LGBT people and suicidality in youth:

A qualitative study of perceptions of risk and protective circumstances

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Research Highlights

- LGBTs discuss perceptions of risk and protective circumstances in youth suicidality

- Uses Goffman-informed analyses to identify themes linked to youth suicide attempts

- Stories of conflict and coming out, mental illness concurrence and grief are told

- Connectedness to other LGBT people and organisations supports well-being

- Seeing LGBT suicidality scenarios as stages with plots, settings and people helpful

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Abstract

Evidence suggests that lesbian, gay, bisexual and trans (LGBT) people are more likely to attempt to take their own lives in their youth when compared to heterosexuals. This study draws on in-depth interviews with 17 LGBT individuals living in England, and explores the narratives used by participants to better understand their perceptions of risk and protective circumstances to explain suicide attempts in youth. Using a Goffman-informed thematic analysis, results identified three key themes that were linked to attempts to end life in youth. The first theme considers the conflicts resulting from first disclosure of sexual orientation and being 'out' to others. The second theme explores participants' accounts of their concurrent mental health issues and how diagnoses of the mental health issues helped them make sense of their own experiences of attempted suicide. The final theme explores the experience of grieving over lost relationships and how that grief is received by others, including health professionals. Our results indicate that some LGBT individuals have effectively, although often arduously, navigated suicidal crises by utilising various approaches to coping. We provide a rich and layered picture of LGBT suicide risk in youth and potential resilience scenarios, although these are a reflection of our specific group of participants' experiences and realities. We argue that it is important to understand how LGBT individuals with a history of suicide attempts narrate and make sense of their experiences in early life and we suggest that the early negative experiences continue to have an effect on LGBT adults today.

Keywords: England, LGBT, suicide, risk, protective, perception, qualitative, youth

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INTRODUCTION

Recent reviews of population studies and systematic reviews of the literature continue to demonstrate that lesbian, gay, bisexual and transgender (LGBT) people are at increased risk of poor mental health and at greater risk of suicidality when compared to their heterosexual and cisgender counterparts (Marshall, Claes, Bouman, Witcomb, & Arcelus, 2016; Semlyen, King, Varney, & Hagger-Johnson, 2016), and this is recognised in health policy. Although completed suicide is more common in older LGBT age groups, evidence suggests that suicide attempts are more likely to occur among young LGBT people (Wang, Häusermann, Wydler, Mohler-Kuo, and Weiss, 2010; Xavier, Honnold & Bradford 2007). As death certificates do not record victims' sexual orientation it is not currently possible to ascertain how many young LGBT people die by suicide. However, Plöderl et al. (2013) reviewed the available evidence, and argued that the numbers are likely to be higher than those found in the general population.

Multiple risk and prevention factors can interact in complex and dynamic ways when in accounts of suicidality (i.e. suicide ideation, thoughts and attempts) for LGBT young people (Hatzenbuehler, 2011). This study uses an in-depth qualitative approach informed by critical re-readings of Goffman's (1963) treatise on stigma and subsequent theorisations of equity, stigma, and power (Link & Phelan, 2014) to identify perceived risk and protective circumstances from LGBT people who themselves had experienced suicidality or suicide attempts as young people. These data are derived from a large five-year study of inequalities in mental health for LGBT people in England (Nodin, Peel, Tyler, & Rivers, 2015).

LGBT wellbeing and mental health

There is limited understanding of the dimensions of sexual orientation and transgender status that are most meaningfully related to suicidality. Surveys conducted in the United States (US) estimated that between 25 per cent and 43 per cent of transgender adults report a suicide attempt over their lifetime (Haas, Rodgers, & Herman, 2014). These figures vastly exceed the estimates within the US population for those who report a suicide attempt across a lifetime (4.6%), and are also higher than the 10 to 20 per cent reported among LGB adults (Haas et al., 2014). Indeed, one Canadian study of adolescents, which incorporated multiple measures of sexual orientation, found that suicidal behaviour was significantly higher in young people who identified as LGB. However, interestingly those who indicated same-sex attraction or behaviour — but identified as heterosexual — did not report a higher rate of suicide attempts than other heterosexual young people without same-sex behaviour or attraction (Zhao, Montoro, Igartua, & Thombs, 2010).

Several experiential factors have been suggested which may predict suicidal behaviour among LGBT young people. These include experiences of homophobia, social isolation, substance abuse, and parental and sexual abuse (Corliss, Cochran, Mays, Greenland, & Seeman, 2009; Hatzenbuehler, 2011; Marshal et al., 2011; Martin-Storey & Crosnoe, 2012; Mustanski & Liu, 2013). However, it has been difficult for researchers to identify a common set of risk factors because they appear to be multiple and cumulative, and, importantly, they are also interconnected with problems common among young people generally (King & Merchant, 2008; Roberts, Ramsey, & Xing, 2010). For example, some young people find the transition to adulthood particularly difficult because of social and economic pressures, and these have been

found to be related to mental health problems, such as self-harm, eating disorders and depression (Coles, 1997).

Although Western societies have seen a shift in terms of the inclusion of all LGBT people, young LGBT people still experience difficulties as they negotiate their own sexual identities in heteronormative communities (McCallum & McLaren, 2010). It has also been observed that many LGBT young people leave home earlier than their peers because of the difficulties they can sometimes face in 'coming out' and living as LGB or T (Henderson, Holland, McGrellis, Sharpe, & Thomson, 2007). With the ubiquity of access to the Internet, there are growing numbers of online platforms that LGBT young people can access, and while this has multiplied opportunities for social interaction and support, it has also opened them up to exploitation (Bauman & Rivers, 2015). Wakeford (2002) has shown that for those with marginalised identities, such as LGBT people, the Internet and its applications can contribute to a crucial demarginalising process (Thomas, 2002). In this sense, while the nature of 'coming out' stories have changed in more recent years - even where heterosexism still exists (Plummer, 1999), many still involve homelessness, bullying at school, truancy, and family rejection (Birkett, Russell & Corliss, 2014; Ray, 2006; Robinson & Espelage, 2012; van Bergen, Bos, van Lisdonk, Keuzenkamp, & Sandfort,, 2013).

Among older LGBT people, experiences of intolerance historically can also play a significant part in their current well-being (Knocker, Maxwell, Phillips, & Halls, 2012), as can emerging feelings of age-related exclusion from the LGBT community (Tyler, Nodin, Peel, & Rivers, 2016). For older LGBT people, anticipation of care in older age brings with it concerns about the nature of the support offered by health care providers and, for those who anticipate

living in communal accommodation, the attitudes of those with whom they will live (Pugh, 2012).

Thus, expectations of further discrimination permeate the narratives of older LGBT people based upon their experiences of times when society was very different. Consequently, as noted above, completed suicide rates are higher in LGBT older adults who perhaps have been unable to engage with the significant social and political changes that have occurred over the last decade in the UK and elsewhere (Semlyen et al., 2016).

Goffman's lens: contributions to understanding stigma and suicide

Goffman's contributions to sociological thinking in the field of mental illness and social interactionism is useful in understanding LGBT suicidality. For Goffman (1963), social life involves the performance of different dramas in a range of scenarios where individuals adhere themselves to complex forms of behaviour, and work hard to maintain that performance and identity. These processes of identity negotiation are problematic because they require strategic plans of self-presentation, i.e., assessments and enactments played out in accordance with circumstantial social scenarios. Discernment is constantly impacted by an individual's capacity to manipulate behaviour (Goffman, 1959), but some individuals have more challenging experiences to overcome.

Goffman (1963) classically defines stigma as a discrediting attribute, which reduces a person in the eyes of 'society'. He constructed this definition from comparisons of attitudes towards people who were considered physically, mentally, and/or socially 'deviant' and as such 'marked' by 'undesirable difference'. Even Goffman's early definition emphasises stigma as action: Stigma is 'applied by society through rules and sanctions resulting in what he described

as a kind of "spoiled identity" for the person concerned' which contrasts with the emphasis that some authors have placed on the actions of stigmatised individuals (Parker & Aggleton, 2003, p.14). Accordingly, we adopt Link and Phelan's (2001, p.367) reframing of stigma with power to stress its relational aspect, where 'elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold'.

Phelan, Link, and Dovidio (2008) attribute three functions of stigma and prejudice: exploitation and domination, norm enforcement, and disease avoidance. This model of 'keeping people down', 'in', or 'away' offers a useful framework for understanding how stigma has been experienced and remembered by LGBT people who went on to attempt suicide. In our re-reading of Goffman (1963), individuals who experience stigma then need to implement forms of coping with difference as well as with stigma; thus, without the provisions of support that, in turn, can make them more vulnerable to self-destructive behaviours (Goffman, 1963). These forms of coping are not necessarily conscious, but may be operationalised as ways of negotiating the *self* and in some cases, resisting stigma. Suicidality scenarios are stages charged with internal and external drama framed by the symbols and language that allow individuals to put feelings and experience into narrative structure. In this article, we take this Goffman-informed approach to understanding LGBT suicidality scenarios as stages – involving plots, settings, and people. We have found it useful in developing in-depth insights into perceptions of circumstances surrounding LGBT suicide attempts, particularly those that occur in youth.

METHODS AND MATERIALS

The data-set for this analysis forms part of a larger study supported by the Big Lottery Fund. The authors affirm that the funder played no part in the development or design of the project, or in the analysis of the data. This analysis draws upon 17 in-depth, semi-structured interviews with adult LGBT participants who reported having attempted suicide as young people. Using a sample of extracts drawn from those interviews, we provide a rich understanding of participants' perceptions of the circumstances that related to their own attempted suicide in youth. Our study used a purposive sampling strategy. Following university ethical approval, participants were recruited as part of the first qualitative stage of our national study (Nodin et al., 2015) through word of mouth, systematic and strategic emailing and follow-up, advertisements in LGBT media, flyers and posters distributed to LGBT-friendly locations in and outside London. Participants underwent an initial screening by the research coordinator to confirm they met selection criteria. To be eligible for this study, participants needed to self-identify as LGB or T, be over 18 years of age, and at least 6 months had passed since their last suicide attempt which was judged to be life threatening (whether they had intended to die or not).

Participants

Participants were aged between 26 and 52 years at the time of interview. The average age at which participants indicated they made their first suicide attempt was 17.6 years (SD = 3.4 years; range 11-24 years). Average number of years between first suicide attempt and their age at the time of interview was 19.9 years (SD = 8.9 years; range 6-34 years). Nine participants reported one suicide attempt, with the remaining participants reported two or more such attempts.

Six participants identified as female, 10 as male and one gender-queer. One identified as bisexual, nine as gay, four as lesbian and three as 'other'. Two identified as trans (one trans man

and one trans woman). While the focus of the study was experiences in England, some participants had migrated to England from a wide variety of countries; therefore, the sample represented an international perspective in terms of early influences.

Data collection

The research team developed an interview guide informed by a thorough review of the literature and the larger project's main research questions. The guide covered background factors that might have contributed to the development of the mental health issues, access to support and recovery factors, among others (the full interview guide can be found in Nodin et.al, 2015).

Interviews were carried out either face-to-face or via telephone. All participants were informed of the scope of the research and of the issues they would be invited to talk about during the interview as part of the informed consent process. They were also given the option to withdraw from the interview without providing an explanation. After giving written consent, participants completed a brief questionnaire which included demographic information.

Participants were also given information about resources and services available to them should issues raised during the interview process have required further exploration or intervention by a mental health professional. All interviews were audio recorded, transcribed verbatim, checked for transcription errors and anonymised to remove any identifying information.

Analysis

Braun and Clarke's (2006) method for thematic analysis was used to analyse the interviews. One of the advantages of this approach is that it is flexible in terms of epistemic and ontological commitments, and therefore it provided flexibility for our Goffman informed

theoretical framework. NN, EP, AT and IR undertook the initial stages of analysis (data familiarisation, coding and initial theme development) inductively whilst also keeping the risk and resilience framework of the broader project in mind. CG then refined the identified themes by repeatedly reading the transcripts in conjunction with the initial coding. CG cross-referred to Goffman's work on presentation of the self (Goffman, 1959) and more recent developments of stigma and power (Link & Phelan, 2014) and the functions of stigma (Phelan et al., 2008) to develop more nuanced understandings of the narrative influences on participants' experiences of suicidal distress, recovery and resilience. Three themes were identified connected to conflict about coming out, concurrent mental health problems, and grieving over lost relationships. Representative quotations from 12 of the 17 participants feature in this manuscript and are used as exemplars.

RESULTS

Theme 1 - Conflicts of being 'out': Stressors associated with LGBT suicide attempts in early life

Participants associated their attempts to take their own lives with memories of their experiences of first disclosure or 'coming out'. The conflicts expressed in these narratives illustrate sometimes constant personal struggles in the face of homo/bi/transphobic lived realities, generally experienced by participants in religious, school, or family settings and among their circle of peers. This was particularly the case where strong religious beliefs included rigid or more 'traditional' views of what it meant to be a man or a woman, as Thomas (aged 34) recalled:

I was a practising Catholic at the time and I had that family upbringing. So one of

the biggest issues to me about being gay was this whole sort of battle and conflict

with my religion […] I hadn't identified as gay or accepted it at that point and I'd

applied to join the training for the priesthood and I guess the propeller for finally

accepting that I was gay came as a result of that process. I had no one to talk to

about that […] I was convinced I was going to hell and a real sort of sense, that's

how much grip these religious thoughts had on me that this was the worst possible

thing and I was going to hell and there was just no hope for me.

Thomas' narrative is not unusual, it illustrates how religious beliefs and the associated cultural norms can create 'internalised homophobia' and the fear of moral condemnation by others. Here, the fear of 'going to hell' and Thomas' own belief that there was a conflict with his religious community and, by extension, his family meant that he did not feel confident in sharing the difficulties he was experiencing.

Such feelings of loneliness and isolation were not solely described in the context of a religious upbringing. Chloe (aged 32) describes how the community and family in which she grew up diminished her confidence in questioning and sharing her feelings during puberty:

I'd been questioning my sexuality from about the age of 12,13 and it was... even though it

was actually... I'm 32 so it would have been the early 90s... so it wasn't as bad in terms of

homophobia as previously but even then, living in [that area].. I don't know if that makes

a difference, a bit more kind of behind [laughs], but it was very sort of clear to me that

this school I went to and my parents and everything else wasn't an option for me if you

see what I mean? It wasn't something that would be okay (Chloe, 32).

Chloe makes explicit reference to temporal and spatial influences on her decisions about how to present and represent herself to her family and in school. She makes connections between her private, cognitive realisations of difference (and the associated internal stigma) and the perceived alienating constructs of family, school and community in which she found herself as both disempowering, and in the absence of support or an effective coping strategy, her only resort was to engage strategies to manage her presentation of self.

For some participants, this social disconnection while 'coming out' at school contributed to a defensive and protective portrayal of 'self'. For example, Donna refers to having 'no one I could turn to' about her feelings for another girl whilst at boarding school:

I was at a boarding school and I'd been involved with a girl from the age of 13 and she left because she was a year ahead of me and I felt really socially isolated [...] there was no-one I could turn to and talk to about my feelings of loss and that's what triggered [*her suicide attempt*]... well it triggered my feelings of self-loathing, disgust with what I'd been doing but still left with this sort of hollow empty place of loss of the relationship […] It played a very big part in it. (Donna, aged 49)

Donna's narrative illustrates not only her sense of grief that followed the other girl leaving her school, but also a concurrent sense of self-loathing and disgust which only came about after the other girl's departure. Whilst her example is unique in its details, it is representative of the way several participants' remembered feeling isolated and not having someone with whom to talk or share experiences. In Donna's case her sense of isolation relates to having no one with whom she could express her feelings openly and, as inferred by her narrative, intimately. Being physically distant from her family may also have compounded her sense of being alone but, perhaps, this point in her life also suggests that, like Chloe, there was a

realisation that the feelings she had for another girl were feelings not typically shared among her same-sex peers.

Linked to isolation was the fear of bullying or harassment, and several participants reported that they had been bullied at school. Sirus (aged 45) recalled how he was constantly bullied as a child:

I failed to engage with other boys playing football or doing things that boys do. At some point being bright and having a family that had more money than the average in the classroom and being very girl orientated, even though I played masculine roles which are something very peculiar. I was isolated from the boys and they started calling me sissy and things like that. They started boycotting me and they started kind of sabotaging me in my things and they used violence in the end. So that's when I knew I was different […] What I suffered most is that the teachers did not pick it up.

Sirus makes explicit reference to having 'played masculine roles' in his self-presentation; however, he notes the incoherence that was picked up between his own characterisation (being bright, having money) and the response from other boys in that setting. Here the other boys are both the audience to his performances and performers themselves. Typically, the other players in his narrative (as they are in the stories of others) are the teachers, whose inaction or lack of attention allows the scene to play out as it does, with stigma turning to violence.

Homophobia and biphobia can be pervasive from a very early age and homophobic and biphobic abuse and exclusion is usually directed at those whose appearance or behaviour are considered different. Trans participants described how their own ostracism arose from their gender non-conformity. They were victimised for their perceived gender transgressive

behaviour. For instance, Maureen, originally from Eastern Europe, had lived in London for a few years and physically transitioned about a year and a half before her interview took place. She spoke of how she was raised in a hostile environment, bullied by people in her social circle, physically abused by her step-father, and reprimanded by her mother because of her presentation of 'self' as trans. Recalling her situation, Maureen said her only means of escape was attempting suicide at the age of 20, which she did while under the influence of alcohol.

> I couldn't go to my parents. I wanted to become self-sufficient, which it wasn't happening. Nobody to talk to, the community boxing you up and they're just not happy with you. I couldn't live my life, they started all the time boxing me in; 'No, you are not a girl, and you can't live as a girl' […] I got very depressed with everything and then I saw the fast moving car, then I saw another one straight after, so I decided to jump underneath it. It was hard; it left me in hospital in stitches. They managed to save me. (Maureen, aged 26)

In addition to the extreme isolation Maureen experienced, her narrative illustrates how she transferred the physical and social harm from others into self-harm. However she also describes how her transformation from a suicidal young person occurred after watching a television documentary on trans issues one morning, realising that she did not have to be alone and that there were others who could help her. After waking in hospital, she reflected upon her future, packed her bags and "disappeared to London", a city where she had a fresh start. She found a job and volunteered to work with a transgender group.

While Maureen's experience resulted in her walking away from her family after a suicide attempt, some participants described how they eventually received a form of qualified support from family members following their first suicide attempt and were able or given permission to

interact with other LGBT people and this made a significant positive impact upon their lives. For example, Esther, who suffered homophobic bullying after coming out at school and attempted suicide at age 17 remembered comparing the attitudes of people in her life at home with those of the people she met at her first LGBT Pride in London:

> I was very aware that I was part of the stereotype, the depressed gay teenager and so it was nice to be around people that weren't that and it was just nice to be around so many LGBT people all in one go and people having a nice time. It felt good. […] I had a lot of people kind of telling me, including my mum in particular, "oh you're destined to be lonely" and "those types of relationships never work" and I guess going there made me realise, actually you're talking crap. (Esther, aged 32)

For Esther and others, making positive associations with people who shared her previously stigmatised identity challenged and perhaps made less powerful the negative 'destined to be lonely' narrative of her mother. Having a sense of belonging to an LGBT community seems to have had a protective influence against further suicide attempts by strengthening individual identity and possibly making young people feel part of a collective identity. Gaining an understanding of LGBT cultures and histories can be an important component in feeling part of a coherent narrative. However, it is important to note that not all participants had this opportunity when they were growing up. Some participants told us about the in-depth strategic planning that was required: to wait to become adults and leave the family home. In the meantime, they focused on their studies or hobbies as a coping strategy, keeping themselves distracted. For example, Ian (aged 52), found refuge in reading novels by gay writers, while Robin (aged 33), who attempted suicide at age 15 focused on figure skating practices.

For our participants, there was always a tension between the ways they learned to present themselves in youth and their ability to control the impression that they made on others. In order to face these adverse scenarios, many said that they used coping strategies in an attempt to resist stigma, These strategies included 'props' such as drinking, smoking, truancy, self-harming, binge-eating, not talking to anyone, crying. Some used more complexly defined gendered behaviours: Sirus said that he tried to be "macho", and Nicky, a trans-man, had made an effort to be "ultra-feminine". Often, two or more strategies were used simultaneously to mask "otherness" and avoid exploitation and discrimination or to cope. Where possible, norms were mimicked rather than enforced and adapted for each scenario that was encountered.

Theme 2: Concurrent mental health problems

The second theme to emerge from the interviews was located around participants' mental health. Here narratives addressed the presence or co-occurrence of mental illness as they grew up. In line with a lay biomedical account of mental illness, participants' emphasised the significance of their mental health problems in their desire to commit suicide. For example, Justine (aged 40) told us that she had attempted suicide more than once. After leaving for college, she reported feeling homesick and very ill-equipped to be living semi-independently. She had not worked most of her adult life because of mental health issues, which were slowly getting better with the help of medication and on-going therapy. Justine, in contrast with the other participants, offered a narrative in which her non-heterosexuality was not directly linked to her suicidality.

> I think because of having mental health problems growing up as a child, but
> nothing was diagnosed growing up […] they were all interconnected with the

lack of confidence, being depressed. What came first the chicken or the egg?

[…] to me it wasn't whether I was gay or not, just that I didn't fit in anywhere

Lucas (aged 27) who was diagnosed with a bipolar disorder, found that the diagnosis helped him to make sense of his suicidality. He described how the diagnosis was a significant positive step in understanding the reasons for feeling that life was overwhelming and unmanageable.

I suppose a diagnosis of some kind would have been good in terms of my mental health because when I was diagnosed with bipolar [disorder] I kind of had a sense of relief and it helped put a lot of things into place […]. If at the time my GP had said you've got depression it would have helped I think. It would have given me a sense of oh you know it's not me, it's like something's wrong and it can be helped.

For Justine and Lucas, knowing that they had mental health issues provided a degree of rationality to their lives – a rationality that did not revolve immediately around their sexual orientation or identity. For Justine adulthood and independence was not the 'escape' described by other participants, it initiated or exacerbated feeling that were already there. For Lucas while the diagnosis would present him with other challenges, labels and oppressions, the assertion 'it's not me' but rather 'something's wrong' helped him frame his own 'self' more positively.

Some participants recounted that their mental health issues remained undiagnosed until much later in adulthood. Nicky (aged 36) discussed three suicide attempts - the first one occurring when he was 15 years old. Nicky was hospitalised following two later suicide attempts, one of which was related to his mother's death. However, between these episodes, he was a street drinker and sold sex until he was diagnosed with bipolar personality disorder aged 26:

I have had suicidal thoughts consistently since I was twelve years old. I have never really felt comfortable as a human being. I've always felt out of place at parties and things and social activities outside of class at school. […] I didn't know how to get it right, I felt uncomfortable in my gender […] I always put a lot of emphasis on what other people think of me or what I think other people think of me. I often feel like killing myself if I feel someone doesn't like me still, which is unhelpful. I think it's just largely due to personality disorder […] It's characteristics of BPD [Bipolar Personality Disorder] that people do self-harm and attempt suicide and things like that.

Nicky's story brings forward some of the ways that a number of significant issues intersect. He stresses his discomfort in particular social settings such as parties and social activities where norms were enforced. He extends his sense of discomfort to his own embodied gender – 'I felt uncomfortable in my gender'. Here, he is able to distinguish that there might be a gap between 'what other people think' and what he *thinks* other people think of him, as well as being able to attribute some of his feelings to bipolar disorder. However, seeking the help that he needed for those problems only seemed possible after receiving help from his attempts to end his own life while grieving his mother's death.

The emotional impact of bereavement or exclusion is very potent throughout participants' narratives. While Nicky needed to resolve his own sense of devastation and loss following his mother's death, another participant, Samir (aged 33) provides a very different narrative of his own mental health problems - one that appears frequently in literature on LGBT mental health. Samir, who grew up in North Africa, recalls being forced to leave his parents' home after several assaults. He described his life before arriving in the UK as follows:

I had people punching me, kicking me, throwing stones at me you know. It got

worse and worse every year. So there were times when the stones hit my head,

my head was open, I had to be taken to hospital. […] the attacks were countless.

Samir's narrative includes discussion of severe depression which he attributes to his

negative experiences and which he describes in terms of post-traumatic stress. Samir's story

resonates with those of Donna, Chloe and Sirus; the persistent isolation and fear of others

brought a feeling of disconnectedness, of being kept down or oppressed – emotionally and

physically. For Samir however, living in a traditional and religiously conservative country, there

were no coping mechanisms upon which he could draw (just like Chloe) and the physical toll of

the numerous attacks he experienced led, in his own mind, to his mental illness.

For Samir, even having escaped the experiences of his youth, he faced further stressors

due to his immigration status in the UK. He explains that, once in the UK, his depression was

aggravated further by the stress he went through being re-housed numerous times, and having to

cope with immigration authorities and the subsequent threat of deportation:

When the case went to court they refused, the judge went against me. I could not

bring myself to say I am gay, but after I had to say I am gay. Let people know,

you know. Then the Home Office refused and said "well you had every

opportunity to admit your homosexuality all these years in England".

Through Samir's narrative we see how having to declare one's non-heterosexuality to

others had the potential to further discredit his application to remain in the UK. The failure of the

courts to understand the impact stigmatisation has upon individuals and what they (the courts)

represent in immigration cases - integration, acculturation and norm enforcement – presented

Samir with a dilemma: acknowledging that he is gay might allow him to remain in the UK, yet

being gay was also the reason why he experienced so much hostility. Unlike many of the other participants interviewed as part of this study, Samir had few props to help him navigate the multiple and cumulative challenges that he faced.

Theme 3 - Grieving over lost relationships

The final theme extends the narrative of grief that appeared earlier and considers how lost relationships have impacted participants' accounts of suicidality. Grieving has cognitive, behavioural, physical and social dimensions (Schwartzberg & Janoff-Bulman, 1991). Although it is a consequence of forming emotional bonds and is part of a natural response to loss, one of the most relevant issues derived from a period of grief is depression, which may include feelings of anger, guilt, sadness and anxiety in an attempt to make sense of or find meaning for that loss. In many ways grief is a normative part of human relationships (Riggs & Peel, 2016) yet, some people may have few mental constructs to help them with the meaning-making process of incorporating loss into a new worldview (Neimeyer & Sands, 2011). This difficulty in adapting to a new reality can lead to erratic behaviours, which occur in interaction with an already undervalued sense of self. This was the case for Ian (aged 52), who attempted suicide at the age of 18. Like Nicky's last attempt, Ian's incident was associated with the death of his mother. He had looked after her for the last five months of her life before she died from cancer.

> I was gay and growing up in a very hostile environment, there was a lot of
> conflict with my father about it. [...] It's complicated because round about the
> same time, my mum in my first year of university died so the whole thing
> culminated in it. But, I know sort of prior to, anything sort of happened to mum,
> I had a lot of negative self-harm thinking that was in place all through my

teenage years. And I just felt that that was the only solution, and there was

nobody to, well I wasn't prepared to speak to anyone about it.

Comparable with many of our participants, Ian faced a great deal of hostility within his family and following the death of his mother, he cut his wrists and as a result was hospitalised. His isolation from his father, the loss of his mother and then, as Ian attests, the lack of compassion shown by a nurse who was dealing with him - suggesting that next time he should try 'a bit harder' very much reinforced the fact that he was different, that he was undesirable and has lost any status that afforded him the right to 'be'. As he put it, 'It wasn't a sympathetic approach,' in many respects it represents the power differential that exists between those who seek to dominate or reinforce norms and those who do not adhere to those norms. While Ian was referred to his GP, he did not receive any form of counselling, as he felt unable to open up. He said he could not trust his GP as the GP had a picture of the day's Conservative shadow health minister in his consulting room. However, like Esther and Nicky, Ian eventually attended therapy after meeting other gay people while he was at university, and through meeting other people and understanding his own mental health, he began to see his identity as a gay man in more positive terms.

Ian's story demonstrated that building a positive social identity requires social networks. These networks not only transform an individual's sense of self, but affords an opportunity to construct a legitimate existence. In the past many teenagers have not had positive social references or LGBT networks to reinforce positive aspects of their identity. As our participants have described, isolation can be exacerbated if there is little in the way of moral support and affirmation from others. Thirty years ago, one participant, Jason, became involved with an older man who was a member of the clergy and, for fear of the repercussions of his actions, the

clergyman put an end to their relationship. The ending of that relationship resulted in Jason attempting suicide by drinking alcohol mixed with over-the-counter medication. Having failed in this attempt, Jason was admitted into a hospital where he saw a counsellor and a psychiatrist.

> We started going into family therapy. We used to go to talk to a counsellor once a week about family dynamics and I found the work very frustrating because for me lots of the issues about why I was unhappy were related to my sexuality: isolation, alienation, insecurity, fears of rejection, all of those things. This counsellor wanted to talk about who did the washing up and how the relationships within the family worked. […] During that time I planned for the next three years. I was going to carry on using the girlfriend to cover and see how long I could keep that up, go to university, which I always knew I would do. […] I would then go off and live my life away from my parents (Jason, 46).

As part of a broader context whereby mental health problems, isolation and heteronormativity impact negatively on a young LGBT person's sense of self and wellbeing, Jason's story like that of Ian resonates with a number of the other narratives offered by participants. He talks of his sense of powerlessness and how his sexuality was ignored and thus discredited by the counsellor, and how family norms were reinforced through therapy sessions. Ultimately, Jason provides a narrative where his plans for the future include not only the establishment of complex forms of behaviour for self-preservation, but a route to escape the domination and lack of affirmation he experienced at home. For Jason, like so many others, the future offered an opportunity to live away from parents and the constraints that were exploitative and disempowering. For some, being able to move away provided a means to escape harassment

and yet for Samir and Justine, leaving the family or community also resulted in isolation and further mental health issues.

DISCUSSION

Our findings offer an insight into the complex and often multifaceted experiences of a sample of LGBT adults who recounted their narratives of growing up – often in hostile or unaffirming environments. Experiences of rejection by intimate partners, peers, friends and, not insignificantly, family members represent a thread we see running through all of our participants' stories. The utility of using a Goffman-informed perspective in this study of suicidality in youth is demonstrated throughout the narratives offered in this article. Comparable with Goffman's (1963) original thesis, participants in this study recounted how they found themselves adhering to complex forms of behaviour and engaging in elaborate strategic plans of self-presentation to mitigate the chances of harassment and discrimination (see Chloe, Ian, Jason, Nicky, Robin and Sirus). For example, Jason told us, 'I was going to carry on using the girlfriend to cover and see how long I could keep that up.' Unfortunately, these coping mechanisms were likely to fail when personal circumstances (i.e., having a mental health issue, going through a grief process, and suffering from social ostracism or bullying) led to a breakpoint where participants could not find help (see Samir). Additionally, Sirus' narrative illustrates how gender roles and socio-economic status can be conflated to compound difference despite managing self-presentation (Pakula, Carpiano, Ratner, & Shoveller, 2016).

The narratives of Esther, Jason, Maureen, Nicky, Sirus and Thomas demonstrate how the process of discreditation can work and how participants felt their lives and the 'value' placed upon them was lessened by others. For example, Esther talked of the prevalent stereotyping of the 'depressed gay teenager' and Nicky reflected upon the insensitive way in which a health

professional engaged with him. As Parker and Aggleton (2003) point out, stigma is about power and through the narratives of our participants we learned how they navigated the rules and sanctions they faced that were imposed by others (see Chloe, Ian, Jason, Maureen, Samir, Sirus, Thomas) and the powerlessness they experienced as a result (Chloe, Donna, Ian, Justine, Nicky, Samir, Sirus and Thomas; Link & Phelan, 2014). Additionally, interview data such as Chloe's discussions around comparisons with how things were in 'the early 90s' to earlier times and Thomas' decision to 'come out' at the time of joining the priesthood illustrate one of Parker and Aggleton's (2003) critiques. Goffman's framework of stigma is often misappropriated to construct stigma as static but it is constantly changing 'and often resisted'. That resistance will be age- and history-graded and can change both within and across generations/societies/cultures (Plummer, 1999). In reflecting the observations of Phelan et al. (2008), we see the ways in which participants in this study recounted how their early lives encompassed experiences that were exploitative and domineering (again linked to the sense of powerlessness mentioned earlier), how norm reinforcement was instilled and emphasised by others (including health professionals) and, in one case, we see how the idea of disease avoidance is realised through a interaction with a nurse (see Chloe, Ian, Jason, Maureen, Nicky, Samir and Thomas). Taken holistically, we see how accounts the of suicidality included in this article are staged and charged with internal and external drama that assists narration. We understand the plots, settings and people involved in participants' stories, and understand the ways in which they operationalised coping strategies in the hope of resisting stigma.

For most participants in this study, appropriate adult and/or professional intervention could have made a difference, although, we must reflect critically on inappropriateness of those interventions in heteronormative and/or homophobic cultures where same-sex desire was

discouraged or forbidden (Weeks, 2007). It is clear that the shame arising from the transgression of social and cultural expectations of growing up 'queer' was linked to feelings of isolation, self-rejection and low self-esteem, and this limited the ability to seek help. Additionally, as Link and Phelan (2014) suggest, stigma has a very powerful relational component where structural stigma (policies, laws, traditions) can influence the degree to which family members can or wish to support LGBT youth, and allow others to discriminate without embarrassment. This has been seen most notably in the stories of those youth who have been ostracised from their family homes because of the condemnation or potential condemnation of the family by others in the community (Potoczniak, Crosbie-Burnett, & Saltzburg, 2009).

In terms of youth suicide, Fullagar's (2005) work demonstrates the centrality of shame in young people's accounts of suicidal experiences and argues that the social dynamics of shame are important in understanding young people's subjectivities. She connects shame to a sense of a failed self and suggests that suicidal thoughts enable young people to escape those pressures that make them feel unworthy. While Fullagar does not address stigma directly, there is a stigma associated with having mental health issues and this is illustrated by the labels to which the young people in her study referred (e.g., 'loser' or 'uncool'). For those who attempt suicide, there is even more condemnation. While Fullagar's research focused on services for rural youth and did not focus explicitly on LGBT youth, it has resonance for this study: the absence of support mechanisms particularly within small, traditional or conservative communities ties in very closely to the experiences of our participants.

Having accessible, positive LGBT role models becomes very important in alleviating distress among LGBT people of all ages – not just the young (see Bird, Kuhns & Garofalo, 2012). Research has shown that where LGBT youth feel an increased sense of belonging in

school there is a concomitant decrease victimisation, depression and psychological distress
(Birkett, Espelage & Koenig, 2009; Heck, Flentje & Cochran, 2011; Martin-Storey & Crosnoe,
2012). By extension the same can also be said for other environment, where positive support for
LGBT people and a celebration of LGBT history can have a positive impact upon inclusion
(Rostosky & Riggle, 2002). Nevertheless, even today students, teachers and employees may still
be constrained in how much they can challenge institutional heteronormativity (see also
Mayberry et al. 2013).

There are also a number of alternative prevention strategies that lie outside the clinical or
professional realms that can reduce LGBT suicidality in childhood and adolescence. Informal
support structures that are non-institutional are believed to help reduce deliberate self-harm and
suicidal behaviour (Fortune, 2008). Such structures may include online chatrooms and forums,
and as Thomas (2002) has shown, sometimes these online interactions can become physical
support groups (meeting in coffee shops), particularly in locations where LGBT people have few
organised opportunities to socialise.

Previous authors have also attested to the protective nature of engagement in activities
such as voluntary work, attending organised LGBT groups, engaging in sports or physical
activities, or education-related activities (see, for example, Ramey et al., 2010; Rivers, 2011). It
is not surprising therefore that many of our participants found LGBT social networks an effective
means of support through sharing experiences with others and developing a sense of community.

For many of our participants, their suicide attempts were marked by the social
asymmetries they experienced in their interactions with others, and by their inability to
implement effective coping strategies to deal with them. Roberts et al. (2010) have discussed
how, in suicidality, a complex interplay of multi-factorial determinants exists that come from a

diverse range of domains and influence an individual's response to external factors or events. These determinants include the individual's psychology, experiences, and mental state as well as the influence of other people and social representations with which they are in contact, through their families, schools, and wider society (Ayyash-Abdo 2002). We see many of these complex multi-factorial determinants at play in participants' narratives.

Based upon our analyses, we argue that the stages where interventions could have made a positive impact to participants' well-being are identifiable. Crucially, participants indicated that family support for their sexual orientation or gender identity, and feeling safe in school would have had a positive impact on well-being early on. Interventions aimed at encouraging greater self-esteem and positive role models for LGBT youth could have had a potentially protective effect against suicide risk. However, it is clear that during their suicide crises most of our participants did not have access to or receive such support. This is not surprising, our participants were rule-breakers and were growing up without many of the protections available today (Parker & Aggleton, 2003). While some participants' narratives indicated that, at the time of their suicide crises, the professional help they received from practitioners in schools, hospitals, and family surgeries was inadequate, historically the general lack of awareness and poor training around LGBT youth issues would have hindered any form of effective provision for this group. Again, the training that is available today for educational and health professionals would, we hope, ensure that LGBT young people receive appropriate help at times of crisis.

CONCLUSION

Although our findings provide a rich and layered picture of LGBT suicide risk in earlier years, these are nonetheless a reflection of our specific group of participants' experiences and realities

and should not be generalised to other LGBT people. All our participants shared an interest and availability in collaborating with a community-based research study, which may have led to self-selection bias in which only people with community attachment, sensitive to the relevance of research and available to discuss their personal stories, came forward and participated in this study. Additionally, enriching as the diversity in our sample is, it is noteworthy that our participants vary widely in their ages at the time of engagement in the study and in the ages at which they attempted suicide. They also varied considerably in their cultural backgrounds thus the political, social and historical contexts in which they experienced their suicide attempts were varied and do not necessarily reflect the current reality of young LGBT people living in England.

Our analysis, however, highlights patterns in the experiences of LGBT people that seem to transcend barriers of age and even nationality. Therefore we argue that this study contributes to a better understanding of a relevant aspect of LGBT people's health and suggests paths to interventions that might contribute to alleviate the suffering of those who still struggle among their families and communities with discrimination, abuse and isolation due to their sexual orientation or gender identity.

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