following, we outline current challenges in the field, and suggest foundational building blocks on which a holistic, public health approach to LGBTQ+ suicide prevention could be developed.

Existing explanations: interpersonal stigmatisation, discrimination and victimisation.

Throughout the existing literature, higher rates of suicidal thoughts and attempts amongst LGBTQ+ people are primarily explained with reference to stigmatisation, discrimination and victimisation targeting LGBTQ+ people (homophobia, biphobia and transphobia; taken together queerphobia (Marzetti, 2018)). This is most often understood as situated within interpersonal conflict either within families who do not accept a relative, most often a child or young person's, coming out (Bosse et al., 2023; Green et al., 2021; Van Bergen et al., 2021); within school-based bullying (Clark et al., 2020; Jadva et al., 2023); or within community settings as a hate crime (Duncan et al., 2014; Flores et al., 2022). Although such interpersonal conflict undoubtedly has a significant, detrimental impact on LGBTQ+ people's mental health, including suicidal distress, we argue that these explanations enact too tight a focus on *individual* victims and perpetrators, assuming such hateful acts contravene an otherwise accepting and tolerant society (Formby, 2015; Marzetti *et al.*, 2023). Such understandings however, fail to account for the realities of the stigmatisation faced by LGBTQ+ people through social cis-heteronormativity and everyday microaggressions (Marzetti et al., 2022; McDermott & Roen, 2016).

To address some features of these more subtle climates, in his seminal work, Minority Stress Theory, Meyer (2003) argued that health inequalities which impact gay and bisexual men were not simply about one's direct experiences of victimisation, but rather the awareness of victimisation within one's community. This then shaped individuals' expectations of what *could* happen to them, and their behaviour to avoid it; in turn impacting on both their physical and mental health. Further to this, Meyer also argued that we must consider how such 'minority stresses' may interact with other life stresses impacting the whole population, which we argue is particularly important within

the context of suicide research where there are many well-established contributors to suicidal distress (Franklin et al., 2017). It is also worth noting that although Minority Stress Theory was initially developed to explain gay and bisexual men's health inequalities, it has subsequently been extended to explain health inequalities across LGBTQ+ communities and as a framework to consider how minority stress might intersect with other types of oppression, for example sexism and racism (Calabrese et al., 2015).

Interrupting the interpersonal

Previous literature has discussed how Minority Stress Theory can be used in complementary ways with central constructs in explanatory suicide theories (e.g., thwarted belonging and perceived burdensomeness (Joiner, 2007)) and humiliation, defeat, and entrapment (O'Connor & Kirtley, 2018). In this editorial however, we argue that these constructs should not be *solely* conceptualised as individual feelings. Instead, they should be considered as potential consequences of hostile socio-economic and political climates that position LGBTQ+ people as burdens; which *other* or alienate LGBTQ+ people, preventing a sense of belonging; and that humiliate LGBTQ+ people in such ways that make it difficult to not feel trapped (McDermott & Marzetti, 2023). This positioning is created and circulated within the very fabrics of our society, and frequently further enabled by media portrayals that can caricaturise and deride LGBTQ+ people.

We contend that this positioning isn't a completely contemporary concern because, when it comes to public health concerns for LGBTQ+ people, there has always been, and perhaps always will be, thin and porous boundaries between public health and politics. This was made extremely clear during the early phases of the HIV/AIDS epidemic in the USA, wherein the reluctance of politicians to act, at least in part motivated by a political conservatism that entailed homophobic views, resulted in the needless loss of lives (Padamsee, 2020). This neglectful inaction was undoubtedly influenced by queerphobia, racism, and classism and is one of the core reasons why we implore governments not to repeat the same mistakes in their consideration of LGBTQ+ suicide and suicide prevention.

Legislation we cannot ignore

Through this editorial, we aim to raise consciousness within suicide prevention networks of the current tide of stigmatising legislation (particularly, although not exclusively, targeting trans people (Pearce et al., 2020)) and the potential impacts of these changes to suicidal distress amongst LGBTQ+ people worldwide. As previously outlined, the primary frame for understanding this health inequality has focussed on interpersonal queerphobia and the more subtle community climates in which this occurs. However, we call for suicide prevention networks to zoom out and consider the ways in which socio-economic and political structures can facilitate, exacerbate or ameliorate LGBTQ+ suicide. To do so, we draw attention to the erosion of LGBTQ+ rights that are currently emerging in countries that have previously hosted progressive legislation protecting LGBTQ+ people from discrimination and victimisation; as well as providing positive rights such as marriage, adoption, and privacy. In addition to stripping away pre-existing advances in LGBTQ+ rights, this wave of regressive legislation has particularly eroded the right to bodily autonomy amongst trans people (Pearce et al., 2020), contravening recommendations from major medical associations and public health organisations (Coleman et al., 2022; Poteat et al., 2023).

Examples of this rising tide of regressive legislative changes have been seen across the globe; from the United States, to Europe, Indonesia, Afghanistan, and multiple African nations, to name only a few. To provide specific examples, the UK recently halted progress towards banning conversion practices (practices condemned by practitioners across a range of health professions (The British Psychological Society et al., 2017)), that aim to 'convert' an individual's sexual orientation or gender identity away from being LGBTQ+. Italy has begun limiting the recognition of same-sex parents on children's birth certificates. The United States has passed increasing numbers of anti-trans legislation in recent years: 79 bills were passed in 2020 and 147 bills in 2021 (Kinney et al., 2022); and record numbers in 2022 and 2023 are thought to have been passed spanning the spectrum of healthcare, legal, educational and occupational environments (Trans Legislation Tracker, 2023). In 2023, over

five US states have banned gender-affirming medical interventions for transgender youth, despite these practices being recognised as best-practice and being endorsed by multiple international health authorities (Coleman et al., 2022). Simultaneously, 19 American states have banned trans students from participating in sports teams that align with their gender identity. Beyond the US and Europe, in 2023, Uganda and Ghana passed repressive anti-LGBTQ+ laws further criminalising homosexuality, and its 'promotion' (which extends to human rights advocacy for LGBTQ+ people). In Indonesia, legislation has passed to ban sex outside of marriage, and in Afghanistan, since the Taliban's takeover in 2021, LGBTQ+ citizens report experiencing unprecedented discrimination and violence.

Alarmingly, these legislative changes do not appear to be isolated incidents and instead, seem to reflect an international trend of regressive policies that threaten the rights and safety of LGBTQ+ people. This adds urgency to existing concerns about the paucity of suicide research and tailored suicide prevention practices possible for LGBTQ+ people in countries in which *being LGBTQ+* is criminalised. Undertaking suicide prevention work, whether research or practice, in such contexts may evoke significant ethical concerns and obstacles for researchers, practitioners, participants and people in need of suicide prevention, and this is especially the case in countries where both *being LGBTQ+* and *suicide* are criminalised. This is of particular concern given that the criminalisation of LGBTQ+ people is disproportionately situated within low and middle income countries (Han & O'Mahoney, 2014), where 77% of the world's suicides occur (World Health Organization, 2021) (, and therefore where LGBTQ+ people could be at even higher risk. However, whilst the decriminalisation of being LGBTQ+ worldwide is slow, progress in this area may help make good practice and policy development easier. It is also worth noting that progress continues to be made, even though it is often hard won by local activists. For example, in December 2022, Singapore repealed its 377A law (a piece of legacy legislation from British colonialism) banning same-sex activity between men; whilst India decriminalised same-sex sexual activity in 2018 and is currently considering same-sex marriage. It is important that we commend these progressions, while

simultaneously advocating against the introduction of the aforementioned regressive policies, acknowledging that progressive changes are possible.

Difficulties with data: statistical invisibility and its consequences

Given the complexities highlighted throughout this editorial, it is clear that more needs to be done both to understand LGBTQ+ suicide and to prevent it. However, numerous challenges presently restrict our capacity to meaningfully advance intervention and prevention efforts. Firstly, LGBTQ+ suicide has conventionally been conceptualised as a relatively young problem, with research typically focussing on those aged 18-25 years. This conceptualisation limits our knowledge about suicidal thoughts and attempts amongst LGBTQ+ children (aged under 18), adults and older adults. Secondly, neither sexual orientation nor trans identity is routinely recorded in mortality data, making it impossible to estimate deaths by suicide amongst LGBTQ+ people. Furthermore, to gain a more contextualised understanding of these statistics, routine recording of sexual orientation and trans identity would also need to be included in census data. Thirdly, there are inequalities in representations across LGBTQ+ identities, with more data focusing on LGB (sometimes termed 'sexual minority') young people and less systematic data available examining suicidal distress amongst trans young people (Connolly et al., 2016; Surace et al., 2021), as well as those whose identities do not fall within binary lesbian, gay, bisexual or transgender categories but who nonetheless are not cisgender, heterosexual people (such as queer, pansexual, asexual people (Frohard-Dourlent *et al.,* 2017)).

Despite recent attempts to include a wider range of LGBTQ+ identities in systematic and narrative review studies, this is often impeded by the lack of accurate data collected within the primary studies and the confusion between sexual orientation and gender identity. That is, researchers assuming LGBTQ+ identities are mutually exclusive, without considering that people could be both a *trans man* and *bisexual* for example, in the same way that one could be both a *cisgender (non-trans) woman* and *heterosexual*. Finally, the available data tends to homogenise

diverse LGBTQ+ communities, without considering the multiplicity of identities held by individuals which may result in them experiencing intersecting oppressions (e.g. homophobia *and* racism) and geographical variations that have material consequences for suicidal distress. This is problematic because it not only hampers our ability to understand LGBTQ+ suicide and suicide prevention better, but because it has also been argued that such "statistical invisibility" can be used to justify leaving LGBTQ+ people out of suicide prevention planning and policy (Marzetti et al., 2023). Some of these statistical invisibilities can only be rectified through strategic government leadership, advancing the collection of national data, for example through censuses enabling more accurate reporting around mortality. However, some could be addressed by co-producing research *with* LGBTQ+ communities to better understand the intra-community nuances and variations crucial to developing prevention research, policy and practice. This could also facilitate developing a better understanding, given the wide gaps in knowledge, about what should be prioritised from a community perspective.

Towards a public health approach to LGBTQ+ suicide prevention

To tackle the challenges outlined in this editorial, it is essential to connect politics with public health. We therefore call for those working in suicide prevention to, where safe, find ways to connect their politics with their research practice. We echo the calls made more broadly in suicide prevention that challenging structural determinants of health (Pirkis et al., 2023), which in this instance involves resisting political regressions, must be seen as integral to, and not separate from, suicide prevention. To do so, we propose some possible starting points.

1. **Co-production and collaborative partnerships:** Research is most meaningful and impactful when conducted with those it effects. An essential part of this must be developing partnerships with researchers, practitioners and community members. This may be particularly important in countries in which LGBTQ+ people have little to no protection, yet where there are devastatingly high rates of suicide. We argue that researchers from countries in which there are greater

protections for LGBTQ+ rights, should consider working beyond borders to provide support for research and practice, where this is desired by local LGBTQ+ or suicide prevention networks.

2. **Holistic and whole-of-government approaches:** Researchers, practitioners and policymakers must broaden the lens through which they conceptualise and approach LGBTQ+ suicide prevention. Whilst current suicide prevention practices such as individual mental health support and crisis interventions are undeniably important, we propose that they should be contextualised and complemented with work to address the broad socio-economic and political determinants, as well as the policy landscape, surrounding LGBTQ+ suicide. We argue LGBTQ+ communities should be seen as a priority group across research, practice and policy, and therefore detailed planning for LGBTQ+ suicide prevention is urgently needed, either within national and international suicide prevention strategies or as separate action plans.. This may include developing dedicated policies or provisions for LGBTQ+ communities. In particular, given the recent rising tide of transphobia, protections, resources and targeted supports for trans people should be prioritised as a matter of urgency.
3. **Data driven:** To address the lack of systematic data collected about people's sexual orientation and gender identity globally, we argue there needs to be vast improvements made to: census data gathering, death registration reporting, either through medical practitioners, public prosecutors or coroners, and primary healthcare registries to help us better understand the data landscape. Further to that, there should also be greater investment in cross-cultural work to understand what contributes to, and protects people from, suicide.
4. **Improve media reporting on LGBTQ+ issues:** We recognise the role of the media in perpetuating harmful stereotypes and wish to work with them to encourage them to take seriously their responsibility to prevent the spread of disinformation by reporting ethically.
5. **Taking an intersectional approach:** Although there are undoubtedly some common goals amongst LGBTQ+ communities, there are also many differences. Taking an intersectional approach to all research and practice means ensuring that we take into account the multiple

intersecting types of oppression members of LGBTQ+ communities face, including but not limited to racism, sexism, ableism, migrantism, and ageism.

These steps offer a small number of suggestions to address some of the challenges previously outlined. We would like to highlight that many of these points will be relevant for any minority groups, so these takeaways should not be regarded as unique to LGBTQ+ communities. This is also not an exhaustive list, instead these points are suggested with the hope of beginning a live conversation, and so we invite others to add to this, drawing on their own research and practice. We are aware that in calling for a widening of the lens on what is considered suicide prevention, we are also calling for a shift, or perhaps even transformation, in the types of questions asked in research; moving away from asking how we can prevent deaths by suicide and towards asking how societies can be organised in such ways that allow LGBTQ+ people to survive and thrive. In doing so, we challenge researchers to shift their analytical stance from asking how we can make LGBTQ+ people more resilient to an increasingly hostile world, to asking how a cis-heteronormative world can steady itself against the urge to surge into a type of moral conservatism that denies LGBTQ+ people the rights that they need to live a fair and equal life. We believe that this is essential for the future of suicide research.

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