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STIGMA DESCRIBED BY ATTEMPT SURVIVORS WITH DIVERSE GENDER AND SEXUAL IDENTITIES IN THEIR SUICIDE STORIES: A HERMENEUTIC PHENOMENOLOGICAL DISSERTATION

By

Sara M. Williams
M.S.S.W., University of Louisville, 2016

A Dissertation
Submitted to the Faculty of the
Raymond A. Kent School of Social Work and Family Science of the University of Louisville
in Partial Fulfillment of the Requirements
for the Degree of

Doctor of Philosophy
in Social Work

Social Work
University of Louisville
Louisville, KY

December 2022

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A Dissertation Approved on

September 23, 2022

By the following Dissertation Committee:

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Dr. Becky Antle

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Dr. Lesley Harris

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Dr. Maurice Gattis

DEDICATION

This dissertation is dedicated to my parents, Mark and Karen Williams, who taught me that life's work should be fulfilling and fueled by passion, and whose unwavering support has carried me through even my wildest ambitions. Thank you, Mom and Dad.

"*Rarely, if ever, are any of us healed in isolation. Healing is an act of communion.*"

– bell hooks

For my gender and sexually diverse folk, you are valid and important.

For all those with suicidal suffering and those impacted by suicide. You are so loved.

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I would like to thank my mentor and dissertation chair, Dr. Laura Frey, for her invaluable guidance and patience. I would also like to thank my other committee members, Dr. Lesley Harris, Dr. Becky Antle, and Dr. Maurice Gattis, whose direction and feedback have helped me grow tremendously over the past few years. I am incredibly grateful to have had the support of others at the Kent School throughout my doctoral journey, including: Dr. Crystal Collins-Camargo, Dr. Adrian Archuleta, Dr. Anita Barbee, and Dr. Geetanjali Gulati. I would like to thank Dese'Rae L. Stage, the creator of *Live Through This* and incredible advocate for people with lived experience of suicide, for allowing me to use her beautiful data for my dissertation research. I would like to thank my colleagues and friends for helping me in myriad ways throughout this program, especially Dr. Rebecka Bloomer, Lisa Purdy, and Dr. Michelle Day. Finally, I would like to acknowledge my dogs, Rocky and George, who made sure I took breaks and went outside occasionally, and who never fail to make me smile.

ABSTRACT

STIGMA DESCRIBED BY ATTEMPT SURVIVORS WITH DIVERSE GENDER AND SEXUAL IDENTITIES IN THEIR SUICIDE STORIES: A HERMENEUTIC PHENOMENOLOGICAL DISSERTATION

Sara M. Williams

September 23, 2022

Suicide is a profoundly impactful issue across societies. Gender and sexually diverse (GSD) populations exhibit rates of suicidal ideation and behavior far greater than those of cisgender heterosexual populations. Stigma impacts health outcomes among GSD populations through stress exposure and response processes. Compound stigma is experienced when individuals occupy positions in multiple stigmatized identity groups and can have multiplicative effects on adverse outcomes. Further, opportunities for positive social support and resilience building may be limited due to the narrow convergence of stigmatized identity groups. Stigma among GSD suicide attempt survivors (GSDAS) is an important phenomenon to explore in order to understand nuanced differences and similarities between experiences, sources, and interactions with stigma within stories of suicide. Using data from the Live Through This advocacy project, hermeneutic phenomenological processes were utilized to explore the lived experience of stigma among GSDAS. The larger study sample was divided into two groups: those with nonheterosexual sexually diverse identities only (n=37) and those with noncisgender gender diverse identities (n=11). Findings from this dissertation indicate a complex web of factors that exist within a pervasive environment of stigma and interact to shape social experiences of GSDAS. This study contributes to our understanding of stigma within the context of suicide stories for GSDAS and can help inform individual and social suicide prevention efforts with an overarching goal to decrease stigma-related experiences and improve outcomes through greater equity, support, and care for GSDAS.

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CHAPTER 1

INTRODUCTION

Gender and sexually diverse populations exhibit suicidal behavior at significantly elevated rates, with estimates indicating 10 to 20 percent of sexual minority adults attempt suicide in their lifetime compared to 4.6 percent for the general population (Hottes et al., 2016). Individuals who have nonexclusive gender attraction (e.g., bisexual, pansexual, queer) experience suicidal ideation and behavior at greater rates than lesbian- and gay-identified individuals (Haney, 2021; Salway et al., 2019). Individuals with diverse gender identities (i.e., transgender, nonbinary, and gender nonconforming [TGNC]) experience suicidality at rates even more elevated than those of individuals with diverse sexual identities (Herman et al., 2019). Compared to 10-20% of sexually diverse adults, an estimated 41% of gender diverse (GD) adults attempt suicide in their lifetimes, with highest prevalence rates in trans men (46%) and trans women (42%) (Haas et al., 2014). In the largest study of transgender individuals in the U.S. to date, nearly 82% of respondents reported thinking seriously about suicide at some point in their lives. Transgender adults exhibit rates of suicidal ideation nearly 12 times greater and prevalence of suicide attempts about 18 times higher than the rates of the general U.S. population (Herman, Brown, & Haas, 2019).

Background

Some literature exists on oppression-related factors and mental health outcomes for various populations, but those observations are limited in their operationalization of oppression (i.e., measurements focused on discrimination) and in their applicability to the gender and sexually diverse (GSD) population (e.g., Arshanapally et al., 2017; Brooks et al., 2020). Similarly, researchers have explored the connection between some factors of oppression, like discrimination, and their association with suicidal ideation and behavior in GSD individuals (Rimes et al., 2019; Mereish et al., 2019), but they've omitted how oppression and enacted

stigma are uniquely experienced by GSD attempt survivors. Because individuals with GSD identities experience suicidal ideations and engage in suicidal behaviors at greater rates than the general population, more research is needed to further investigate the experiences of these individuals in the hopes of breaking a cycle that could inhibit recovery from suicidality. Moreover, much of the albeit limited research on this topic has relied on quantitative methodology, which likely misses some of the rich nuances and subtleties involved in the singular experiences and perceptions of GSD individuals with lived experience of suicide. Some qualitative examinations have begun to delve into these experiences (e.g., Bergmans et al., 2017; Sellin et al., 2017), but few have utilized samples with multiple stigmatized identities such as those with lived experience of suicide and gender and sexual diversity. Therefore, a qualitative study to elucidate the unique experiences of oppression experienced by those with GSD identities is warranted.

The following dissertation will begin by providing definitions of key terms and concepts related to GSD populations and suicide, followed by a discussion of social factors contributing to and protective against disparate mental health outcomes among these social groups. These sections provide the argument for why this study is needed and how the new information generated by this study will benefit GSD populations with lived experience of suicide. Then, sensitizing theoretical orientations are discussed along with their applicability to the proposed study. Chapters two and three of this manuscript each consist of a standalone manuscript intended for publication. Chapter four of the dissertation integrates and synthesizes findings from across studies and provides implications for social workers and social work as a field.

Defining Terms and Concepts

Language Related to Suicide

Critically important to the field of suicidology is shared understanding of language; miscommunication about suicide is dangerous and can have lethal consequences (Silverman et al., 2007; Frey et al., 2019). Suicide-related language evolves with our expanding knowledge of suicide experience, so language is an important aspect not only in our communication about suicide but in our understanding of the suicidal experience. This section will provide definitions of suicide-related nomenclature that is recommended by leaders in the field.

Suicide is defined as death from injuries inflicted upon oneself with at least some intention to die as a result of those injuries (Silverman et al., 2007). *Suicidal behavior* is an expansive term that encompasses actions taken with at least some intent to die (e.g., at attempt) as well as preparatory steps taken to prepare for a suicide attempt, such as collecting medications, researching methods on the internet, or acquiring a firearm (Silverman et al., 2007). *Suicidal ideation* refers to thoughts about suicide and suicidal behavior, which may include intrusive thoughts about suicide, passive ideation (e.g., "I do not want to wake up tomorrow."), and active intent and planning (e.g., "I am going to kill myself.") (Silverman et al., 2007). *Intent* is an important factor in determining whether a specific injurious or life-threatening behavior is suicide-related; *suicide intent* indicates a conscious desire to escape from life as we know it through suicide (Silverman et al., 2007). A *suicide attempt* is a nonfatal self-injurious action taken with at least some intent to die; this is in contrast with *nonsuicidal self-injury,* in which the behavior is self-inflicted yet there is no intent to die (Silverman et al., 2007). Suicide attempts are compellingly salient self-labeling events (i.e., "My attempt is part of who I am.") to make personally relevant the stereotypes of suicide (Lehmann et al., 2016). Additionally, attempt survivors often identify their suicide attempt as a significant aspect of their lives and who they are (Fulginiti & Frey, 2018).

Recovery related to suicidal ideation and behavior may be defined in alignment with the mental health recovery model: "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2010, p. 3). In contrast to other models of rehabilitation related to suicide that emphasize abstinence from suicidal ideation (Surgenor, 2015), the recovery model acknowledges the variety and, for some, chronicity of mental health challenges, including suicidal ideation. This holistic and strengths-based definition of recovery highlights health, home, purpose, and community as major dimensions of recovery (SAMHSA, 2010). In alignment with social work core values, the recovery model is person-driven, emphasizing self-determination and agency of the individual (SAMHSA, 2010; NASW, 2018). The recovery model underscores the importance of community involvement and support, social connection, and self-respect (SAMHSA, 2010).

Language Related to Gender and Sexual Diversity

Gender and sexual diversity, or *gender and sexually diverse (GSD) identities* refers to the range of gender and sexual identities not aligned with cisgender (gender identity) and heterosexuality (sexual orientation identity) and includes myriad unique experiences and identities (Park, 2016). A related term—*gender and sexual minorities (GSM)*—is often used interchangeably and emphasizes the oppressed social status of GSD populations (McCann & Monaghan, 2020). *Gender identity* refers to the deeply felt sense of gender with which an individual identifies (e.g., female, transgender male, nonbinary) (Park, 2016). Historically, U.S. society has conceptualized gender as a mutually exclusive dichotomous trait which is determined at birth and remains static throughout the life course: one was born either male or female (Steensma et al., 2013). The rigidity inherent in medicalized conceptualizations of sex and gender leave little room for variation and diversity in the presentation of sex characteristics and limit the reality of gender for those who do not fit neatly within the definitions of male and female. For intersex people, medical definitions of gender are exclusionary and present problems associated with autonomy (Davis, 2015). *Intersex* is a term used to describe a condition in which a person is born with sexual characteristics that are not strictly within the confines of male or female (Intersex Society of North America (ISNA), n.d.). Intersexuality is not always recognized during infancy, and many people with differences in sexual development that would fall under this category are never aware of their intersexuality (ISNA, n.d.). Modern perspectives on gender in the U.S., however, are shifting toward a view of gender as socially constructed, fluid, and existing in myriad forms (Steensma et al., 2013).

The majority of the adult U.S. population, an estimated 99.4%, is cisgender, which means their assigned sex at birth and their gender identity align (Herman et al., 2022; Park, 2016). Although accurate counts are difficult to obtain—especially due to the removal of GSD data in the 2020 census (O'Hara, 2017) and intentional exclusion of GSD-related questions on national surveys (Cahill & Makadon, 2017)—almost 1.4 million (0.6% of U.S. adults) adults identify as transgender (Conron & Goldberg, 2020) and about 1.2 million identify as nonbinary (Wilson & Meyer, 2021) in the U.S. It is important to consider the possibility of sizable overlap in

representation due to variations in operationalization and collection of gender identity information (Romanelli et al., 2020).

People whose gender identities do not align with their assigned gender have diverse gender identities, such as transgender or nonbinary (Park, 2016). Stryker's (2017) definition of transgender emphasizes the social nature of gender and encompasses a diverse range of individuals:

> People who move away from the gender they were assigned at birth, people who cross over the boundaries constructed by their culture to define and contain that gender. . . It is the movement across a socially imposed boundary away from an unchosen starting place, rather than any particular destination or mode of transition, that best characterizes the concept of transgender.
>
> (Stryker, 2017, p. 1)

Transgender or *trans* is an umbrella term encompassing all gender identities that are not cisgender (Coleman et al., 2012). *Nonbinary,* which falls under the *trans* umbrella, is a term describing an individual whose gender identity does not fit into a prescribed set of characteristics like male or female (Rider et al., 2019). *Transitioning* is the social and/or medical process through which an individual begins to live as their affirmed gender identity (Coleman et al., 2012). During transition, an individual makes changes to their gender presentation through altering their clothes, hair, physical appearance, and/or behavior (Coleman et al., 2012). Transitioning is not the same for everyone and not all people who identify as trans will transition (Coleman et al., 2012). For persons whose identities fall under the trans umbrella but do not adhere to binary representations of gender (e.g., nonbinary, genderqueer), there can be stigma both inside and outside the GSD community regarding the validity of their identity (Worthen, 2021). The majority of the U.S. population, an estimated 99.4%, is cisgender, which means their assigned sex at birth and their gender identity align (Flores et al., 2016; Park, 2016). Although accurate counts are difficult to obtain—especially due to the removal of GSD data in the 2020 census (O'Hara, 2017) and intentional exclusion of GSD-related questions on national surveys (Cahill & Makadon, 2017)—almost 1.4 million (0.6% of U.S. adults) adults identify as transgender (Conron & Goldberg, 2020) and about 1.2 million identify as nonbinary (Wilson & Meyer, 2021) in the U.S.

Gender and sexual identity groups are not homogenous. Gender and sexual identity exist in infinite variations and expressions, and an individual's blend of identities is a singular combination and the language surrounding that identity is integral to their sense of being

(American Psychological Association, 2017). The language an individual uses to describe their identities may change over time as identity exploration and understanding evolve (Luoto et al., 2019). Gender and sexual identities do not occur in isolation but work in conjunction with an individual's other social identities. For example, gender and sexual identities do not occur in isolation but work in conjunction with an individual's other social identities. A Black, bisexual, trans woman experiences life not only as a Black person or a queer transgender woman but as a Black, queer, transgender woman, influencing perceptions and experiences by and with others and self. Some identity groups experience discrimination not only within general society but also within GSD-defined spaces. This discrimination is a common experience with individuals whose sexual orientation identities are *nonmonosexual* (i.e., experiencing attraction to multiple genders, such as bisexual or pansexual) (Doan Van et al., 2018), contributing to the worst mental health outcomes of all sexual identity groups (Salway et al., 2019; Stinchcombe & Hammond, 2020). For example, individuals with nonbinary identities or gender nonconforming expression experience greater mental health burdens related to the cumulative effects of compounding and intersectional minority stress faced by those with multiple marginalized identities (Pellicane & Ciesla, 2022; Maksut et al., 2020). The language an individual uses to describe their identities may change over time as identity exploration and understanding evolve (Luoto et al., 2019).

Sexual identity (or *sexual orientation* or *sexual orientation identity*), is the sexual self-identification, attraction (e.g., physical, romantic, or emotional attraction), fantasy, and behavior of an individual toward others (e.g., bisexual, queer, lesbian, gay) (Park, 2016; Haas et al., 2011). Recognized by Kinsey (1948) as existing on a continuum from completely heterosexual to completely homosexual, sexuality is now understood as more complex. Contemporary conceptualizations of sexual orientation depict this aspect of identity as a constellation of factors that come together to represent an individual's unique personal identity (Sedgwick, 1990). For example, many sexual minorities who identify as *queer* would not see themselves on Kinsey's scale (Zietsch & Sidari, 2020): *Pansexuality* (i.e., an attraction to a person regardless of gender) and *asexuality* were not recognized as sexual identities (National LGBTQIA+ Health Education Center, 2020). Moreover, many GSD individuals are uncomfortable with being labeled as any particular category of sexual orientation (Scheffey et al., 2019; Williams et al., 2018). This

demonstrates the fluidity of the conceptualization of both sexual identities and queerness (van Anders, 2015). Sexual orientation and identity may transform throughout an individual's life as that person's understanding and expression of their sexual identity evolve (Luoto et al., 2019). For example, when initially exploring and understanding one's sexual identity, they may start with the recognition of same-gender attraction and identify as bisexual. Then, later in life after more life experience, they may identify as queer or another term that they feel more authentically represents their identity.

Coming out is the process through which an individual discloses their gender or sexual identity to another person or group of people (National LGBTQIA+ Health Education Center, 2020). A GSD person may be *out* to all, part, or none of the members of their social networks. The coming out process is ongoing and must be engaged with all new relationships and settings; individuals must regularly make decisions as to whom to disclose gender identity and sexual orientation (Ryan, et al., 2015). *Strategic outness* is the continual and contextual management of identity in which one is never fully 'out' or 'closeted' (Orne, 2011). Strategic outness describes the conception of coming out that is interactional and rooted in social context, wherein GSD individuals must consider a variety of reasons to come out or stay in any given social context (Orne, 2011). For example, a person who is out to their friends and within social settings needs to assess the safety of coming out in professional settings or within unfamiliar social groups; risks and benefits must be weighed for each new identity disclosure. Additionally, individuals whose relationships are nonmonosexual must often navigate confronting assumptions (e.g, "Oh! You're dating them? I thought you were gay!") and disclosing their sexual identity (e.g., "No, actually, I'm bisexual").

Language Related to Social Processes

Our experiences and perceptions are shaped by the interactions we have with the social world (Berger & Luckmann, 1966). Some groups and individuals have been historically excluded from aspects of society which has resulted in marginalized identities in the United States. Oppression and stigma are two ways dominant cultures and identities have pushed groups with specific identities to the margins of society, thus impacting their ability to have sociopolitical power (Young, 2011; Goffman, 1963). *Oppression* relates to systemic structures which enforce

continued power imbalance between social groups in which the dominant party benefits while those outside the group are disadvantaged by society (Young, 2011). An example of oppression in recent political discourse is the removal of questions related to sexual orientation and gender identity in national surveys and the U.S. Census (Cahill & Makadon, 2017; O'Hara, 2017); the exclusion of this data has dire implications for GSD individuals as their identities are erased from the population. Oppression results from group differences perceived by those in power and their efforts to retain power, wealth, and privilege (Young, 2011).

For GSDAS, oppression has far-reaching implications. From policies and institutions restricting full participation in social life to actively facing violent assault, oppression may damage the safety, health, and wellbeing of GSDAS (Herek & Garnets, 2007; Fredriksen-Goldsen et al., 2014; Hatzenbuehler & Pachankis, 2012). Structural stigma plays a role in the social environment for GSDAS and can work in the absence of individual-level discrimination to impact lived experience (Turan et al., 2017). For example, no federal-level legislation exists that protects individuals from discrimination on the basis of sexual orientation or gender identity (ACLU, 2021) and some states have adopted policies that restrict access to healthcare among gender-diverse individuals (ACLU, 2021). Further, adverse physical health outcomes like increased rates of cardiovascular disease are associated with experiencing oppression (Pascoe & Richman, 2009).

Manifestations of oppression are observable as stigma-related events (Bos et al., 2013). *Stigma* refers to

> the negative regard and inferior status that society collectively accords to people who possess a particular characteristic or belong to a particular group or category. Inherent in this definition is the fact that stigma constitutes shared knowledge about which attributes and categories are valued by society, which ones are denigrated, and how these valuations vary across situations.
>
> (Herek, 2009, p. 66)

In his seminal text on stigma, sociologist Goffman (1963) conceptualized stigma as a deeply discrediting attribute that reduces one from a whole person to a stereotyped version of their identity and attaches to them undesirable characteristics. Application of stereotypes to individuals is how humans process information in the world around us (Goffman, 1963). In social interactions, it is common to make quick judgments on the perceived gender and/or sexual identity of a person when interacting with them. These judgements are based on previous experiences and socialized expectations (Goffman, 1963; Link & Phelan, 2001). Social

expectations and norms come from the process of socialization, through which we are conditioned to think and act (Goffman, 1963). Tied to these expectations are socialized notions of what is acceptable and valued in a culture. For example, in a patriarchal society such as the U.S., masculinity is valued over femininity; this value is called *androcentrism* and is the root of misogyny (Mendoza-Pérez & Ortiz-Hernández, 2019). Certain attributes are associated with cultural codes for masculinity, such as physical strength and stoicism, and different codes for femininity, such as passivity and compassion. When persons reject or do not adhere to gender roles, they are often met with stigma and discrimination (Mendoza-Pérez & Ortiz-Hernández, 2019; Hayes et al., 2011).

Stigma is often associated with a perceived failure to meet stereotypical expectations, such as the assumption that one is heterosexual (the assumption of which is called *heteronormativity*) (Warner, 1993) or cisgender (this automatic assumption is termed *cisnormativity*) (Bauer et al., 2009). The dominant social group identity—in this case, cisgender and heterosexual—is the presumed identity. Heteronormativity and cisnormativity may place GSD people in an awkward (and sometimes dangerous) position of needing to assess the safety of their current situation and to make quick decisions about identity disclosure. Even beyond general social interactions, there are also dominant assumptions within GSD groups. For example, LGBTQ+ spaces have been described as white, cisgender, gay male spaces, with negative implications for anyone who does not fit that description (Mendoza-Pérez & Ortiz-Hernández, 2019). This presumption represents cisnormativity and white privilege. Further, *homonormativity*, the assumption and acceptance of homosexuality or monosexual queerness as the default and standard alternative to heterosexuality, can further stigmatize persons with nonmonosexual attraction (specifically, bisexuals) and fluid sexual identity. Perhaps this stigma is one reason why these groups experience negative mental health and suicidal ideation more frequently than those who identify as gay or lesbian (Doan Van et al., 2018; Haney, 2021; Flanders et al., 2019; Salway et al., 2019).

Stigma may impact persons in three ways: through enacted stigma, felt stigma, and internalized stigma (Bos et al., 2013). Individuals perceived as part of GSD identity groups are frequent targets of *enacted stigma*, or discrimination, that stems from oppression (Martin-Storey &

Fish, 2019; Young, 2011). *Discrimination* is the unfair or prejudicial treatment of people and groups based on a socially defined attribute or characteristic (e.g., race, gender, sexual orientation) and protects privileged groups at the detriment of other groups (Young, 2011). *Felt stigma* is the experience or anticipation of being the target of enacted stigma (Jacoby, 1994) and may be more detrimental to mental health than actual experiences of enacted stigma (Jacoby, 1994; Scambler & Hopkins, 1986). Experiences of stigma are related to mental health, with higher levels of perceived stigma and felt stigma relating to increased depression and anxiety symptoms (Bockting et al., 2013; Chi et al., 2014). Even when individuals do not directly experience overt discrimination, many still report some level of felt stigma, as reported in a study involving adults who stutter: Most participants did not experience enacted stigma, but they still anticipated negative responses from others (Boyle, 2018; Lekas et al., 2006). Further, felt stigma may be exacerbated by experiences of discrimination (Herek, 2009).

Stigma occurs at structural, interpersonal, and individual levels. Structural discrimination can be seen in macro-level conditions, such as laws and policies, that limit opportunities and resources of oppressed groups (Young, 2011). An example of structural discrimination is the deficit of protection at state and federal levels of legislation for individuals based on sexual orientation and gender identity expression (American Civil Liberties Union (ACLU), 2020). Discrimination at the interpersonal, or meso, level occurs through social interactions with other individuals (Martin-Storey & Fish, 2019). Interpersonal discrimination can be overt, like a sidewalk preacher at a Pride Festival shouting hate speech and attendees and passersby or, even more grievous, violent hate crimes against GSD individuals. More often, though, discrimination is seen in an evolved, subtle form, microaggressions (Peterson et al., 2021). *Microaggressions* were initially observed and documented in the 1970s as “subtle, stunning, often automatic, and nonverbal exchanges which are ‘put downs’ of blacks [sic] by offenders” (Pierce et al., 1977). Scholars have built upon Pierce et al.’s definition of microaggressions to explicate common manifestations: “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (Sue et al., 2007, p. 88). The concept of microaggressions has since been applied GSD groups (e.g., Evelyn et al., 2022; Swann et al.,

2020). An example of a microaggression that may be directed at a GSD person is someone saying, “Oh! I had no idea you were gay. You don’t look like a lesbian!” The comment may seem innocuous (or even complimentary) to the person speaking, but the statement has deep roots in oppressive stereotyping and can be harmful to GSD persons (Sue et al., 2007; Flanders et al., 2019).

Ambient discrimination is overhearing, witnessing, or being aware of discriminatory behaviors directed at someone in a social group other than yourself (Woodford et al., 2012). For example, an individual at a party with a group of people might overhear one of them making a joke about the “he-she” that just walked in the room, regarding an individual whose gender expression is nonbinary or does not fit expected gender presentation for their assumed gender. Witnessing discrimination against someone in the identity group to which one personally belongs is distressing and can lead to or exacerbate anxiety and feelings of ostracism (Woodford et al., 2012). Direct and ambient discrimination are associated with psychological pain and suicidal ideation (Peterson et al., 2021).

At the individual level, stigma can be understood as a social stressor that can lead to long-term negative mental and physical health outcomes (Pascoe & Richman, 2009). Hatzenbuehler’s (2009) psychological mediation framework describes how minority stigma contributes to psychological turmoil and negative mental health outcomes, such as suicidal ideation and behavior. Briefly, this framework posits (a) minorities face increased stressors resulting from stigma; (b) that stigma-induced stress increases challenges with coping, emotional regulation, cognitive processes, and social interactions; and (c) these processes mediate the relationship between stress and negative mental health outcomes (Hatzenbuehler, 2009). Discrimination has been found to be associated with anxiety and depressive symptoms and higher levels of suicidal ideation (Battalen et al., 2021), and with decreased coping resources (Farrelly et al., 2015). Discrimination may be more chronic and unrelenting than other types of social stressors and may therefore contribute to hopelessness or feeling trapped (Battalen et al., 2021), which are contributing factors for the development of suicidal ideation (Grafiadeli et al., 2021).

Experiences of discrimination may also lead to *internalized stigma* or *self-stigma*, which refers to the personalizing of negative stereotypes and beliefs about an identity into one's own attributes. For GSD individuals, internalized stigma about sexual orientation, gender identity, and gender expression can lead to feelings of shame and self-hate based upon the belief that their identity makes them inferior (Peterson et al., 2021; Salentine et al., 2020; Testa et al., 2017). This *self-stigma* can contribute to reduced self-esteem, as the individual believes the legitimacy of stigmatized statements (Corrigan, 2002). Self-stigma is also theorized to contribute to the "Why Try?" effect (Corrigan et al., 2015, p. 10), in which individuals self-isolate, withdraw, and retreat from efforts to achieve personal goals as a result of reduced self-efficacy associated with stigmatizing appraisals of their identity (Corrigan et al., 2015; Link et al., 2001).

Identities or traits that are attributed to individual choice may carry an additional stigma as they can be characterized as immoral or as an act of intentional deviance (Anderson, 2007; Weiner, 1988). Stigmatizing ideas of gender and sexual diversity are associated with deviance that is caused by immoral temptation (Anderson, 2007). Consider the conversion therapy efforts to change the gender or sexual identities of recipients as a contemporary example of the association of GSD with deviance. These conversion therapy efforts are incredibly harmful for individuals who endure the processes; those individuals frequently experience anxiety, depression, and suicidal ideation related to the experience (Goodyear et al., 2021; Salway et al., 2020). A more subtle example of the deviant belief can be seen in statements such as telling a lesbian-identified woman, "you just haven't found the right man yet," or telling a gay man he "just needs a good night with a woman."

The perception of controllability of one's condition is an important concept in understanding stigma surrounding suicide (Weiner, 1988). People are likely to ascribe blame and responsibility when situations or events are viewed as controllable by the individual person (Corrigan, 2000). Further, Corrigan's (2000) path model of stigma-based reactions suggests that the perceived controllability of a person's status acts as a mediator in that responses to uncontrollability are frequently pity, empathy, and helping behavior, whereas controllability is met with angry, defensive, and punishing behaviors. For example, people who disclose suicidal ideation or behavior without an easy-to-understand trigger may be perceived as dangerous or

uncontrollable (Corrigan, 2000) and met with punitive or coercive actions, such as involuntary hospitalization (Hughes et al., 2009) or loss of personal decision-making rights (Melamed et al., 2000), which represent defensive stigma-based reactions. Contrastingly, those whose suicidal experiences are perceived as outside of their individual control (e.g., such as an attempt immediately following being victimized by sexual violence) may receive empathic and helpful responses that prioritize the individual's autonomy (Corrigan, 2000).

Felt stigma can contribute to the desire to avoid potential interactions that could increase the risk of being a target of enacted stigma (Corrigan & Matthews, 2003). One mechanism of self-protection is impression management, which, for many, means identity concealment (Binnix et al., 2017; Goffman, 1963). While some identities are externally observable by others, other identities may be hidden. A *concealable stigmatized identity* is an aspect of one's identity that is stigmatized in some way but which the individual possessing the attribute can hide from others (Quinn & Chaudoir, 2009). For example, trans people who are living as their affirmed gender may not disclose their trans identity. A history of lived experience with suicide and current suicidal ideation are also aspects that a person may choose to conceal from others with whom they come into contact (Fulginiti & Frey, 2018). Living with a concealable stigmatized identity may increase social and psychological stress as individuals manage discussions and behaviors to avoid unintentional disclosure (Quinn & Chaudoir, 2009). Secrecy about suicidal ideation, behavior, or history may contribute increased feelings of disempowerment and hopelessness, as well as increased suicidality (Mayer et al., 2020; Moses, 2011; Hughes et al., 2009). Identity concealment may also contribute to feeling disconnected from relationships, especially when one's identity is kept from key confidants (Suppes et al., 2021). GSD attempt survivors have described feeling like they are leading a double life when they are concealing part(s) of their identity from their social networks (Williams et al., 2018). Identity concealment is often employed as a primary mechanism of stigma management: If one's stigmatized identity is concealed, one reduces the risk of being associated with that social group (Goffman, 1963; Corrigan et al., 2013).

Individuals who fall into multiple stigmatized identity categories may face stigma and stressors above and beyond that of those with only one stigmatized identity (Crenshaw, 1991). This concept of interlocking and irremovable aspects of identity related to social positioning is

called *intersectionality* and is a critical component of interpreting the lived experience of stigmatized individuals and to understanding the complex layers of oppression (Fredriksen-Goldsen et al., 2014; Crenshaw, 1991). For example, a Black trans woman living in poverty faces far more stigma-related challenges than would a wealthy white, heterosexual woman: Racism, classism, cisnormativity, and sexism coalesce to shape the experience of each woman. Although both may experience sexism, the white woman retains power through her race, cisgender, and class while the Black trans woman faces compounding obstacles. This interplay of oppression has been termed *compounding stigma* (Corrigan et al., 2003; Bockting et al., 2013). Compound stigma is associated with a multiplicative effect on stressors: individuals who experience stigma based on multiple aspects of their identity face more mental health challenges (Swann et al., 2020; Schimanski et al., 2019; Bahm & Forchuk, 2008). Experiencing or being exposed to multiple types of stigma, especially when associated with personal identities, is associated with increased mental health challenges, including suicidal ideation and behavior (Kelleher, 2009; Swann et al., 2020). The impact of compound stigma on GSD individuals with lived experience of suicide may be even more harmful as their opportunity for finding peers with similarly stigmatized identities is reduced; the convergence of identities gets narrower with each intersection (Schimanski et al., 2018; Williams et al., 2018). Conversely, persons with multiple stigmatized identities may also possess greater resilience through community belonging and the development of skills to cope with and combat stigma (Turan et al., 2019; Perrin et al., 2019; Schimanski et al., 2018).

Defining the Population

Humans develop conceptions of different groups as part of socialization in our culture (Link & Phelan, 2001). Social identities can be forced upon people through mere perceptions of otherness or, in many cases, deficiencies, which is how stigma becomes attached to identities and groups (Goffman, 1963). Group meanings partially constitute persons' *social identities* (Goffman, 1963) in terms of social situations, cultural norms, and history that group members know as theirs because those meanings have been "forced upon them or forged by them or both" (Young, 2011, p. 44). This identity-group stigma is communicated through cultural, societal, and

interpersonal messaging and affects the way we think about and perceive members of that group (Goffman, 1963).

Affiliation with a social group has the power to positively socialize an individual and build positive association with their identity. A GSD person lacking group affiliation may feel “different” (e.g., Downs, 2005) from a young age and develop negative feelings about their identity as a result. However, upon expanding their social networks, they may be exposed to individuals with similar identities. This socialization with others could offer the opportunity to connect with their identity differently and forge positive perspectives related to their identity as a result. This increased exposure to others with similar interaction experiences can enhance wellbeing and provide a safe milieu for GSD exploration and expression (Singh et al., 2014). Community involvement and interaction may also offer protective factors that buffer from the experiences of discrimination, such as enhanced belongingness, identity pride, and social support (Perrin et al., 2019).

Gender and Sexual Diversity

The constructs of gender and sexuality are inherently linked in Western understanding. Social categorization of individual identity is rarely left in control of the individual—persons are assessed by others with whom they interact or by whom they are observed and then placed into a social category based on the observers’ perceptions and stereotypes (Goffman, 1963; Link & Phelan, 2001). Because these two concepts are frequently conflated, people with vastly diverse gender and sexual identities are often grouped together despite major differences in their composition and the influence of those differences on experiences of group members (Weiss, 2003; Bostwick & Hequembourg, 2013). People with GSD identities are classified into the “them” category of not-straight and not-cisgender (Plante, 2006). With the understanding that some experiences may overlap between gender and sexually diverse persons, it is important to recognize differences in these experiences among and GSD between groups.

Lived Experience of Suicide

The experience of suicide is deeply impactful for those who have lived through ideation and attempt (Williams et al., 2018). This profound connection with the experience of suicide may lend persons with a history of suicidal ideation or behavior to identify strongly with their attempt

survivor identity (Williams et al., 2018). Historical stigma and accompanying social and public policies (e.g., suicide was criminalized until the 19th century in the U.S.; Witte et al., 2010) associated with suicide in the U.S. contributes to the stigmatization of having experienced suicidal ideation or behavior (Witte et al., 2010; Joe et al., 2007). Suicidal behavior is commonly viewed as an act of selfishness or a strategy to manipulate others (Batterham et al., 2012; Arnautovksa & Grad, 2010). This stigma is essential to understand and consider as it is a primary barrier to seeking help (Romanelli et al., 2020; Blanchard et al., 2018). Studies have shown positive correlations between suicidal history and perceived stigma, in which individuals with multiple suicide attempts perceive greater stigma (Salway et al., 2018; Scocco et al., 2016). Further, the stigma surrounding suicide may be internalized and exacerbate feelings of social disconnection (Witte et al., 2010).

The ability to hide one's history of suicidality makes having suicidal experience a concealable stigmatized identity (Fulgitini & Frey, 2018), making it a potentially important component to consider when investigating the lived experience of suicide attempt survivors. Recovery is facilitated by positive support from core members of one's social network, including family members and key others (Sellin et al., 2017; Zhang et al., 2015). Peer support has also been identified as beneficial in healing and recovery following a suicide attempt (Williams et al., 2018). Another crucial aspect in facilitating recovery is having a safe, nonjudgmental space within which to speak about experiences with suicidality (Zhang et al., 2015). For many GSD individuals, having an affirming and understanding environment to discuss their experiences with suicidality can be lifesaving; especially because suicidality is stigmatized within the general population and within the GSD community, individuals may be reluctant to disclose suicidal ideation or history without those safe spaces (Schimanski et al., 2018). Indeed, GSD youth have expressed their likelihood to report suicidal ideation or to seek help during crisis would greatly diminish if they were unable to seek help through GSD-affirming services (Goldbach et al., 2019). This is incredibly important, as attempt survivors may live with recurrent or chronic suicidal ideation and ambivalence toward death (Bergmans et al., 2017). For individuals with suicidal ideation, disclosure is a critical intervention point without which help is difficult to access (Fulginiti & Frey, 2020).

Statement of the Problem

The multiplicity of causes and motivations for engaging in suicidal behaviors and attempts make addressing the issue complicated. While no singular cause exists for suicide, several factors increase vulnerability to experiencing suicidal ideation and behavior. Risk factors are characteristics that may make it more likely an individual will experience suicidal ideation or behavior (SPRC, 2011). A holistic approach to understanding suicide must include individual, social, and environmental contexts. On the individual level, general risk factors include (a) having a history of one or more previous suicide attempts, (b) having a history of nonsuicidal self-injury, (c) having a mental health disorder, such as depression, (d) experiencing social isolation, (e) facing criminal or legal problems, or job or financial difficulties, (f) having a serious or chronic illness, and (g) using or abusing substances (CDC, 2021; SPRC, 2011; McLean et al., 2008). At the interpersonal (social) level, risk factors include (a) having adverse childhood experiences, (b) experiencing bullying, (c) having a family history of suicide, suicide loss, or exposure, (d) experiencing relationship problems, and (e) having a history of sexual violence (CDC, 2021). At the environmental (community/society) level, risk factors include (a) stigma associated with mental health challenges or help-seeking, (b) easy access to lethal means, (c) barriers to care, (d) community exposure to suicide, and (e) unsafe portrayals of suicide in the media (CDC, 2021; McLean et al., 2008).

Protective factors are characteristics that make it less likely that an individual will attempt suicide (SPRC, 2011). Individual-level protective factors include (a) having coping or problem-solving skills, (b) engagement in treatment, (c) having religious or cultural beliefs that discourage suicide, and (d) the presence of hopefulness and reasons for living (CDC, 2021; SPRC, 2011; McLean, et al., 2008). Social protective factors include being connected to friends, family, and community support and having a supportive relationship with care providers (CDC, 2021; SPRC, 2011; McLean et al., 2008). Macro-level, societal protective factors include (a) a history of supportive school environments, (b) limited access to lethal means, (c) the presence of general social support, and (d) access to care (CDC, 2021; McLean et al., 2008; SPRC, 2011). Specific individual characteristics, such as older age, rurality, and minority race are individual-level risk factors to consider (CDC, 2021). Increased rates of suicide among subpopulations may lead to

increased exposure to suicide in those populations, as seen in elevated rates of suicidal exposure among gender diverse veterans (Tucker et al., 2019). Exposure to suicide or loss of a loved one to suicide can also increase risk for suicidal ideation and behavior (Young et al., 2012).

Risk Factors for Suicide in GSD Individuals

Beyond the common risk factors experienced by the general population, GSD individuals face significantly more challenges that increase their likelihood for suicidal experiences. These challenges include minority-identity-specific stressors such as discrimination, victimization, and internalized stigma (Hottes et al., 2016; Meyer, 2003). To start, common risk factors—such as chronic stress, poverty, and unemployment—disproportionately impact GSD populations (Badgett et al., 2019). Individuals with GSD may face discrimination in obtaining employment (Sears et al., 2021) or housing (Romero et al., 2020) and are more likely to experience homelessness in their lives than those without GSD identities (Wilson et al., 2020). The inability to find gainful employment impacts the financial stability and well-being of GSD people (Badgett et al., 2019), potentially exacerbating their mental health and contributing to the development of perceived burdensomeness, which has a direct link to the desire to die (Van Orden et al., 2010). The impact of these and other minority stressors can lead to the development or worsening of negative physical and mental health conditions such as anxiety, depression, post-traumatic distress, and suicidal ideation or behavior (Hatzenbuehler, 2009; Meyer, 2003; Marshal et al., 2011; King et al., 2008).

Experiencing discrimination is serious risk factor for suicide in GSD populations is (Layland et al., 2020). GSD individuals are more frequently targets of victimization than their cisgender heterosexual counterparts (Kaufman et al., 2019) and experience negative mental health outcomes and increased prevalence rates of suicidal ideation and behavior (Clements-Nolle et al., 2006; Goldblum et al., 2012; Hatzenbuehler & Pachankis, 2016). GSD persons experience criminal victimization at a much higher rate (71.1 per 1000 people) than their cisgender heterosexual counterparts (19.2 per 1000 people) (Flores et al., 2020). Microaggressions and other nuanced forms of discrimination can have a deleterious effect on mental health (Gattis & Larson, 2016; Woodford et al., 2012; Salentine et al., 2020). Similarly, transgender youth who experienced interpersonal microaggressions were significantly more likely

to report suicide attempts than those who did not experience microaggressions in a recent study by Austin et al. (2021).

Family rejection is one form of identity-based discrimination surrounds a phenomenon commonly and uniquely experienced by individuals with diverse gender and sexual identities (Ryan et al., 2008). Rejection by and lack of support from childhood family are associated with increased vulnerability for experiencing emotional distress, mental health challenges, and suicidality (Klein & Golub, 2016; Skerrett et al., 2015) and are uniquely common among GSD populations (Ryan et al., 2008). Family rejection may be especially devastating due to many individuals' beliefs that family is the one source of support that would be available unconditionally (Williams et al., 2018). Moreover, family emotional neglect and family rejection have been associated with two and a half times the likelihood of attempting suicide and high levels of family rejection have been associated with threefold risk of suicide attempt in TGNC individuals (Austin et al., 2021; Klein & Golub, 2016).

Managing the risk of discrimination and victimization for some GSD people means concealing their gender or sexual identity from all or part of their social networks. Identity concealment may be helpful in the reducing fear and ambiguity in uncertain social situations (Pachankis, 2007). Social environments that are hostile or intolerant of GSD are associated with negative mental health and increased suicidality in GSD individuals (Hatzenbuehler, 2009). Suicide attempts are more frequently experienced by TGNC individuals who were always or almost always recognized as being TGNC (Haas et al., 2014). Conversely, individuals who perceived that others could only occasionally or never were able to identify them as TGNC reported the lowest rates of suicidality (Haas et al., 2014). Identity concealment may serve to protect individuals from the stigma and consequences of being identified as GSD (McIntyre et al., 2014), but it may also serve as a constant stressor (Quinn & Chaudoir, 2009). For example, the feeling of hiding one's identity from people in their lives or of having to keep aspects of their identity hidden can cause a great deal of stress and anxiety (Williams et al., 2018).

Internalized stigma is an important contributor to the development of suicidal ideation and behavior for GSD individuals (Baiocco et al., 2014; McAndrew & Warne, 2010; Perez-Brumer et al., 2015; Testa et al., 2017). Internalized stigma regarding one's identity may lead to negative

perceptions of oneself as a whole, contributing to the development of self-hate (Pistella et al, 2016; Williams et al., 2018). For example, if one is continually exposed to messaging that their gender identity is invalid, they are likely to internalize the perception of something being wrong with them or their identity. Internalized stigma is related to the development of suicidal ideation and attempts in GSD populations (Austin et al., 2021). Family support, social support, peer support, and the presence of positive coping skills can help reduce the risk of internalizing stigma to the point of adverse outcomes (Hatzenbuehler, 2009; Kaysen et al., 2014; Pistella, 2016).

Protective Factors for Suicide in GSD Individuals

Protective factors can serve to buffer against the development of suicidal ideation and behavior and to build and fortify resilience for GSD individuals. As within the general population, social connection is incredibly important for the wellbeing of GSD individuals; this may even be more salient for GSD individuals who are facing minority stressors on top of general stressors (Austin et al., 2021; Busby et al., 2020). Parental and family support may be particularly effective bulwarks against suicidal ideation and behavior (Park et al., 2021). However, some evidence suggests that this positive social support may not serve as a strong enough buffer in combating the impact of minority stressors (Craig & Smith, 2014; Austin et al., 2021). For some, social support lessens the impact of adverse events but does not erase their deleterious effects on mental health: One study found that perceived emotional support served as a protective factor only when incidents of enacted stigma were low (Romanelli et al., 2018). In contrast, those with more identity-related stigma events experienced distress beyond the buffering effect of social support. Despite this challenge, those who do feel a sense of belonging are far less likely to attempt suicide than those with lower belongingness (Austin et al., 2021).

Adolescence and young adulthood are periods when many GSD individuals begin to explore their sexual orientation and gender identity (Cass, 1989). Identity exploration, accompanied by incongruence between reported sexual identity and sexual behaviors, during this time of life is developmentally normal but may also contribute to distress and anxiety (Romanelli et al., 2020). It is also a stage in which many individuals experience suicidal ideation and behavior, and this age range is a critical time for developing adaptive coping and social skills to manage distress, developing one's identity, and for setting the stage for adulthood (Woodford et

al., 2012). Youth who perceive adequate positive social support are less likely to attempt suicide (Bränström et al., 2020; Park et al., 2021; Austin et al., 2021) and therefore are less likely to have a history of suicidal behavior as they enter adulthood.

Social connections with GSD communities can also foster positive identity affirmation, thereby enhancing the wellbeing of GSD individuals (Johnson et al., 2020; Barr et al., 2016). Johnson et al. (2020) found that involvement with trans communities facilitated social connection and wellbeing through key processes of (1) normalizing trans identity and experience, (2) developing a social support network, and (3) empowering trans people. Positive identity affirmation is associated with greater wellbeing and social connectedness for GSD individuals, and these factors can be protective against suicide (Busby et al., 2020; Barr et al., 2016).

The most influential protective factor against suicidal behavior is having a supportive social network, including peer support and family belonging (Parra et al., 2021; Austin et al., 2020). Yet, because of group affinity and the tendency for GSD individuals to associate with one another, it is likely that GSD individuals experience greater exposure to suicide through their social networks (Cerel et al., 2021). Thus, group affinity may act as both a protective and risk factor for those with GSD identities. Exposure to suicide, especially by someone with whom an individual has a close relationship or shared identity, may contribute to the development of suicidal ideation in GSD persons (Mitchell et al., 2021; Cerel et al., 2021). This creates a unique problem for GSD individuals, because GSD individuals are at greater risk for suicidal behavior and also commonly exist in social groups comprised of other GSD individuals. Exploring this tension between positive and negative features of social group affiliation relative to suicidality for GSD attempt survivors may offer insight into how to better create and approach preventative measures within GSD communities.

Diverse Intersectional Experiences

The implications of occupying space in both identity groups are important to recognize for researchers, practitioners, and policymakers. For example, participants in one qualitative study with GSD attempt survivors spoke of their intersecting identities, highlighting events in which they experienced discrimination or stigma surrounding one or more facets of their identity (Williams et al., 2018). The compounding stigma of the specific intersection of GSD identity and lived

experience of suicide impacts individuals' lives in multiple domains, including relationships, coping, and self-esteem (Williams et al., 2018). When an individual identifies with one or more marginalized groups, the interaction between those identities may exacerbate existing stressors, leading to increased suicidality (King et al., 2008). It is likely that the people who occupy space in both GSD and suicide experience identity groups have smaller social networks than those of individuals who have one or no stigmatized identities and therefore many shared social connections. Further, these smaller social networks are likely to include suicide attempt survivors and increased exposure to suicide attempts and death (Cerel et al., 2021).

Suicidality is stigmatized in society overall as well as in GSD communities (Williams et al., 2018; Schimanski et al., 2018), so individuals may be likely to conceal their experience with suicidality in both settings to avoid ostracism or rejection (Batterham et al., 2013; Schimanski et al., 2018; Williams et al., 2018). Identity concealment may be particularly appealing to individuals who belong to multiple oppressed groups (McIntyre et al., 2014). If many individuals hide their GSD identity or experience with suicide, others may not be aware that they have a shared stigmatized identity: thus, exacerbating social isolation. GSD individuals with lived experience of suicide are a pivotal population to reach due to the staggering association between history of suicidal behavior and eventual suicide death (Joiner, 2005) and because of the high rates of suicide exposure in this population (Cerel, 2016; Cerel et al., 2021).

Although individual factors may be important, they are impacted within the social context in which they exist; the social context for individuals with stigmatized identities is grounded in power relations (Hatzenbuehler, 2007). Social conditions place people "at risk of risks" (Hatzenbuehler, 2010, p. 35), ensuring that some people (but not those within dominant groups) are exposed to factors that confer risk through being denied access to resources, such as money, power, prestige, and social support (Hatzenbuehler, 2010).

Stigma is ubiquitous and influences virtually every aspect of lived experience (Herek, 2009; Goffman, 1963; Berger & Luckmann, 1966; Corrigan et al., 2004). Attention to various manifestations of stigma elucidates the vast impact of stigma on the everyday lives of persons with stigmatized identities. Structural-level policies intentionally (such as laws restricting the rights of individuals with a mental illness diagnosis or history) and unintentionally (such as health

insurance parity laws) restrict opportunities and impact the lives of those with stigmatized identities (Corrigan et al., 2004; Corrigan, 2007). Individual-level experiences with stigma are associated with increased rates of anxiety, depression, and suicidal ideation and behavior through exacerbating stressors and contributing to reduced self-esteem (Costa et al., 2017; Chi et al., 2014; Bockting et al., 2013). Because the experiences of individuals with GSD identities and lived experience of suicide may differ involving social, interpersonal, and internal processes surrounding oppression, it is critical to recognize how this stigma may impact or interact with the development of suicidality. Understanding the instances and perceptions of oppression experienced by GSD attempt survivors plays an important role in helping address social roots of suicidality and promoting recovery for GSD attempt survivors. Theories that address specific manifestations of stigma and their related consequences are discussed in the next section.

Theoretical Frameworks

Before embarking on any inquisitive expedition, it is essential to determine theoretical perspectives and philosophical assumptions that shape how we experience, perceive, and understand everything around us. These assumptions are evident in our approaches to inquiry and how we interpret data (Creswell & Poth, 2018). Social constructivism assumes that it is through relationships and interactions with other individuals and groups that we can understand the world around us and our place in it; through these interactions, we begin to understand and construct our identities. The highly social nature of humans is reflected by the frequency in which people report relationship problems as significant precipitating factors to the development of suicidal ideation or behavior (Jobes & Mann, 1999; Green et al., 2020; Testoni et al., 2021). Queer theory asserts multiple realities are constructed in the social environment based on power and identity struggles (de Laurentis, 1991). Guided by social constructivism and queer theory, this research seeks multiple perspectives versus one objective truth in understanding the experiences of stigma for GSDAS and how those experiences are impacted by their social positions and interactions. See Figure 1.1 for a graphic representation of the philosophical assumptions and interpretive frameworks guiding this study.

Efforts to address suicide are often focused on risk assessment and management, emphasizing individual-level characteristics resulting in suicidal behaviors. However, focusing on

the individual alone negates community- and society-level factors (Standley, 2020). Negative mental health outcomes, such as suicide, can be the one result of an intricate interplay between systemic oppression due to individual identities and the meaning making that occurs within the individual (Button & Marsh, 2020). To explore the relationship between stigma experienced by individuals with GSD identities and suicidal behavior, theoretical orientations across ecological levels—micro (individual), mezzo (group), and macro (society) (Bronfenbrenner, 1981)—were utilized. Stigma theory (Goffman, 1963) and Minority Stress Theory (MST) (Meyer, 2003) were used to contextualize macro-level components, and the Interpersonal Psychological Theory of Suicide (IPTS) (Joiner, 1995; Van Orden et al., 2010), Minority Stress Theory (MST) (Meyer, 2003), and the Minority Strengths Model (Perrin et al., 2019) were utilized to frame micro- and mezzo-level interactions. These theories span social levels and provides a lens through which to understand the crux of the lived experience of stigma for GDAS.

Stigma Theory

"Stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (Link & Phelan, 2001, p. 377). Building on Goffman's (1963) that stigma requires a relational conceptualization rather than a definition that focuses on individual attributes or characteristics, Link & Phelan (2001) have developed a conceptualization of stigma that involves the convergence of the interrelated components of (1) distinguishing and labeling differences, (2) associating differences with negative attributes, (3) separating "us" from "them" (p. 370), and (4) status loss and discrimination. See Figure 1.2 for a graphic depicting stigma.

Distinguishing and labeling differences comprise the first component of the theory. The differences identified in others are socially defined and based on salience in place and time, and once the differences are labeled, they are typically taken for granted as legitimate reality (Link & Phelan, 2001). The second component, associating differences with negative attributes, involves a stereotype linking a labeled person to a set of undesirable characteristics (Link & Phelan, 2001). For example, the stereotype of people with lived experience of suicide being dangerous, unpredictable, or undeserving of help can influence others to desire social distance from persons with suicidal experiences. The third component in the stigma process occurs when social labels

designate a separation of “us” from “them” (Link & Phelan, 2001). This divisive process is formed from the first two processes and asserts fundamental differences between labeled persons and “normals” (Goffman, 1963, p. 5); this belief fuels stereotyping and discriminatory beliefs because there is little harm to the dominant party in applying any and all bad characteristics to “them.” The fourth component of stigma processes, occurs when those persons who are labeled, marginalized, and stereotyped experience status loss and discrimination (Link & Phelan, 2001). Status loss is an almost immediate consequence of labeling and stereotyping (Link & Phelan, 2001). Stigma shapes interactions with individuals, groups, and institutions (Link & Phelan, 2001). For example, a man whose gender expression is visibly in ill alignment with cultural expectations of masculinity may be undermined, disrespected, or overlooked in a setting in which other, more masculinely presenting men are present.

Link & Phelan assert that stigma is a “persistent predicament” (2001, p. 379). The negative consequences of stigma are challenging to eradicate because the range of mechanisms for achieving discriminatory outcomes is flexible and widespread (Link & Phelan, 2001). Consider the pervasive negative stereotypes regarding the GSD community: despite decades of progress in human rights and increasing acceptance, stigma still greatly impacts members of this social group. Link & Phelan (2001) link stigma processes with inequitable distribution of life chances and diminished social status. Further, stigmatized identity status may remain salient even when that stigmatized status is no longer occupied by the individual (Jacoby, 1994; Jenkins & Carpenter-Song, 2008). Take, for example, individuals with a history of suicidal behavior who retain the label of “suicidal” and are assumed to be dangerous and instable far beyond their suicidal crisis, a process termed “stigma despite recovery” (Jenkins & Carpenter-Song, 2008, p. 381).

Applying stigma theories directly to sexually diverse populations, Herek proposed the power differential of heterosexism as the “foundation and backdrop” (Herek, 2009, p. 67) for *sexual stigma.* Herek’s model (2007; 2009) pays particular attention to the structural stigma that restricts opportunities for stigmatized groups and embeds stigma within society’s institutions. Structural stigma promotes heteronormativity and cisnormativity and perpetuates the marginalization and “othering” of GSD individuals by reinforcing GSD identities as abnormal, unnatural, and deviant (Herek, 2007, 2009). Herek’s model situates sexual stigma as embedded

in micro, mezzo, and macro realms and as impacting the social, psychological, and physical wellbeing of GSD persons (Herek, 2007). Enacted stigma can be observed in instances of discrimination, which may be individual (within interpersonal social interactions) or structural (accumulated institutional practices that work to disadvantage the oppressed group) and can appear across myriad settings (Link & Phelan, 2001).

Minority Stress Theory

To explore processes that may contribute to suicidal ideation and behavior in GSD populations, minority stress theory (MST; Meyer, 2003) provides a useful framework. MST offers a theoretical explanation of how stressors that are uniquely experienced by members of minority groups can contribute to disparate health outcomes (i.e., suicidal ideation and behavior) in those populations (Meyer, 2003). Examples of minority-specific stressors include employment discrimination, social rejection, and identity-based victimization. Proximal stressors, such as internalization of stigma, are the primary focus of the MST model. Internal processes, such as expectation of rejection or identity concealment, surrounding distal stressors are more indicative of outcomes related to mental health and suicidality than the distal stressors themselves (Meyer, 2003). Because structural and societal discrimination occurs at a step removed from the labeling of an individual, distal processes may be more difficult to identify than instances occurring in individual discrimination (Link & Phelan, 2001). The model posits overlapping factors in which distal minority stressors such as discrimination or violence and proximal stressors overlay general stressors, with minority identity affecting minority stress processes (Meyer, 2003). Figure 1.3 displays a figure depicting these components. The interaction between general stressors and minority-specific stressors combine to influence mental health outcomes including suicidality. Characteristics of minority identity, like integration, coping skills, and social support, moderate and mediate paths to mental health outcomes (Meyer, 2003). Accepting and disclosing one's identity may provide avenues for social support that could provide protection against stressors (Suppes et al., 2021). Identity pride has been associated with increased wellbeing and social connectedness among GSD populations (Johnson et al., 2020; Barr et al., 2016).

Aspects of MST that are frequently discussed in suicidology are distal stressors like harassment or discrimination and proximal stressors such as internalized stigma and identity

concealment. For example, one study tested a model for suicidal ideation in gay men and found that experiences of discrimination (distal stressors) were associated with the development of internalized homophobia and identity concealment (proximal stressors), which then related to the development of depressive symptoms and suicidal ideation (Michaels et al., 2016). Another study found depressive symptoms and past-year suicidal ideation to be particularly high among sexual minority and racial minority youth, indicating increased minority stressors when one belongs to multiple stigmatized groups (Gattis & Larson, 2016). The authors posit that perceived racial discrimination may be particularly stressful because race is not concealable, which aligns with minority stress models (Gattis & Lawson, 2016). Further support for this notion is the finding that TGNC individuals who are always or almost always recognized as being TGNC have highest rates of suicidal ideation among all gender identities (Haas et al., 2014).

When an individual identifies with one's minority status, they often experience *internalization of stigma* or *self-stigma (*Meyer, 2003; Goffman, 1973; Corrigan, 2000). Internalized stigma regarding one's identity may lead to negative perceptions of oneself, thereby contributing to the development of self-hate (Williams et al., 2018). For example, if one is continually exposed to messaging that their gender identity is invalid, they are likely to internalize the perception of something being wrong with them or their identity. The internalization of stigma has been associated with increased risk of suicidal ideation and behavior (Baiocco et al., 2014). Anomie is an important component of social models of suicide and represents an uprooting or breakdown of norms and expectations (Durkheim, 1951). For GSD individuals, there are uncertain expectations for behavior in the context of their GSD identity in the world around them as well as navigating the GSD community and environment, possibly for the first time. A specific example of anomie in relation to MST would be the coming out process, which is wrought with emotional distress and associated with elevated levels of suicidality (Ryan et al., 2015). The period surrounding coming out can be so tumultuous that an individual's entire worldview may be altered (Corrigan & Matthews, 2003). Anomie related to coming out may stem from conflicting values from society at large versus identity group values. For example, desire to embrace one's new-found GSD identity and community may go against their family's desire to maintain privacy or secrecy around their GSD identity.

Concealing one's status as a gender or sexual minority may reduce fear of discovery and discomfort with ambiguity in social situations (Pachankis, 2007). Fear of rejection, safety concerns, and one's stage of identity development may prevent disclosure (Quinn & Chaudoir, 2009; Potoczniak et al., 2007). In instances where individuals receive a negative reaction to coming out, especially by family members, consequences are often long-term and lead to the development and exacerbation of internalized stigma, decreased social support, and increased anxiety, depression, and suicidality (Puckett et al., 2015; Michaels et al., 2016). This negative response may deter individuals from further sharing their identity to avoid rejection (Quinn & Chaudoir, 2009). Identity concealment has been associated with heightened levels of anxiety and depression in GSD samples (Potoczniak et al., 2007 and identified as a constant stressor by gender and sexual minorities (Williams et al., 2018), suggesting that identity concealment may be beneficial for members of GSD communities in some contexts and situations, but not in all. Individuals with less perceived social support may be more likely to conceal aspects of their stigmatized identities (Potoczniak et al., 2007). Further, concealing one's identity limits access to a community of peers that could otherwise provide support (Weston, 1991; Williams et al., 2018).

Minority Strengths Model

While Minority Stress Theory primarily addresses the negative impact of social stressors on health outcomes, it stops short of highlighting the strengths associated with minority identity. The Minority Strengths Model (MSM) (Perrin et al., 2019) was developed to build upon the framework provided by Minority Stress Theory (Meyer, 2003) and to emphasize the positive aspects of minority identity. MSM incorporates the strengths-based factors of social support and community consciousness as critical components of minority strength, through which positive health behaviors are developed (Perrin et al., 2019).

The model rests on the foundation of connection to minority community. Community connection increases availability of social support, which provides a protective barrier against psychological distress and the development of suicidality (citation). Related to social support is community consciousness, whereby an individual possesses a connection, affiliation, and identification with a specific minority community (Perrin et al., 2019). For GSD individuals, communities can provide a sense of belonging and identification, sharing common experiences

and culture. Community consciousness can increase involvement with communities, serving as another path for receiving social support. Through identification and affiliation with the community, as well as the availability of social support, community consciousness can buffer against stigma and stress (Perrin et al., 2019).

Social support and community consciousness may aid in the development of identity pride, in which an individual not only accepts their identity but derives satisfaction from and fully immerses themselves in that identity (Cass, 1979). Identity pride considers whether the identity makes the person feel special, whether they are comfortable sharing the identity, and whether they would rather share their identity and risk rejection than conceal the identity (Testa et al., 2015). Individuals whose identities are affirmed are more likely to have identity pride and to have access to greater social resources (Fredriksen-Goldsen et al., 2017). Having identity pride promotes engagement with identity community, enhances opportunities for affirmation, and can help promote self-worth (Dunn & Burcaw, 2013).

The Minority Strengths Model (MSM) suggests that identity pride is likely to manifest in self-esteem, which has been associated with higher self-forgiveness, lower shame proneness, social support and connectedness, active coping, and outness among GSD populations (Perrin et al., 2019). Self-esteem may help GSD people adapt more positively to adversity, a concept known as resilience, which can bolster positive adaptation to minority stress and buffer the deleterious impact of minority stress (Meyer, 2015). Resilience is associated with more positive mental health and well-being (Breslow et al., 2015). Figure 1.4 illustrates the minority strengths model.

Interpersonal Psychological Theory of Suicide

A micro-level framework enables us to understand how the consequences of stigma can lead to the development of suicidal ideation and behavior on an individual level. A leading theory in suicidology is the interpersonal psychological theory of suicide (IPTS) (Joiner, 1995; Van Orden et al., 2010) which proposes that the desire for suicide is ultimately the product of interpersonal-psychological needs that go unmet, leading to thwarted belongingness and perceived burdensomeness (Joiner, 1995). The theory posits that the presence of these two unmet interpersonal needs coupled with an acquired capacity to act on suicidal ideation interact

and lead to suicidal behavior and death (Joiner, 2005). See Figure 1.5 for a visual representation of IPTS.

Thwarted belongingness is the perception of being unwanted or unable to fit into society and is one of the two constructs that lead to the desire to die (Joiner, 2005). The theory states two components of belongingness must be present for an individual to be fully satisfied: interacting with others and feeling cared about (Joiner, 2005). When these needs are not met, a feeling of thwarted belongingness develops and may lead to a desire to die (Van Orden et al., 2010). The theory posits that social connectedness needs to be both supportive and reciprocal (Van Orden et al., 2010). Social isolation, which occurs when social connectedness is missing, is one of the strongest indicators of suicidal ideation and behavior across the lifespan (Van Orden et al., 2010). GSD individuals' experiences of social rejection and isolation, especially when that rejection is identity-based, lead to the development and exacerbation of suicidal ideation (Yadegarfard et al., 2014; Hequembourg & Brallier, 2009; Bauer et al., 2015). This is evidenced by the close connection between family rejection and suicidal ideation among GSD persons (Ryan et al., 2008).

The other primary component involved in the desire to die is *perceived burdensomeness*, in which an individual perceives their own death to be beneficial to others in their group, community, or society, or that one's mere existence is creating hardship for others (Joiner, 2005). When an individual comes to believe they are no longer contributing to society or relationships, the perception of being a burden often develops (Joiner, 2005); for example, the thought, "everyone would be better off without me" is representative of perceived burdensomeness. Perceived burdensomeness comprises two separate concepts: (a) liability, which is the belief that one's death is worth more than their life to others, and (b) self-hate, which is described as emotionally laden thoughts of self-loathing (Van Orden et al., 2010). For GSD persons, the development of perceived burdensomeness, and especially self-hate, may be related to experiences of oppression. For example, self-hate may amass when identity-related stigma is internalized (Hendricks & Testa, 2012). Experiences with invalidation of gender or sexual identity may also contribute to the feeling of being a liability for one's loved ones: some GSD individuals report feeling like a burden on their family because they do not want to be an embarrassment or

bring shame to their family's name (Peterson et al., 2021; Goodyear et al., 2021). Thwarted belongingness and perceived burdensomeness are necessary components contributing to the desire to die and further to suicidal ideation but not sufficient in themselves to lead to lethal suicidal behavior (Joiner, 2005).

According to IPTS, a final component is present in lethal suicide attempts: the *acquired capability* for suicide (Joiner, 2005). Acquired capability is theorized to occur through an interaction between a reduction in one's fear of death and an increase in physical pain tolerance (Joiner, 2005). Factors associated with an individual's capability to attempt suicide include practical capability (e.g., access to lethal means), dispositional capability (e.g., genetic predispositions), and acquired capability (e.g., increased pain tolerance, reduced fear of death) (Klonsky & May, 2015). Survival is a basic human instinct, and in such, fear of death is an evolutionary advantage (Ohman & Mineka, 2001); taking action to end one's own survival, therefore, is contrary to the fear of death we possess (Van Orden, 2010). The attainment of acquired capability is made possible through habituation and activated responses to repeated exposures to pain or fear-inducing experiences (Van Orden et al., 2010). Pain tolerance, and therefore acquired capability for suicide, can be increased through exposure to *painful and provocative events*, which are emotionally or physically afflictive, fearful, or distressing experiences thought to contribute to the acquired capability for suicide through increasing pain tolerance (Bauer et al., 2020). Discrimination can have such an impact on mental health that it has been identified as a painful and provocative event (Brooks et al., 2020): Stigma-based violence, discrimination, and harassment may be painful enough to enhance the acquired capacity for suicide (Plöderl et al., 2014). Due to the disproportionately high rates of suicidal ideation and behavior in GSD populations (Haas et al., 2010; Haas et al., 2014) and that GSD individuals are likely to have social circles comprised of others with GSD identities (Weston, 1991), it is likely that those with GSD identities have greater exposure to suicide within their social networks. Through increased exposure to suicide (Cerel et al., 2021) and more prevalent experiences of identity-based victimization (Plöderl et al., 2014), GSD individuals may acquire greater capability to act on suicidal ideation.

IPTS has been tested in gender and sexually diverse populations (e.g., Testa et al., 2017; Battalen et al., 2021). Both thwarted belongingness and perceived burdensomeness have been associated with elevated risk for suicidal ideation and behavior in GSD individuals (Baams et al., 2015). Deficits in the bedrock social needs described in IPTS, belonging and effectiveness (Joiner, 2005), may be partly explained by minority stressors, as posited in minority stress theory (Meyer, 2003). Indeed, the feeling that one is deeply flawed because of their GSD identity may contribute to perceived burdensomeness (Battalen et al., 2021). The marginalization and exclusion of individuals with diverse gender and sexual identities, compounded by cultural and societal attitudes of inferiority and/or disdain for GSD individuals, can isolate already-suffering individuals even further from potential sources of support. Understanding the processes of IPTS is integral to our knowledge of the individual experience of suicide. However, broadening our focus to social contexts and interactions is essential for suicide prevention.

Applying and Connecting Theories

The theoretical perspectives discussed in the preceding chapter will shape the research proposed in the following chapter. Through analyzing lived experience and perceptions of enacted stigma within the stories of GSD attempt survivors, we can begin to contextualize their challenges within a culture of oppression versus focusing solely on individual psychological factors. Identifying instances of stigma and utilizing stigma theory (Goffman, 1963; Link & Phelan, 2001), Minority stress and strengths models (Meyer, 2003; Hatzenbuehler, 2009; Perrin et al., 2019) and interpersonal psychological theory of suicide (IPTS) (Joiner, 2005; Van Orden et al., 2010) to understand their impact can guide future directions of intervention and research for suicide prevention among GSD populations.

Figure 1.6 provides a conceptual model for how the previously discussed theories will be integrated to better understand experiences of enacted stigma by gender and sexually diverse suicide attempt survivors. Based on ecological systems models (Bronfenbrenner, 1981), which encompass micro, mezzo, and macro levels of factors, the theories are merged to cultivate a comprehensive depiction the experience of enacted stigma for GSD persons with lived experience of suicide. Stigma theory provides a macro-level context within which there is a power imbalance held by the dominant group(s) in society (i.e., cisgender heterosexuals). Stigma

processes cut through to the meso-level as seen in minority stress theory, in which categorization into a stigmatized identity group creates the position of a minority identity. Stigma-related minority stressors can impact meso-level factors like relationships and interpersonal challenges as well as contributing to individual, micro-level factors such the development of internalized stigma leading to self-hate.

Integrating these theoretical models may provide a more thorough lens to explore the processes and experiences by GSD individuals with lived experience of suicide. MST processes (i.e., distal and proximal stressors) lead to the factors that combine to create the desire to die (i.e., thwarted belongingness and perceived burdensomeness), as proposed by IPTS. Distal stressors, such as legislation allowing vendors to refuse service to GSD individuals, may lead to the development of thwarted belongingness as the individual recognizes society's ostracism of their identity group (Meyer, 2003). Proximal stressors such as the internalization of stigma and the notion of their identity as unwanted may incite the perception of burdensomeness (Meyer, 2003). This interweaving process helps us understand minority-specific stressors that contribute to the well-being of GSD persons. Suicidal ideation and behavior are presented as results of a process by which minority-identity stressors combine with general stressors to impact mental health and contribute to suicidal ideation and behavior (Meyer, 2003; Hatzenbuehler, 2010). Shame and self-hate surrounding GSD identity due to the stereotyped negative associations with GSD groups that are perpetuated by society contribute to unbearable psychological pain that in turn leads to suicidal ideation (Mereish et al., 2019b). For example, in Downs's (2011) explication of gay male life, one individual died from suicide; his suicide note read, "I'd rather be dead than gay" (p. 42). Downs takes the stance that suicide can be viewed as a drastic way of avoiding the stigma associated with non-heterosexual identities (2011). Taking a more expansive perspective that encompasses systemic, institutional, and political contexts will enable us to the role enacted stigma may play in the development of suicidal ideation and behavior for GSD persons.

Innovation

This study will contribute to the field of suicidology, queer studies, and social work through adding to the literature an analysis of different types of oppression within the stories of

gender and sexually diverse attempt survivors. This paper seeks to narrow the gap in our understanding of stigma as experienced by gender and sexually diverse persons with lived experience of suicide. Incorporating issues of oppression is crucial to holistically addressing factors contributing to suicide. This work will inform our ability to develop and implement upstream interventions to address root causes of stigma-related stressors for sexual minority persons. Stigma can be a major impediment to seeking care or to disclosing information that could save lives. Elucidating the experiences of stigma within the stories of gender and sexually diverse suicide attempt survivors can help us increase engagement in care and help-seeking among this population.

Purpose of the Study

Experiences of stigma for GSDAS at their unique intersection of identities may provide pivotal insight into how stigma impacts their experiences surrounding suicidal suffering. This dissertation aimed to explore perceptions of oppression, to uncover connections between experiences of enacted stigma and minority stress processes, and to identify systemic points of intervention to address the roots of social problems contributing to suicidality among gender and sexually diverse populations. To meet these goals, this dissertation is separated into two studies by splitting the sample in terms of identity: One sample consisted of sexual minorities and the other consisted of gender minorities. This dissertation attempts to answer the following question: "When GSDAS share their experiences of suicide, how do they describe both experiences of sexual diversity stigma and experiences of suicide stigma?"

CHAPTER 2

RAINBOW SKELETONS: A PHENOMENOLOGICAL STUDY OF SEXUALLY DIVERSE SUICIDE ATTEMPT SURVIVORS' DESCRIPTIONS OF STIGMA

Communities of sexually diverse (SD) individuals are burdened with disparate rates of suicidal suffering: Sexually diverse populations exhibit suicidal behavior at significantly elevated rates, with estimates indicating 10 to 20 percent of sexual minority adults attempt suicide in their lifetime compared to 4.6 percent for the general population (Hottes et al., 2016). *Sexual identity* (or *sexual orientation* or *sexual orientation identity*), is the sexual self-identification, attraction (e.g., physical, romantic, or emotional attraction), fantasy, and behavior of an individual toward others (e.g., bisexual, queer, lesbian, gay) (Park, 2016; Haas et al., 2011). Recognized by Kinsey (1948) as existing on a continuum from completely heterosexual to completely homosexual, sexuality is now understood as more complex. Contemporary conceptualizations of sexual orientation depict this aspect of identity as a constellation of factors that come together to represent an individual's unique personal identity (Sedgwick, 1990). For example, many sexual minorities who identify as *queer* would not see themselves on Kinsey's scale (Zietsch & Sidari, 2020): *Pansexuality* (i.e., an attraction to a person regardless of gender) and *asexuality* were not recognized as sexual identities (National LGBTQIA+ Health Education Center, 2020). Moreover, many SD individuals are uncomfortable with being labeled as any defined category of sexual orientation (Scheffey et al., 2019; Williams et al., 2018). This demonstrates the fluidity of the conceptualization of both sexual identities and queerness (van Anders, 2015). Sexual orientation and identity may transform throughout an individual's life as that person's understanding and expression of their sexual identity evolve (Luoto et al., 2019). For example, when initially exploring and understanding one's sexual identity, they may start with the recognition of same-gender attraction and identify as bisexual. Then, later in life after more life experience, they may identify as queer or another term that they feel more authentically represents their identity.

Individuals who have nonexclusive gender attraction (e.g., bisexual, pansexual, queer) experience suicidal ideation and behavior at greater rates than lesbian- and gay-identified individuals (Haney, 2021; Salway et al., 2019).

For sexually diverse suicide attempt survivors (SDAS), oppression can have far-reaching implications. From policies and institutions restricting full participation in social life to actively facing violent assault, stigma damages their safety, health, and wellbeing (Herek & Garnets, 2007; Fredriksen-Goldsen et al., 2014; Hatzenbuehler & Pachankis, 2012; Binnix et al., 2018). For example, no federal-level legislation exists that protects individuals from discrimination on the basis of sexual orientation or gender identity (ACLU, 2021). Discrimination can be understood as a social stressor that can lead to anxiety and depressive symptoms and higher levels of suicidal ideation (Battalen et al., 2021), and with decreased coping resources (Farrelly et al., 2015). Discrimination may be more chronic and unrelenting than other types of social stressors and may therefore contribute to hopelessness or feeling trapped (Battalen et al., 2021), which are contributing factors for the development of suicidal ideation (Grafiadeli et al., 2021). The impact of these and other minority stressors can lead to the development or worsening of negative physical and mental health conditions such as anxiety, depression, post-traumatic distress, and suicidal ideation or behavior (Hatzenbuehler, 2009; Meyer, 2003; Marshal et al., 2011; King et al., 2008).

Managing the risk of discrimination and victimization for some SD people means concealing their gender or sexual identity from all or part of their social networks. Further, having personal experiences with suicide may be classified as having a concealable stigmatized identity (Fulginiti & Frey, 2018). Identity concealment may be helpful in the reducing fear and ambiguity in uncertain social situations (Pachankis, 2007). Social environments that are hostile or intolerant of SD are associated with negative mental health and increased suicidality in SD individuals (Hatzenbuehler, 2009). Identity concealment may serve to protect individuals from the stigma and consequences (McIntyre et al., 2014), but it may also serve as a constant stressor (Quinn & Chaudoir, 2009). For example, the feeling of hiding one's identity from people in their lives or of having to keep aspects of their identity hidden can cause a great deal of stress and anxiety (Williams et al., 2018).

Internalized stigma is an important contributor to the development of suicidal ideation and behavior for SD individuals (Baiocco et al., 2014; McAndrew & Warne, 2010; Perez-Brumer et al., 2015; Testa et al., 2017). Internalized stigma regarding one's identity may lead to negative perceptions of oneself as a whole, contributing to the development of self-hate (Pistella et al, 2016; Williams et al., 2018). Internalized stigma is related to the development of suicidal ideation and attempts in SD populations (Austin et al., 2021). Family support, social support, peer support, and the presence of positive coping skills can help reduce the risk of internalizing stigma to the point of adverse outcomes (Hatzenbuehler, 2009; Kaysen et al., 2014; Pistella, 2016).

Purpose of Study

The multiplicity of causes and motivations for engaging in suicidal behaviors and attempts make addressing the issue complicated. While no singular cause exists for suicide, several factors increase vulnerability to experiencing suicidal ideation and behavior. Risk factors are characteristics that may make it more likely an individual will experience suicidal ideation or behavior (SPRC, 2011). A holistic approach to understanding suicide must include individual, social, and environmental contexts. Beyond the common risk factors experienced by the general population, SD individuals face significantly more challenges that increase their likelihood for suicidal experiences. These challenges include minority-identity-specific stressors such as discrimination, victimization, and internalized stigma (Hottes et al., 2016; Meyer, 2003). Although individual factors may be important, they are impacted within the social context in which they exist; the social context for individuals with stigmatized identities is grounded in power relations (Hatzenbuehler, 2007). Social conditions place people "at risk of risks" (Hatzenbuehler, 2010, p. 35), ensuring that some people (but not those within dominant groups) are exposed to factors that confer risk through being denied access to resources, such as money, power, prestige, and social support (Hatzenbuehler, 2010).

Stigma is ubiquitous and influences virtually every aspect of lived experience (Herek, 2009; Goffman, 1963; Berger & Luckmann, 1966; Corrigan et al., 2004). Attention to various manifestations of stigma elucidates the vast impact of stigma on the everyday lives of persons with stigmatized identities. Structural-level policies intentionally (such as laws restricting the rights

of individuals with a mental illness diagnosis or history) and unintentionally (such as health insurance parity laws) restrict opportunities and impact the lives of those with stigmatized identities (Corrigan et al., 2004; Corrigan, 2007). Individual-level experiences with stigma are associated with increased rates of anxiety, depression, and suicidal ideation and behavior through exacerbating stressors and contributing to reduced self-esteem (Costa et al., 2017; Chi et al., 2014; Bockting et al., 2013). Because the experiences of SDAS may differ involving social, interpersonal, and internal processes surrounding intersectional stigma, it is critical to recognize how this stigma may impact or interact with the development of suicidality.

Given the interweaving complexities of experience for those identifying as sexually diverse suicide attempt survivors (SDAS), the inextricable nature of their identities and social interactions must be understood in relation to varied sources and layers of stigma. The study aims to explore perceptions of enacted stigma, to uncover connections between experiences of stigma and minority stress and strengths processes leading to the desire to die, and to identify systemic points of intervention to address the roots of social problems contributing to suicidality among sexually diverse populations. This study seeks to answer the question: When SDAS share their experiences of suicide, how do they describe both experiences of sexual diversity stigma and experiences of suicide stigma?

Method

This study utilized a hermeneutic phenomenological design. Where transcendental phenomenology aims to describe the essence of experience while intimacy with the data and words of individuals with lived experience (sometimes referred to as *pure phenomenology* (van Manen, 2014), hermeneutic phenomenology involves contextualizing the essence of the lived experience within the social world by examining the "texts of lived experience" (van Manen, 1990, p. 39). Hermeneutic phenomenology embraces the pluralism and malleability of experience by acknowledging that all our experiences are shaped by what we know and believe and therefore, as researchers, we must also take into consideration the social context of experience. A hermeneutic approach integrates extant understandings of the world with the individual experiences of a phenomenon. As persons in a social environment, our interactions and

interpretations shape our realities (i.e., social constructivism; Berger & Luckmann, 1966). The aim of constructing a full interpretive description of a lived experience while consistently remaining aware that lived life is always more complex than any one interpretation can encompass highlights the pluralistic epistemology of this approach. Hermeneutic phenomenology integrates the parts and the whole and encourages a thoughtful awareness to the details and interactions of our everyday lives (van Manen, 1990). With this approach, we can apply interpretive frameworks to our analysis of the lived experience to grasp its singularity and significance (van Manen, 1990) more fully.

Data

Data for this study came from the Live Through This advocacy project, which comprises a non-probabilistic convenience sample recruited through snowball sampling methods. Data were gleaned from the transcripts of in-depth interviews with individuals who have lived experience of suicidality. Interviews were collected as part of Live Through This, an advocacy project that collects the personal stories of suicide attempt survivors. The project posts portraits of attempt survivors along with interview transcripts, with a goal of personifying or humanizing the lived experience of suicidality. These interviews and portraits are shared publicly on the project's website (***www.livethroughthis.org***), in films (e.g., The S Word, 2017), and in talks and presentations given by the creator of the project. The creator of *Live Through This*, who also serves as the interviewer and photographer for the project, met volunteer participants in locations of their preference and conducted an interview about the person's experience with suicide followed by an intimate portrait session. The interviewer provided just two prompts, "Tell me your story," and "Is suicide still an option for you?" with the goal of hearing the attempt survivor's story of their suicide attempt(s) and their retrospective thoughts about their suicidal experiences in their own words. Interviews were recorded and transcribed by members of the *Live Through This* team.

Participants

The inclusion criteria for the Live Through This project includes being 18 years of age or older, having had at least one year since their most recent suicide attempt, and being willing to

sign a release to use their full name and likeness and to have their voice recorded. The sample for this analysis includes a subsample (n = 37) from this larger project (N = 102) of interviews that took place from 2011-2015 and comprises individuals who self-identify as having diverse sexual orientation identities (i.e., gay, bi, queer). The lead researcher read through interview transcripts to identify self-disclosure of sexually diverse identities. Participants ages ranged from 19-62 (μ=33.89). The sample was primarily cisgender women (n = 31), representing lesbian (n = 17), bisexual (n = 12), pansexual (n = 1), and queer (n = 1) identities; the 6 cisgender men in the sample all identified as gay (n = 6). Other demographic data for the sample was not available from the texts.

Analysis

Analyses and memoing were conducted using the Microsoft Office Suite (i.e., Word, Excel, etc.) and Dedoose (SocioCultural Research Consultants, LLC, 2022) software. The researcher analyzed interview transcripts using hermeneutical phenomenological methods. The researcher conducted a naïve reading of the interview transcripts to orient the researcher to the overall sense of lived experience of oppression within the context of suicidal experience. The researcher then conducted a detailed reading and a thorough analysis of the texts to identify significant units of meaning (van Manen, 1990) utilizing concepts of stigma theory and minority stress and strengths processes. To enhance analysis and strengthen the rigor of this project, a second coder trained in qualitative analysis concurrently coded transcripts from the sample and both coders engaged in discussions about the meaning units identified to reach consensus in code meaning. In addition to analyzing the transcripts for oppressive experiences, hermeneutic phenomenology involves taking a critical approach to extant knowledge (van Manen, 1990) and analyzing the texts for experiences with stigma and minority identity that are not captured by the aforementioned theories.

From the meaning units identified in this phase of analysis, the researcher conducted a thematic analysis, which is the process of recovering themes that are embodied and dramatized in the stories of lived experience (van Manen, 1990). Thematic analysis involves the researcher *intuiting* meanings through creative thinking and reflection based upon knowledge gleaned from

persons' experiences of phenomena and then situating those observances within the reduction and our presuppositions (van Manen, 2014; Finlay, 2008). This "dialectical dance" (Finlay, 2008, p. 4) of the hermeneutic reduction requires the remaining as open as possible to the experience and meaning of others while interpreting these experiences and meanings against the backdrop of social and personal dynamics (van Manen, 1990). This process is facilitated through memoing (van Manen, 1990), in which the researcher will make notes of preliminary analysis ideas, connections between and among interviews or experiences, and connections to theory and data. The memoing process also facilitates engaging in reflexivity, an important practice in qualitative research that seeks to minimize researcher bias (Charmaz, 2014; van Manen, 1990). The researcher utilized the iterative process of memoing to enhance minimize potential bias. Congruent with phenomenological methods, bracketing was used by the researcher to mitigate bias (Moustakas, 1994). Themes were elucidated from the interview transcripts to portray the interactions with stigma shape the experience of SDAS within the context of their suicide attempt stories.

Finally, the researcher developed textural descriptions (what was experienced) and structural descriptions (how it was experienced). The iterative process of developing these individual and group descriptions keeps the researcher engaged with the data at a close proximity throughout the analytic journey, ensuring authentic representation of the data as the researcher moved from concrete to abstract interpretations. These descriptions were followed by a composite description that weaves together the experiential meanings with the contextual backdrop of stigma and minority stress and strengths processes (van Manen, 1990/2014; Goffman, 1973; Meyer, 2003; Perrin et al., 2020).

Reflexivity Statement

The author is a White, queer, woman (she/her) who was raised in the Southern United States and has personal experience suicidal intensity and suicide loss. She has experienced stigma as a member of multiple minority groups and have witnessed the impacts of stigma on others. Her research centers on suicide and suicidal experiences in gender and sexually diverse populations, with an emphasis on amplifying the voices of suicide attempts survivors and others

with lived experience of suicide. The author has extensive service experience with suicide prevention and with gender and sexual diverse populations. As a member of the SD community, the author drew from her own experiences to approach this research with sensitivity and compassion to the stories of SDAS. The author regularly discussed analysis and interpretations with colleagues and with others in her community who share these experiences.

Results

Within their suicide stories, participants discussed aspects of stigma and the ways in which they interacted with that stigma. Apparent themes in the narratives depicted the nuanced and often conflicting natures of existing and navigating life as SDAS. Participants commonly reported an environment of stigma that included dialectically interconnected themes—(a) otherness, (b) facing stigma, (c) openness, (d) community and relationships, and (e) giving back—that contributed to both positive and negative experiences of SDAS. These themes are overlapping and may be understood as points in an emergent dialectical process. See Figure 1 for a graphic depiction of these factors. To start, I'll describe the environment of stigma in which SDAS live, followed a description of the individual themes listed above.

Existing in a Climate of Stigma

Each SDAS shared living in an environment of stigma, which refers to the pervasive way in which stigma permeated their lives and shaped their interactions with the social world. Participants spoke of stigma surrounding suicide, sexual diversity, and mental health more broadly. The backdrop of stigma shaped social interactions and contributed to the worldviews of SDAS and their understandings of their place in the social environment. One participant compared suicide stigma with sexual diversity stigma, implying a link between experiences of stigma experienced in relation to both aspects of social identity: “It's kind of like being the gay kid in rural Kentucky: it's not widely accepted” (Kelly (she/her), 34, lesbian woman).

All participants (37 of 37) shared observations of stigma surrounding suicide. Some remarked on the inherent negativity communicated through the language we use to discuss suicide. They made note of the semantics of suicide and of the negative connotations associated with the phrase “committed suicide,” which they felt connected suicide to a crime or a sin. SDAS

expounded on differences in language used by someone who has attempted suicide versus someone who has not, asserting that suicide is sometimes a rational reaction, even when others cannot see it that way. They also expressed the irrationality implied in others' communication about suicide, invoking hesitance among SDAS to share their personal experiences with suicide to preserve their credibility. Further motivating concealment of suicidal suffering was an intense fear of being abandoned or rejected if anyone found out about their suicide attempt. SDAS described stigma as contributing to suicidal suffering through exacerbating feelings of being alone in their experiences.

SDAS noted an expectation of silence and secrecy surrounding suicide and mental health challenges. They pointed to stigma and expected silence as barriers to care, perceiving an inability to be open about their suicidal suffering or being dismissed on occasions when they did share their suicidality. SDAS spoke of stigma in mental health services, where their suffering was not taken seriously or their personhood was diminished as a consequence of their suicidal past. Because of the rampant negative messaging about mental illness and suicide in our society, SDAS recognized their precarious social standing if their SAS identity was exposed. They feared rejection from others in their social networks, which were already limited due to their sexual orientation identity.

Many participants (26/37) spoke of stigma surrounding sexual diversity. This theme was more pronounced among older participants but extended into the stories of participants across age ranges. Sexual diversity stigma contributed to perceptions of sexual orientation for SDAS and fostered a hostile setting in which to live authentically. Eliza (she/her), 27, lesbian woman) shares the connection between her suicidality and the stigma associated with her sexual orientation identity: "Being queer is a huge part – was a huge part of, I was just discovering that I was gay when I attempted suicide." Angelica (she/her, 43, lesbian woman) spoke of the violently oppressive environment for sexual diversity in her hometown: "There weren't gays in our town, you know. I'm sure they would have been killed had there been." Another example comes from Gabby (she/her, 46, lesbian woman), whose environment promoted violent stigma against sexually diverse people: "Coming from a small town, I always said, 'I'd rather spit on a faggot than

look at one.'" In the same vein, Eliza (she/her, 27, lesbian, woman) spoke of her exposure to sexual diversity within her family and using the reactions of others as a gauge for how they felt about sexually diverse individuals, recalling the treatment of her gay aunt by her grandparents as sending the message that sexual diversity was "despicable." SDAS learned through this and other similar experiences that their sexual orientation identity was not acceptable.

Religion was mentioned by many participants (14) as the source of originating stigmatizing attitudes and beliefs about sexuality. One SDAS spoke of the intricate connection between her sexuality and suicidal suffering, making an astute connection between sexual diversity, suicide, and religious influence:

> I would go into these phases where I would want to date girls or, you know, start looking at girls and be attracted to them, but I had also been very religious as a child because of my father's upbringing in the church, and I started feeling suicidal about that because we were taught that being gay was not…that it was a sin, that we would go to hell no matter what, that there was no forgiveness for it. . . Suicide, well, suicide was also a sin. So, you know, I don't know if that was part of my rationale at the time, but the thinking behind it was that I would rather die than have to live in this world, and there were times that I wouldn't date women.
>
> Claudia (she/her), 34, bisexual woman

Religiously oriented messages surrounding sexual diversity were frequently stigmatizing and contributed to negative beliefs about SD persons. The association of SD with sin painted a picture of SD people as sinners and, therefore, as undeserving of acceptance and happiness. For some SDAS, this expectation of misery contributed to hopelessness about their ability to live a life of contentment.

Otherness

Integrating stigma from their environments into their worldview, each SDAS sensed differences between themselves and those around them. Through social interactions and observations, they sensed they were recognized and labeled as *other*, even when they did not understand the root of this identification. Adrienne (she/her, 38, bisexual woman) shared her experience during youth, recalling she "never seemed to fit in." Beatrice (she/her, 27, bisexual woman) felt similarly and recalled thinking during childhood, "I feel like a weirdo and I don't want to be here." These excerpts suggest the inherent *otherness* perceived by SDAS even in the absence of an identified source of difference.

Sexual orientation stigma prompted hesitance to acknowledge and accept one's own sexual identity, as sexual diversity was seen as undesirable and problematic. SDAS learned through social observations that sexual diversity was a taboo subject and as an unacceptable attribute. As participants began to recognize their sexual orientation identity, they felt compelled to repress the reality of that identity. Some SDAS interpreted their sexual orientation as the root cause of their problems, sometimes feeling as though they were deserving of suffering because of their sexual orientation identity.

Suicidal experience as *other* was incorporated into the self-image of SDAS beginning early in life. Many SDAS shared the notion there was something inherently wrong with them. Participants recognized that not everyone shared their experiences with suicidal intensity and that people who did not have that shared understanding were fundamentally different from them. For some SDAS, this exacerbated existing feelings of separation and increased their sense of isolation. Some SDAS expressed feeling like they were the only ones who had felt they wanted to die, which led them to believe they would not be understood if they did express their suffering.

One manifestation of self-stigma that appeared in the stories of many SDAS (22) was the conceptualization of suicide attempts as a hierarchy, wherein some attempts were considered less valid than others. Some participants were unsure if they met criteria for participating in the project or for belonging to the attempt survivor community. For some, this uncertainty contributed to feelings of ostracism from others with suicidal experiences, or they felt as though their past did not warrant the same level of compassion as others who attempted suicide. Participants also discussed a disagreement with the way service providers conceptualize suicide attempts, emphasizing that their personal definitions of suicide attempts may not have qualified as a suicide attempt from the perspective of providers. Further, behaviors they would previously have not considered suicide attempts may earn them the label of attempt survivor. They talked about differences in operationalization of suicide attempts and attempt severity. For some, discussions around suicide attempt severity validated their suffering and enabled them to feel understood. For others, the incongruence between the way they thought and spoke about suicide and the way their providers addressed suicide created a rift in the therapeutic relationship, at times eroding

their trust in the mental healthcare system. Leela (she/her, 24, bisexual woman) spoke of a suicide attempt in childhood to highlight the severity of all suicide attempts, arguing that regardless of objective lethality as assessed by medical professionals, any suicide attempt made by a child should be taken seriously. Some SDAS took this sentiment further, declaring all suicidal suffering as valid and all attempts as an indication of intense pain.

Many SDAS (18) recognized the compounding stigma impacting them as they occupied space in multiple stigmatized identity groups. Leela (she/her, 24, bisexual woman) joked about dismissive reactions to both bisexuality and suicidality: "Suicide is exactly like being bisexual! You'll just grow out of it!" While able to see these intersecting stereotypes through a lens of good humor, SDAS also recognized the impact of compounding stigma as they navigated life with multiple stigmatized identities. Another participant shared her concerns about the intersectional oppression with race, sexuality, and suicidality, exacerbating her feeling of otherness and contributing to compounding stigma at the intersection of multiple diverse identities. She expresses the erasure of the struggling of Black women by society. In doing so, she calls out systemic issues that contribute to the overall stress of Black women and the expectation of Black women to maintain silence around their suffering. Some SDAS shared their location at conflicting intersections of identities, such as Christianity and sexual diversity, which was a particularly tense combination and a source of stress. Many participants shifted away from religious affiliation when they embraced their sexual identity, but others forged self-acceptance of both facets of their identities.

SDAS reflected on the challenges of finding peers community at the convergence of intersectional identities, wherein additionally stigmatized identities make narrower the opportunities for shared experience, understanding, and culture. Theo (he/him, 21, gay man) shared a particularly poignant observation, comparing the struggle of suicide attempt survivors to the struggle of sexually diverse in finding community, saying it is "hard to build communities of any kind, much less around being queer or, like, struggling with mental health challenges." Similar difficulties were expressed by many SDAS as they anticipated stigma in GSD spaces surrounding their attempt survivorship and expected GSD and suicide stigma in mental health spaces.

Participants described their otherness as intrinsically attached to their identities. They understood their differences as inherent to their individuality, ascribing a deep personal connection to the sense of being an interloper: "There's always that kernel inside of you that's just always like, I'm different, I'm an outsider" (Rudy (he/him), 35, gay man). Interactions with pervasive stigma induced internalization of negative beliefs about sexuality, suicide, and the perception of innate interwovenness of stigma with their identities fostered the development of self-stigma among SDAS.

Self-stigma and the continued application of negative beliefs to their own person, along with feelings of shame, provoked the development of self-hate. Some SDAS expressed the onset of self-hatred as tied to their sexual orientation identity discovery, with one participant (Eliza, she/her, 27, lesbian woman) explaining that at the beginning of her understanding of her sexual orientation, it "became really problematic for me. . . I hated myself for it for a while." Other SDAS spoke of self-hatred surrounding their suicide attempts' one participant wondered aloud if she felt so much shame tied to her suicidality because it means "you failed as a person, you failed in life" (Marisol, 48, lesbian woman). Some participants expressed deep self-loathing and thought of that as a piece of themselves they should hide.

Facing Stigma

In contrast with the implicit discrimination in the climate of stigma, within which SDAS navigated social interactions in daily life, SDAS described incidents in which they were confronted with explicit, direct experiences of stigma. The thematic category of "facing stigma" encompasses being the target of discrimination as well as actions taken by SDAS to manage stigma. Most SDAS (30) shared experiences of rejection as contributing to their suicidal suffering. Some participants spoke of rejection and conflict based on their sexual orientation identity, sharing anecdotes about anti-queer discrimination: from a hate crime involving vandalism with the word "faggot," to being victims of bullying and "being outed," SDAS shared multiple stories of blatant discrimination based on their perceived sexual orientation identity.

All participants voiced experiencing stigmatization related to their suicidality. Harmful responses to suicidal crises were discussed by most SDAS (32). Unhelpful responses from family members were shared by some participants, such as this story from Vince (he/him, 25, gay man) about his father discovering his suicide attempt: “My father actually took a knife and he was like, ‘Do you want me to do it for you?’” Luella (she/her, 23, queer woman) shared a similarly troubling response from her stepmother: “When my stepmom found me, she called me pathetic and asked me what I was trying to show her.” SDAS recollected responses to their suicide attempts they felt were punitive, ranging from heightened parental involvement to intense social and environmental restrictions, which further intensified suffering for some.

Some SDAS discussed being the target of rejection or conflict following disclosure of suicidal thoughts or behavior. Rae (she/her), 22, bisexual woman) shared one such experience: “He blamed me a lot for the suicide attempt and kind of stopped speaking to me after I went into the hospital the second time. It just broke my heart.” Similarly, Rudy (he/him, 35, gay man) spoke of his friends’ avoidance and dismissal of him following his suicide attempt: “Some of my friends, I wish they would just say, ‘I don’t trust you anymore. I don’t think I can forgive you.’ Just say that to me. That’s a starting point, and we can go from there.” Another SDAS shared her experience of ostracism following disclosure of a suicide attempt in a group setting, remembering a “collective” “pulling back” from others in the group (Valerie (she/her), 31, lesbian woman).

Many SDAS (28) chronicled experiences of interpersonal dismissal regarding their suicidal experiences, sharing intensely negative interactions in which their personhood was diminished. Some shared of being treated “like shit” and being spoken to in “that condescending tone” others deploy in talking to people with suicidal suffering. They recognized they were perceived as “unsound” and as though they “can’t possibly be reasonable” because they are “desperate” to have even considered suicide. Perhaps most detrimentally, some of these negative interactions occurred in mental health treatment settings, like psychiatric hospitals or outpatient therapy groups.

SDAS pointed to inadequate resources and services to address their suffering. For some, institutional stigma impeded getting the help they needed to alleviate their pain and reduce their

suicidal intensity at the time of the incident and in the future. Examples of this barrier to care were expounded by several participants, whose experiences exemplify the structural stigma against suicide that is embedded in the healthcare system. Some SDAS shared stories of following the avenues prescribed to them (i.e., "[When] you're suicidal, you go to the emergency room, you call the hotline."), only to be "brushed off" by providers who conveyed the message that their attempts were "trivial," they were "not really suicidal, just trying to get attention," or they were "not in crisis right now." Interactions like this with healthcare providers prompted SDAS to feel "frustrat[ed]," like they "couldn't find any help," and in a "worse frame of mind" than when they initially sought help.

Openness

The theme of openness encompasses coming out, living openly, and overcoming self-stigma. The lower end of the openness spectrum represents stigma management tactics of keeping secret and identity concealment, while at the higher end of the openness spectrum rests being out and living openly in their intersectional identities.

Encounters with stigma prompted SDAS to find ways to manage stigma in efforts to reduce its impact on their wellbeing. For many participants (35), stigma management took the form of concealing their identities or experiences, keeping secrets from their immediate and extended social networks. Some participants discussed hiding their sexual orientation identity by keeping it secret and performing to social expectations, as portrayed by Quentin (he/him, 23, gay man): "In high school I had a girlfriend for about two years. . . I literally was convincing myself that I was straight."

Many SDAS spoke of keeping secret their struggles with suicidal intensity because "We live with this stigma. Certain parts of my family don't want to talk about it. They just want to shove it underneath the carpet" (Marisol (she/her), 48, lesbian woman). Another participant explained: "I used to always be terrified of anybody knowing I had those thoughts" (Sonya (she/her), 33, lesbian woman). Compounding the necessity for stigma management is membership in multiple stigmatized social groups, as playfully expressed by Kade (she/her, 37, lesbian woman): "I guess

people have all kind of skeletons in their closets, so if you want to put it that way, rainbow skeletons, some of us."

Lower openness may restrict access to community and support but may also protect against stigma. Higher openness provided opportunities for SDAS to overcome self-stigma and reach for self-acceptance, both in terms of their sexual identity but also their attempt survivor identity. Kelly (she/her, 34, lesbian woman) talked about overcoming shame about her suicide attempt and feeling more comfortable sharing that experience with others: "I think I got past the shame at some point. It's not really a highlight in my life, but it's also not something I'm like, 'Don't tell anybody.'"

Some participants associated the disclosure of suicide history with coming out as sexually diverse, comparing the experiences and using similar language and making note that talking about their suicide attempts feels like coming out of the closet again. Openness about identity and experience allowed some SDAS to make connections: When they were open about their suicidal suffering, others with lived experience of suicide were able to identify them as peers and as safe people with whom to discuss suicide, a topic which is avoided in most social spaces. Some SDAS pointed to their openness as an avenue for fostering peer connection and opening the doors for suicide-related discourse.

Some SDAS shared journeys of overcoming self-stigma to embrace group affiliation and lean into their identities. Cathy (she/her, 47, lesbian woman) explains why she would rather be open from the beginning of a social relationship than to hide her identities, describing a person's reaction to her disclosure as "kind of a litmus test" for whether to invest her energy into a relationship with the person. Others contributed their perspectives, indicating they would rather be openly themselves than to conceal their truth only to be rejected later in the relationships.

Community & Relationships

All SDAS expounded on the importance of social support in their suicide survival narratives. As illustrated by Rosie (she/her, 36, lesbian woman) in the following quote, the complex interplay of community and relationships can play a pivotal role in exacerbating or alleviating suffering: "People were a big part of my recovery or a big part of my obstacles." As

community connection and relationships strengthen, the capacity of SDAS to utilize their coping skills and resilience grew. Conversely, with declining social connection came intensified suicidal thoughts and desires.

Family of Origin

The family of origin served as a prominent source of social stress for SDAS. Most participants (34) shared stories involving interactions with their families of origin as pertinent to their suicide attempts, saying they "didn't really fit in," their families "not accepting" them or not being "cool with" their sexual diversity. Many felt an extra layer of heartache because the "people who [they] cared about the most" did not provide the love and support SDAS desired: "if they don't like you, who do you have?" SDAS highlighted this family estrangement as a unique problem facing GSD communities, commenting that being shunned and outcast from family is not a problem faced by most groups.

Contrarily, positive interactions and perceived support from family members enhanced resilience and wellbeing for SDAS. One participant shared the joy she felt upon receiving positive reactions to initially coming out to her social network: "Man, that felt good. It just felt amazing." Oscar (he/him, 29, gay man) shared how his relationship with his father improved following his suicide attempt, saying his father went from being emotionally reserved to "such a nurturing guy" who openly exhibited emotional and social support for his son. Another participant explained how the support of her family may have saved her life, explaining that "if it hadn't been for the fact that I have a family who's extremely supportive," her attempt "wouldn't have been treated like an attempt at all," pointing to the importance of family support and to a fear of being dismissed when seeking help for suicidal suffering.

Isolation

Experiences of ostracism and rejection led to feeling isolated for many (29) SDAS. Rosie (she/her, 36, lesbian woman) stated: "I always felt alone and I always felt that I wasn't worth it." They felt isolated in their suicidal experiences: "I didn't really have any friends. I didn't feel like there was anybody I could talk to about it." SDAS connected their feelings of isolation to their desire to die, as illustrated in the recollection of one participant: "If I had not felt so horribly alone,

I think I might have saw [sic] some value in continuing." SDAS felt cut off from other people and experienced desolation and hopelessness related to belonging.

Positive Support

A powerful source of protection against the deleterious effects of rejection and other social stressors is the presence of positive social support. Most SDAS (33) discussed instances of receiving positive support from others. This support often came from friends and family. One participant shared a conversation with her brother that provided her the hope to continue living and persist through a suicidal crisis when he did not "freak out like everybody else was freaking out," and instead validated her suicidal suffering and offered emotional support.

SDAS shared the importance of being able to reach out to trusted others when in heightened distress: "I've gotten comfortable enough to be able to tell the people that are close to me when that's happening." They found strength in the support and compassion of their loved ones, learning to trust in their friends' and families' desire and capacity to help them. Through receiving positive support, SDAS began to recognize the strength of their support networks and started accepting the notion of being loved and accepted: as they received acceptance and support from trusted others, they began to accept themselves.

Peer Understanding

Peers offered a particularly potent source of social support and acceptance for SDAS. Most participants (34) discussed beneficial aspects of being connected with people who possessed shared identity, experience, and knowledge. One participant elucidates an important component of peer understanding:

> I would compare it to being gay. When I talk about relationships, my straight friends can go a certain distance with me because relationships are kind of universal in some ways, but only my gay and lesbian friends can understand it fully. Only someone who's tried suicide can really get it. Only somebody who cuts or has cut can really get it. Anybody can get feeling really bad or really depressed, because most of us have been there in some way, whether we admit it or not, but not everybody understands taking the step where it's [become] unbearable and you have to get out of it.
>
> (Kelly (she/her), 34, lesbian woman)

Peer support provided perspective and assurance that the experiences of SDAS were not entirely singular and that they were not as alone as they may have felt. Shared understanding was an

important point of connection with others, alleviating isolation and providing opportunities to help others through their own suffering. SDAS expounded on the nature of peer understanding and support: “I feel more safe [sic] with people who have gone through it.” They spoke of the safety of being in the presence of others who have been “in the same boat” and “survived what you’re going through.” They elucidated on the pertinence of resources at the disposal of attempt survivors who have “suffered a lot” through the profound pain of suicidal intensity: “The worst of the worst.”

Safe Spaces

Having a safe space within which to share experiences and feelings was incredibly valuable to SDAS. Within these spaces, SDAS did not have to fear rejection or violence, as there was a culture of understanding and an expectation of support from peers. Further, safety when discussing suicide is not always guaranteed, as one participant explains: “No one’s going to say, ‘Yeah, I’m suicidal,’ because where are they going to take you? They’re going to put you in a turtle suit and put you in a cold room!” For SDAS, having that “safe space” to express their thoughts and feelings was vital to their recovery.

SDAS recognized the exclusivity and disconnection between identity-specific communities, in which suicidal experience and mental health challenges were stigmatized in SD spaces and SD was stigmatized in mental health spaces. Some participants discussed similarities between LGBTQ+ communities and mental health or suicide communities:

> I think that one of the struggles that is very similar to the one that the LGBTQ community faced a long time ago is that it's hard to tell for a lot of people. You don't go around wearing a sign usually that says, "I attempted suicide" or, "I am bipolar" for multiple reasons. Not the least of which being that those are still kind of hush hush things that we don't talk about.
>
> (Theo (he/him), 21, gay man)

SDAS recognized the importance of peer support and safe spaces by the absence of those spaces in their own lives. For example, one participant shared, “I just think as a kid if I had been allowed to go to the queer youth center. . . I think I could have at least found enough peace to not try to kill myself.”

Giving Back

All SDAS spoke about shifting their focus to the bigger picture and of combatting stigma and giving back as a major impetus to—and benefit of—living openly in their identities. One participant referred to the "canary in the coal mine" colloquialism to explain how she views the way in which one participant can be reflective of the larger community.

> I think that people with illness of any sort are a canary for our community, saying something that is sick inside of the community that needs fixing. So if we manage to bring the community together in a manner of healing people, we're healing the community as a whole and there will be less sickness of all sorts. In the community and that's my point of view. I think mental illness is the result of a sick community. Time and time again it's proven itself true.
>
> Sidney (she/her), 21, bisexual woman

As they grew more connected to their communities, SDAS shifted perspectives from their suffering because of something wrong with them to understanding their experiences within social contexts. As illustrated in the preceding quote from one SDAS, some were able to position their experiences and suffering as the result of conditions in their social environments. GDAS began to broaden their perspectives and get to a position from which they could "learn how to see hope" and recognize their strength as "survivors."

Because many SDAS had found comfort in hearing or reading the stories of other attempt survivors, they felt it was important to share their story. Some participants indicated that if sharing their story could help make somebody "feel less alone and less like they want to disappear," then they could make meaning from their experiences and their suffering would not have been completely in vain. They remembered how isolated they had felt in their struggles and regarded living openly as one avenue to helping others feel less alone in their experiences and, ultimately, to providing hope for other SDAS. Some also viewed sharing their stories as "radical" and "powerful," in large part because they are sharing "what we've been told not to share," prompting discourse on social contributors to suffering and amplifying the voices of SDAS.

Considered holistically, the findings from this study paint a picture of complex and interconnected dialectical themes consisting of dynamic moving parts which mold the experiences, perceptions, and beliefs of SDAS. Situated within a climate of stigma and shaped by social interactions and connections, SDAS described complex experiences and perceptions of

stigma which shaped their understandings of their positions in the social world. When SDAS experience the convergence of high otherness, low openness, high stigma, and low social connectedness, suicidal suffering was most intense and suicide risk was greatest. Conversely, SDAS exhibited greater resilience and increased capacity for coping in the overlapping conditions of low otherness, high openness, low stigma, and high social connection. Refer to Figure 2.1 for a visual representation of these points of high risk and high resilience for SDAS.

Discussion

Understanding myriad ways in which intersectional stigma impacted the experiential meanings of SDAS has the potential to aid the development of interventions to reduce suffering and increase well-being for SDAS. Sexually diverse suicide attempt survivors (SDAS) navigated life with an omnipresent climate of stigma, through which they directly and indirectly received messages about sexual diversity and suicide. The climate of stigma permeated all social interactions and shaped the perceptions of SDAS, contributing to feelings of otherness and diminished value. Stigma reduction initiatives targeting harmful assumptions about sexual orientation identity could curtail the development of suicidal intensity through fostering more supportive environments for SDAS and reducing self-stigma (Downs, 2012). Stigmatizing beliefs about suicide are linked to emotional pain, including loneliness and hopelessness, which are key components in the development of suicidality (Oexle et al., 2019). Suicide stigma may impede help-seeking, recovery, and social change (Binnix et al., 2018; Blanchard et al., 2018; Mayer et al., 2020; Scocco et al., 2017). Stigma reduction initiatives should target suicide stigma within GSD communities, healthcare systems, and general communities.

Religious affiliation and beliefs were a potent source of stigma for many SDAS, who spoke of religion condemning their suicide attempt and their sexual orientation identity. Research has shown a complex relationship between SD persons and religion, wherein some religious denominations may be a protective factor against or a risk factor for suicide, depending on the religion’s attitudes and teachings about sexual diversity (Blosnich et al., 2020; Gattis et al., 2014; Oh et al., 2022). When SD persons perceive stigma from followers of the religion, they experience greater psychological distress, but when the religious entity promotes affirming

attitudes toward sexual orientation identity, affiliation may serve as a protective factor (Gattis et al., 2014; Blosnich et al., 2020; Price-Feeney et al., 2021). One method to enhance the protective properties of religion is to reduce SD stigma within the religious environment. For example, the Family Acceptance Project (familyproject.sfsu.edu) has developed a family support model with training, consultation, and resources for promoting acceptance in the context of families, cultures, and faith communities; the model provides culturally appropriate education and resources to help families promote wellness for their SD youth in a context that remains true to their faith beliefs (Family Acceptance Project, n.d.).

SDAS felt as though stigma necessitated careful management of the impressions they present to others. SDAS managed stigma and its impact through concealing their sexual orientation identity or suicide attempt history. This finding coincides with a study of suicide survival narratives which elucidated a complicated and dialectical belief system about stigma in which impression management led to concealment from and misunderstanding by others (Binnix et al., 2018). Maintaining silence, SDAS may widen existing gaps between them and others and further isolate themselves from potential sources of support. Barriers to social integration served to enhance feelings of not belonging to a community, which is a central component of the development of suicidal desire (Bränström et al., 2020). Experiencing any form of discrimination has been associated with thwarted belongingness, contributing to mental health challenges and a greater likelihood of suicidal thoughts and behaviors among SD individuals (Battalen et al., 2021; Busby, et al., 2020; Fulginiti et al., 2020; Woodford et al., 2014; Salentine et al., 2020; Humphries et al., 2021; Peterson et al., 2021; Turpin et al., 2020; Dorrell et al., 2021). In the convergence of high feelings of otherness, low openness, intense stigma, and low support, SDAS faced the greatest suicidal intensity.

Connection with peer communities and positive interpersonal relationships facilitated recovery and empowered SDAS to utilize personal and interpersonal resources to alleviate suicidal suffering. This finding is in alignment with minority strengths model, which posits a positively correlated relationship wherein community connection and identity stimulate self-compassion and self-acceptance (Perrin et al., 2019). Relatedly, peer support may be a powerful

shield against harmful impacts of stigma (Dorrell et al., 2021; McClay et al., 2020; Park et al., 2021; Ream et al., 2021; VanBergen & Love, 2021). Having a safe space within which to authentically express themselves was a major boon to reducing self-stigma among SDAS, which is in alignment with other research that suggests community participation and interactions with like others can reduce isolation and increase well-being and resilience (Pilling et al., 2017; Goldbach et al., 2019; Mereish et al., 2022; Schimanski & Treharne, 2019). A critical target of interventions, then, is removing barriers to social integration and facilitating community connection for SDAS. With social support and validation, SDAS began unlearning stigmatizing beliefs and working toward self-acceptance and living openly. As they were increasingly accepted by others, their self-stigma lessened, and their self-esteem increased. As SDAS recognized their personal strengths, they were emboldened to combat stigma and give back to others who may be struggling through sharing their stories. Where low otherness, high openness, positive support, and giving back meet, SDAS possess the greatest resilience and capacity to cope with and move through suicidal intensity, facilitating recovery.

Limitations

Some important considerations arise with this data set. Use of secondary data limits the ability of the researcher to recontact participants for follow-up interviews and therefore leaves the potential for gaps in the conceptualization of the impact of stigma on the experiences of SDAS. Further, interview questions were not developed for the purpose of research. Although interview prompts were intentionally limited to preserve proximity to the phenomenological experience, further research could include probing questions and additional lines of inquiry to enhance the narratives and provide supplemental knowledge that is not currently captured.

Because the entire sample chose to tell their story with the Live Through This project and have it shared in a public way, this sample of respondents may not accurately represent the SDAS population. Their experiences may differ from those who are not openly sharing their suicide stories. Future work might be helpful to determine if giving back through sharing their story is something all SDAS desire or if it's a significant marker of a positive recovery trajectory. Additionally, interview transcripts were collected with the intention of being published on the

Internet, where they are available for public consumption, so participants may have excluded sensitive information from their stories. Further research would be helpful in gaining more keen insight on the private experiences of SDAS. Considering these limitations, this research offers insight into the lived experience of stigma by SDAS.

Implications

Findings indicate directions for future research, including a more intersectional approach that includes additional demographic data, large and diverse samples that would enable in-depth analyses of different SDAS groups, and research addressing suicide stigma in GSD communities. Further research would benefit from increased diversity in the sample for a richer understanding of the experiences of stigma faced by SDAS in different social groups (e.g., race, geography, income, education).

Findings from this study indicate multiple areas of intervention that could benefit SDAS by reducing stigma, increasing resilience, and improving social conditions for those occupying space in this unique intersection of stigmatized identities. Implications at the macro level that could enhance well-being of SDAS include legislation that protects people on the basis of sexual orientation identity and gender identity and expression. The explicit inclusion of sexual orientation and gender identity in these policies is important in pragmatically protecting rights. Local, state, and federal-level protection can enhance well-being for SDAS. Further, legislation that improves the availability of and accessibility to inclusive services for SDAS can increase help-seeking and provide valuable resources for SDAS in alleviating suffering and improving overall well-being.

Another implication suggested by these findings is an urgent need for stigma reduction across communities. Findings from this study point to stigma as a major contributing factor to suffering and as a point of intervention to enhance well-being. Incorporation of suicide education and curricula that are GSD inclusive and affirming into education and other institutions could play a major role in not only reducing stigma, but also in providing perspectives and skills that facilitate positive social interactions and environments for SDAS. Providing positive representation of SDAS may help combat negative messaging surrounding and provide hope to SDAS who frequently lack positive reference points that reflect their identities. Encouraging SDAS to share

their stories in healthy ways can empower them in overcoming self-stigma and may serve to foster connection among SDAS as their stories open the doors for conversation and make visible their intersectional identities.

Findings point to a need for improved suicide risk assessment and management training for social workers and other service providers with whom SDAS come into contact. Mental health services should incorporate client-first approaches to suicide risk management that enhance autonomy and preserve the rights of SDAS seeking care. Fear of undesired consequences, such as involuntary psychiatric hospitalization, can be a major barrier to care. Such fear can be alleviated through comprehensive informed consent processes and transparency surrounding what actions are legally required for clinicians to take and what actions can be taken to mitigate suicide risk and negate the need for inpatient hospitalization. Moreover, SDAS indicated disheartening responses to their suicidal suffering from mental health and crisis service providers, which suggests a dire need for improved training for providers at all levels of the care continuum. An important implication for social work is the need for education about GSD and suicide in social work training programs. SDAS indicated stigmatizing interactions related to their suicidal suffering and to their sexual orientation identities, which indicates the importance of providing accurate education about these subjects.

Direct practice implications include providing education to clients, their families, and others in the social environment. Accurate and inclusive information can reduce stigma and increase acceptance of SDAS, strengthening social relationships and community connection. Working with clients to understand the impact of stigma on their experiences and perceptions is another important indication of this work. Clients may not be aware of the complex consequences of stigma and can benefit from learning about and working through internalized stigma. Social workers may also be in a prime position to foster community connection and provide safe spaces for SDAS. Group settings may provide vital social connection and peer support for SDAS. Social workers can facilitate SDAS support and therapy groups to supplement individual therapy, promote peer connection, and provide safe spaces for SDAS. Another way social workers and others can promote peer connection is through referring SDAS to existing safe spaces in the

community and online. Providing suicide prevention gatekeeper trainings to GSD audiences and in GSD community spaces can bolster the capacity of GSD communities to support SDAS and can provide important skills to help someone through a suicidal crisis. This type of training may also serve to reduce stigmatizing reactions to suicide in GSD communities and spaces.

Conclusion

This study explored descriptions of stigma in the suicide survival narratives of SDAS. Findings point to the profound impact of stigma in the lives and experiences of SDAS. From complicating social interactions and relationships to playing an active role in the development of a suicidal crisis, a pervasive climate of stigma was apparent in their stories. Compounding stigma made social and community connections difficult and provided unique challenges to well-being for SDAS, but when they accessed positive social support and peer understanding, they were empowered to accept their identities and their place in their communities. This fostered resilience and self-esteem and allowed SDAS to move through suicidal suffering with intrapersonal and interpersonal resources. They shifted toward an understanding of their experience within social contexts and began conceptualizing positive social changes to alleviate suffering and build safe and accepting environments for other SDAS.

CHAPTER 3

AUTHENTICITY OR DEATH: GENDER DIVERSE SUICIDE ATTEMPT SURVIVORS' INTERACTIONS WITH STIGMA

Gender diverse suicide attempt survivors (GDAS) occupy a unique intersection of stigmatized identities (Williams et al., 2018; Fulginiti & Frey, 2018). The complex interplay of oppression has been termed *dual discrimination* or *compound stigma* (Corrigan et al., 2003; Bockting et al., 2013). Compound stigma is associated with a multiplicative effect on stressors in which targets of stigma based on multiple components of identity face greater levels of stress, including suicidal ideation and behavior (Kelleher, 2009; Swann et al., 2020; Schimanski et al., 2019; Bahm & Forchuk, 2008). The impact of compound stigma on GDAS may be even more harmful as their opportunities for connecting to communities and finding peers with similarly stigmatized identities are reduced (Schimanski et al., 2018; Williams et al., 2018).

Individual factors are important in the conceptualization of suicidal suffering, but they are impacted by the social context in which they exist and overemphasis of individual-level factors overlooks social and contextual factors (Cramer et al., 2021). Social conditions place people "at risk of risks" (Hatzenbuehler, 2010, p. 35), ensuring that people in oppressed groups are exposed to factors that increase risk through being denied access to resources, such as power, money, and social support (Hatzenbuehler, 2010). Beyond the common risk factors experienced by the general population, GD individuals face significantly more challenges that increase their likelihood for suicidal thoughts and behaviors. These challenges include minority-identity-specific stressors such as discrimination, victimization, and internalized stigma (Hottes et al., 2016; Meyer, 2003).

Identity-based stigma influences virtually every aspect of lived experience for those in stigmatized social groups (Herek, 2009; Goffman, 1963; Berger & Luckmann, 1966; Corrigan et al., 2004). Attention to various manifestations of stigma helps contextualize the omnipresence of stigma in the everyday lives of persons with stigmatized identities. Structural, social, and

individual-level stigma experiences are associated with increased rates of anxiety, depression, and suicidal ideation and behavior through exacerbating stressors and contributing to reduced self-esteem (Costa et al., 2017; Chi et al., 2014; Bockting et al., 2013; Corrigan, 2007; Corrigan et al., 2004). Understanding the instances and perceptions of stigma experienced by GDAS plays an important role in helping address social roots of suicidal suffering.

The impact of stigma can lead to the development or exacerbation of mental health challenges such as anxiety, depression, post-traumatic distress, and suicidal ideation and behavior (Hatzenbuehler, 2009; Meyer, 2003; Marshal et al., 2011; King et al., 2008; Schweizer & Mowen, 2020). Discrimination has been found to be associated with anxiety and depressive symptoms and higher levels of suicidal ideation (Battalen et al., 2021; Cramer et al., 2021) and with decreased coping resources (Farrelly et al., 2015). Discrimination may be more chronic and unrelenting than other types of social stressors and may therefore contribute to hopelessness or feeling trapped (Battalen et al., 2021), which contribute to the development of suicidal ideation (Grafiadeli et al., 2021). Experiences of discrimination may lead to *internalized stigma* or *self-stigma*, which refers to the personalizing of negative stereotypes and beliefs about an identity into one's own attributes. For GDAS individuals, internalized stigma can lead to feelings of shame and self-hate based upon the belief that their identity makes them inferior (Pellicane & Ciesla, 2022; Peterson et al., 2021; Salentine et al., 2020; Testa et al., 2017). This *self-stigma* can contribute to reduced self-esteem, as the individual believes the legitimacy of stigmatized statements (Corrigan, 2002; Pellicane & Ciesla, 2022).

Protective factors can buffer against the deleterious impacts of stigma on GDAS and deter the development of suicidal ideation. Social connection is an incredibly important protective factor GDAS (Austin et al., 2021; Busby et al., 2020). Parental and family support may be particularly effective bulwarks against suicidal ideation and behavior (Park et al., 2021). Social connections with GD communities can also foster positive identity affirmation, thereby enhancing the wellbeing of GD individuals (Johnson et al., 2020; Barr et al., 2016; Hendricks & Testa, 2012). Johnson et al. (2020) found that involvement with trans communities facilitated social connection and wellbeing through key processes of (1) normalizing trans identity and experience, (2)

developing a social support network, and (3) empowering trans people. During early trans identity development, representation of and connection to the trans community can reduce identity-based distress and internalized stigma, which can have a life-saving effect—in one study, this connection to the trans community reduced suicide rates by half (Testa et al., 2014). Positive identity affirmation is associated with greater wellbeing and social connectedness for GSD individuals, and these factors can be protective against suicide (Busby et al., 2020; Barr et al., 2016).

Theory

Theoretical orientations across ecological levels—micro (individual), mezzo (group), and macro (society) (Bronfenbrenner, 1981)—guided this study. Macro level factors were contextualized within stigma theory (Goffman, 1963; Link & Phelan, 2001) and minority stress theory (MST) (Meyer, 2003). Mezzo and micro level components are encompassed in MST, the minority strengths model (MSM) (Perrin et al., 2019), and the Interpersonal Psychological Theory of Suicide (IPTS) (Joiner, 1995; Van Orden et al., 2010). These theories provide a lens through which to understand the lived experience of stigma for gender diverse suicide attempt survivors (GDAS).

Goffman conceptualized stigma as an attribute that discredits a person and reduces them to a stereotype of their identity (1963). Building on this assertion that stigma requires a social and relational milieu, Link & Phelan (2001) developed a model of stigma that results in negative health outcomes through interrelated processes of (1) distinguishing and labeling differences, (2) associating those differences with negative attributes or stereotypes, (3) separating “us” from “them” (p. 370), and (4) the stigmatized individual experiencing status loss and discrimination.

As targets of stigma, GDAS are encumbered by minority stress, which originates in stigma (Meyer, 2003). Minority stress theory (MST) posits minority-specific distal (structural and societal) and proximal (individual) stressors that interact with general stressors to influence health outcomes (Meyer, 2003; Hatzenbuehler, 2011). Proximal stressors like anticipated stigma, internalized stigma, and identity concealment, are associated with reduced self-esteem, increased psychological distress, and the development of suicidality (Michaels et al., 2016;

Hatzenbuehler, 2011). Community integration, social support, and other characteristics of minority identity can mediate and moderate paths to mental health outcomes (Meyer, 2003). Accepting one's minority identity and living openly in that identity may increase access to social support and community connection, which are important protective factors for GDAS (Suppes et al., 2021). Further, identity pride is linked to increased well-being and social connectedness among GD populations (Johnson et al., 2020; Barr et al., 2016). The Minority Strengths Model (MSM) (Perrin et al., 2019) was developed to build upon MST by emphasizing the positive aspects of minority identity. MSM proposes a process through which community consciousness and social support promote the development of self-esteem and resilience (Perrin et al., 2019). The process begins with connection to minority community, which increases the availability of social support, providing a barrier against negative impacts of minority stress, including suicidality (Austin et al., 2020).

The Interpersonal Psychological Theory of Suicide (IPTS) (Joiner, 1995; Van Orden et al., 2010) provides a lens through which to understand suicide from a psychological perspective that focuses on interpersonal needs deficits: the desire to die develops when perceived burdensomeness and thwarted belongingness are present and contribute to interpersonal hopelessness (Van Orden et al., 2010). The relational and social components involved in IPTS can help identify stigma's role in the development of suicidality and can help direct interventions to reduce suicidal suffering in GDAS.

Purpose of Study

Despite the growing body of research on gender diversity, more information is still needed. Some literature focuses on oppression-related factors and mental health outcomes for various populations, but those observations are limited in their operationalization of oppression (i.e., measurements focused on discrimination) and in their applicability to the gender and sexually diverse (GSD) population (e.g., Arshanapally et al., 2017; Brooks et al., 2020). Similarly, researchers have explored the connection between some factors of oppression, like discrimination, and their association with suicidal ideation and behavior in GSD individuals (Rimes et al., 2019; Mereish et al., 2019). Much of the albeit limited research on this topic has

relied on quantitative methodology (e.g., Battalen et al., 2021; Austin et al., 2020; Peterson et al., 2021; Maksut et al,. 2020), which likely misses some of the rich nuances and subtleties involved in the singular experiences and perceptions of GD individuals with lived experience of suicide. Therefore, a qualitative study is warranted to elucidate the unique experiences of stigma described by gender diverse attempt survivors (GDAS).

Given the interweaving complexities of experience for those identifying as gender diverse suicide attempt survivors (GDAS), the inextricable nature of their identities and social interactions must be understood in relation to varied sources and layers of stigma. This study seeks to answer the question: How do GDAS describe gender diversity stigma and suicide stigma when sharing their experiences of attempting suicide? The study aims to explore perceptions of stigma, to uncover connections between experiences of stigma and minority stress and strengths processes leading to the desire to die, and to identify systemic points of intervention to address the roots of social problems contributing to suicidality among GDAS.

Method

This study utilized a hermeneutic phenomenological design, which involves contextualizing the essence of the lived experience within the social world by examining the "texts of lived experience" (van Manen, 1990, p. 39). This method embraces the pluralism and malleability of experience by acknowledging that all our experiences are shaped by what we know and believe and therefore, as researchers, we must also take into consideration the social context of experience (van Manen, 1990). A hermeneutic approach integrates extant understandings of the world with the individual experiences of a phenomenon.

Data

Data for this study came from the *Live Through This* advocacy project (www.LiveThroughThis.org), which collects the personal stories of suicide attempt survivors with the intention of humanizing the lived experience of suicide attempt survivorship. The project utilizes snowball sampling methods and participants volunteer to share their stories by submitting a form on the project website. The inclusion criteria for participating in the project include being at least 18 years old, having had at least one year since their most recent suicide attempt, and being willing to

sign a release to be recorded and for the project team to use their full name and likeness. The creator of *Live Through This* met participants and conducted a face-to-face interview about the person's lived experience with suicide and then took portraits of the participants. The interviewer provided minimal prompts, beginning with "Tell me your story," with the goal of hearing the attempt survivor's story and thoughts about experiences in their own words. The project publicly publishes interview transcripts, along with the portraits of survivors, on the website, social media, in films (e.g., *The S Word,* 2017), and in presentations given by the project's founder. Interviews included in this sample were conducted and recorded during 2011-2015 and transcribed by members of the *Live Through This* team.

Participants

The sample for this analysis includes a subsample from this larger project (*n*=102) and comprises individuals who self-identify as having diverse gender identities (i.e., transgender, nonbinary). To identify participants, the researcher read each interview in the dataset for self-disclosure of gender minority identity. The sample of *gender diverse attempt survivors (GDAS)* is extracted from the larger dataset and consists of 11 individuals (*n* = 11). Of those individuals, eight were assigned female at birth, two were assigned male at birth, and one is intersex. In terms of gender identity, four are transgender men, two are transgender women, three are nonbinary, one is genderqueer, and one is genderfluid. These gender identities fall under the trans umbrella but not all individuals use transgender to describe themselves. Sexual orientation identities in this sample are five queer, two pansexual, one heterosexual, and one gay; the other two participants did not explicitly state their sexual orientation but mentioned involvement in the queer community. Three participants' personal pronouns are "she/her/hers," three are "he/him/his," and five are "they/them/theirs." Ages of this sample ranged from 18 to 54, with a mean age of 30.8 years. Other demographic data for the sample was not available from the texts.

Analysis

The researcher conducted analyses using the Microsoft Office Suite (i.e., Word, Excel) and Dedoose data analysis software (SocioCultural Research Consultants, LLC, 2022) using hermeneutic phenomenological analysis methods laid out by van Manen (1984; 1990). Beginning

with a naïve reading of the interview transcripts to become oriented to the overall essence of lived experience with stigma as described by GDAS in their suicide stories, the researcher then conducted a thorough analysis to identify significant meaning units (van Manen, 1990) utilizing minority stress and strengths models to guide the process. A second coder trained in qualitative analysis coded transcripts and both coders engaged in discussions to reach consensus about code definition.

From the identified meaning units, the researcher conducted a thematic analysis to uncover themes that are embodied in the stories of lived experience (van Manen, 1990). Themes were recovered from the interviews to portray the interactions with stigma that shaped the experiences of GDAS described in their suicide attempt stories. The final step in the process involved writing descriptions of stigma experiences and meanings made from those interactions. The researcher wove together experiential meanings against a contextual backdrop of stigma and minority stress and strengths processes (van Manen, 1990; van Manen, 2014).

Reflexivity Statement

The researcher is a White, queer, genderqueer person who was raised in the Southern United States. They have personal experience with suicidal suffering and suicide loss. Their graduate and doctorate degrees are in social work. Their research focuses on gender and sexual diversity and suicide. They have extensive service experience with GD communities and suicide prevention efforts.

Results

Gender diverse attempt survivors (GDAS) experienced stigma as a ubiquitous force that impeded their wellbeing, something with which to cope and eventually resist to make their life livable. The battle with stigma was exacerbated when GDAS lacked social support or were faced with discrimination or rejection. Conversely, positive social support, especially when provided by peers, mitigated some of the distress related to stigma and boosted the ability of GDAS to manage suicidal intensity. Invariant aspects of the stories were those described by all participants in some manner and informed the development of five themes that speak to the experiences with stigma of GDAS: (a) existing in an environment of stigma, (b) feeling different, (c) living a double

life, (d) community (dis)connect, (e) living authentically or not at all, and (f) looking toward the bigger picture.

Existing in an Environment of Stigma

All participants experienced stigma as a pervasive and omnipresent force. They recalled feeling different or like something was wrong from an early age, recognizing that they were somehow unlike their peers. This noted difference contributed to the notion of being unwelcome in their environments as their true selves. GDAS experienced stigma through their environment in direct and indirect ways. Social environments provided messaging about gender diversity and expectations of gender performance. Participants spoke about a general awareness that gender diversity "wasn't something that was accepted." Some GDAS discussed their hometowns as environments conducive to minority stress and spoke of a realization at an early age that they would need to get out of their hometown to fully live the life they wanted. They recognized their environment as "narrow-minded," "conservative," and "not a place for people like me."

Some GDAS described instances in which they directly observed family members' disparaging language and attitudes about gender and sexual diversity in their homes. They connected their families' hateful language about sexual diversity to attitudes about gender diversity with the understanding that if sexual diversity was shunned, so too would be gender diversity. One participant described their grandmother as their unwitting "biggest bully" because she would openly share stigma-based attitudes in their home environment without realizing the impact that messaging had on their grandchild.

The pervasiveness of stigma in their environments contributed to feeling like they did not fit in or belong to the social community around them. They recognized this otherness, even when they did not have the language or concepts to understand the root of this separation. This environment of stigma was an enduring presence in the lives of GDAS and shaped their experiences and interactions in their daily lives. Contributors to this environment of stigma were experiences with gender diversity stigma, suicide-related stigma, expectations to keep those facets of themselves private, and pop culture discourse about gender diversity and suicide.

Gender Diversity Stigma

Observations of and interactions with gender diversity stigma were described by most of the sample (10/11). The GDAS spoke of having no point of reference for gender diversity, which complicated and exacerbated the sense of isolation felt by GDAS. Participants discussed specific instances of stigma events related to gender identity. The differentiation between genders and the social expectations associated with genders was noticed early in life; some participants recalled being more interested in “boy” toys or games than the expected girl activities. There was a common observation that gender diversity was not to be discussed or accepted in their immediate environment. Whether rooted in personal experiences or social observations, the environment of stigma around gender diversity was evident in the stories of GDAS. GDAS expressed “extra hurdles of navigating the world as a trans person.”

An incredibly impactful type of stigma interaction mentioned by the participants was invalidation of their gender identity. These experiences of invalidation served as a stressor and contributed to self-stigma for GDAS, contributing to hopelessness regarding social acceptance and affirmation of their gender identity, as illustrated by one participant’s recollection of an experience with discrimination in which their affirming name was questioned by someone, prompting the GDAS to feel like they were “never going to be validated.”

Some GDAS reflected on the complexity of some relationships in which one may receive some positive support, but in other ways is invalidated. This dichotomy was sometimes present within the same interpersonal relationship. For example, Frankie (he/him), 25, pansexual trans man, shared his mother’s behaviors toward him, in which she displays some support, but in ways that are not fully accepting of his identity: “[My mother] doesn't really like to use my name, even though it is my legal name. She doesn't really use my pronouns, but she also doesn't use my “dead-name” or mis-pronoun me.” Frankie recognizes the complex dialectic nature of this support, in which his mother displays limited support for his identity through using his correct name but does not display such support as using the pronouns Frankie has asked her to use. This speaks to the experience of many gender diverse persons when seeking connection with family. The validation they receive, even when it is minimal, is recognized as progress toward

acceptance. Another GDAS described the contempt exhibited by their brother, who refused to use their correct name or pronouns, which ultimately resulted in an estranged relationship with their brother and other members of their family. Invalidation from family members strained relationships and fostered an environment in which GDAS could not be authentic. The invalidation occurring in interactions such as these increases stress and limits social support.

Overt discrimination was described by some GDAS, including an instance in which one GDAS was told to kill themselves, suggesting that death is preferred to trans existence. This experience with stigma also points to the deep-seated social association of suicide with being trans. Participants expressed stigma within the GSD community, an environment in which many expected to provide acceptance and safety. One participant shared an experience in which they were stereotyped in an intensely negative manner by a coworker who had previously experienced interpersonal conflict with another trans person, which led to her "hat[ing] every trans person" and using phrases like "fucking tranny" to talk about gender diverse people. This experience felt like rejection from a peer community and served to widen the gap between GDAS and their sense of belonging.

Representation of gender diversity in popular culture played a role in the environment of stigma described by the participants. Not seeing themselves reflected in the media they consumed or hearing anything close to their experience discussed in wider society, participants discussed feeling different than others and disconnected from their peers and social networks. If they did see representations of gender diversity, the messages were often laden with stigma and perpetuating negative attitudes and beliefs about people with diverse gender identities. Associated with these stigmatizing representations was the notion that trans people are often discussed only after they have died from suicide or been the victim of a horrendous tragedy—as if trans life does not matter until it is gone.

> Stop painting it as black and white. I'm so tired of seeing trans faces as: you're a Hollywood star and you got it all going on, or you're a victim, or you're a tombstone. There's an in-between that suffers, but they're not dead yet. Just because they're not dead, doesn't mean we shouldn't care.
>
> Frankie (he/him), 25, pansexual, trans man

Suicide-Related Stigma

Further complicating their social experiences was their lived experience of suicide, in which they felt alone, misunderstood, and frequently dismissed. The majority of participants (10/11) discussed suicide-related stigma with examples ranging from socially observed misconceptions about suicide to harmful interactions from providers in healthcare settings. Participants alluded to a general ignorance around suicide and what to do if someone is struggling. They observed that this lack of knowledge manifested as fear of those with suicidal experience or avoidance of suicidal issues and people altogether, commenting that there is a lack of education around suicide and “what to do for your friends or your comrades who are struggling.”

Participants reflected misconceptions about suicide, including generalizations about the reasons someone would attempt suicide and general misinformation about suicidal experiences. In these instances, participants reflected on seeing others reduce any negative experience lived by gender diverse people to solely the result of their gender identity. These ideas frequently came from media representation discourse about suicide in other pop culture venues. Participants made note of the way suicide in transgender populations is discussed by media: “They’re saying it’s because they were transgender, but they don’t mention the fact that it was because their boyfriend broke up with them or because they got an F. All those reasons are valid, too.” GDAS spoke of their suicidal suffering being reduced by others to being resultant of their gender identity, rather than the outcome of a complex constellation of factors. This type of stigma inherently linked their suicidal suffering to their gender identity, contributing to feeling of being different or somehow wrong in their existence. Moreover, this approach makes invisible the issues that are actually contributing to suicidal suffering and erases opportunities for intervention. One participant shared a reflection of this type of experience:

> You're a minority dealing with these issues, and if you go to someone, they're not going to see you as someone who wants to hurt themselves. They are not going to see you as someone who wants to kill themselves. They are going to see you as, "Oh, you're one of those trans people. Okay. So, have you had 'the surgery'? How do you go to the bathroom?" It's like, "Can we cut this shit for a minute? I'm upset. I feel this way because of this, this, and this, and you doing this right now is just making it worse. You're completely erasing the fact that I'm a human being."
>
> - Frankie (he/him), 25, pansexual, trans man

Many participants (9/11) spoke of being dismissed as a result of stigmatizing attitudes about suicide held by others. These interactions included being reduced to one piece of their identity, invalidation of emotional distress, and not being taken seriously as a person following disclosure of suicide history. They recalled feeling like their “credibility” and “sanity” were put into question in ways that made them feel like less of a person.

Another aspect of stigma-related dismissal was suicidal intensity not being taken seriously or being treated as attention-seeking or not serious enough to warrant treatment. GDAS recalled negative experiences with mental health providers when they sought help. The negative interactions ranged from feeling brushed off by providers to being actively harmed by the service environment. Some participants discussed feeling like stigma-based interactions made them feel like “a baby” and like they “couldn’t do my own thing” because of the intense surveillance they were placed under following a suicide attempt.

Loss of personal agency was one of the most harrowing experiences for GDAS. Compounding the distress of experiencing a suicidal crisis was the reaction to that crisis from others. When disclosing their suicidality to seek support, GDAS were faced with challenging circumstances that exacerbated their distress. Reflecting on experiences of stigma during inpatient hospitalization, one participant stated, “the number two thing that would make me want to kill myself was being in the psych ward.” Participants experienced loss of agency upon psychiatric hospitalization, increasing their distress and suffering. GDAS discussed the contradiction in the help they received, “they put me in this place that was so much worse for me, and that was supposed to help,” and that “all of your agency is taken away.”

Participants discussed being aware of an informal code of silence about suicide and mental health, which was enforced by their families or by others in their social environment. Participants described family rules of not discussing mental health, even when a family member is experiencing crisis. The cultural expectation was that these topics are to be minimized and kept secret. GDAS reflected being “taught through experience, desire, and social interaction” to “be as little-noticed as possible” and avoid putting oneself in “the public light.”

Further, the representation of suicide in pop culture and media was rooted in stigma and associated with ideas of danger, insanity, and untrustworthiness. Participants were cognizant of pervasive stigma related to mental health and understood mental health as a taboo topic that should not be shared openly, if at all. Pop culture informed and intensified the environments of stigma described by GDAS and contributed to the experiential disconnection between themselves and social others.

Participants voiced the complex intersection of their gender diverse identities and their suicide experience, understanding both as stigmatized within their personal social environments and more broadly. This additional stigma perpetuated ostracism and negative self-image. When GDAS already felt the impact of gender identity stigma, suicide-related stigma exacerbated feelings of inferiority and marginalization. The compounding nature of stigma targeted at multiple components of one's identity enhanced the belief of being somehow inherently wrong or broken and intensified feelings of difference.

Feeling Different

All participants spoke of feeling different from others at a young age. The expectations of gender performance were noticed by participants even in childhood. They learned through their social environments that deviation from those gender-based social prescriptions would not be accepted. As they were exposed to wider social circles, the environment of stigma often expanded, but they also had more opportunity to come into contact with other gender diverse individuals. In school and other social settings, they witnessed or were subject to gender-based discrimination. This environment grew within the participants a feeling of being fundamentally different from their peers. Many participants discussed having these feelings early in their childhood, but not having the capacity to fully understand or explain the difference, describing feeling like "something wasn't right," "I wasn't supposed to be a boy," and recognizing discrepancies between their expected and actual gendered behaviors: "Even from when I was like three years old, just preferring the boy toys in the kid's meal or whatever." Feeling different, especially when isolated from communities of shared experience and culture, contributed to feeling isolated and marginalized, contributing to negative beliefs about themselves and their identities. Conversely, when GDAS were connected with others who shared

their experiences or identities, feeling different transformed to a more positive notion, enabling GDAS to understand their identities as unique and worthy of belonging.

Participants discussed ways in which their experiences of stigma related to their mental health challenges and suicidal experiences directly connected with feelings of separation. These stories often related to secrecy around their own attempts, wherein their families did not address or discuss any aspects of the attempt. Their families' avoidant attitudes surrounding their suicidal experience fueled ostracism and exacerbated GDAS' feelings of being different, frequently prompting concealment of their challenges from their family members. This reticence extended into their personal behaviors in other social settings as they felt compelled to remain silent about their mental health struggles, often inhibiting their willingness and ability to seek help. Further, participants recognized a difference between their life experiences and those of people without lived experience of suicide.

A common experience of participants was lacking language and points of reference to explain—or even discern—their gender identity experiences. Some participants related this to the conservative environments in which they lived or to the lack of general awareness and acceptance in society. Either way, this uncertainty increased the feeling of being different and widened the gap between their reality and the environment around them. GDAS explained that constructs surrounding gender diversity were outside their realm of knowledge, understanding that they were "different and the inside didn't match the outside," but lacking access to information about gender diversity. One participant reflected that when she was born, "there was no such thing" because the "word 'transgender' hadn't been coined." With no exposure to gender or sexual diversity, GDAS may have felt they were different from others around them but not have a clear understanding of the source of this difference, as described by one participant, who said, "I don't know what normal is, but I do know that this doesn't feel okay."

Because they had no known peers or public figures whose identity experiences they shared, GDAS had some difficulty positioning their own identities within the socially accepted binary. One participant shared their internal dialogue surrounding their gender identity confusion:

> Am I trans? Am I genderfluid? Am I this? Am I that? I didn't know how to describe it. I'm like a guy sometimes and a girl other times, but then not like any gender at

> other times. It was a struggle, like, who am I? What am I? How do I explain this to people?
>
> – Shay (they/them), 18, queer, nonbinary, intersex person

GDAS were targets of stigma in various social settings, and invalidating interactiosn were commonly mentioned as a great source of stress, which ultimately contributed to the development of self-stigma. One participant experienced such intense stigma-fueled behavior from his partner at the time that he internalized the belief that no one would ever love him because he is trans, saying he was “thoroughly convinced” that he would be unable to find love.

Existing within and interacting with the environments of stigma surrounding their gender identities and their experiences with suicide, the GDAS began to internalize the stigmatizing messages they were receiving and applying them to their beliefs about themselves. One participant commented that for years they had “known deep, deep, deep down in my heart that I was crazy, because why else would you want to kill yourself?” and said that that was how suicide had been explained to them. Another participant exemplifies this self-stigma in describing their belief that they are “crazy in the bad way” because of their experiences with suicide.

Living a Double Life

Most GDAS (10) managed their interactions with stigma through performing to perceived expectations, which was described as living a double life. This frequently entailed concealing all or part of their identities or experiences. Participants spoke of keeping their mental health challenges secret and of concealing their gender identities from those around them. For many, this felt like “living a double life” or having to maintain two entirely separate forms of existence. This constant duplicity was stressful for GDAS. At times, the concealment of their identity felt to them like they were lying to their social networks. GDAS described the practice of concealing parts of themselves as living “dual/secret lives,” having a “double life,” and living as their assigned gender “during the day, and at night” as their affirmed gender.

Aware of pervasive stigma in their environments, participants concealed their gender identity and tried to perform to social expectations of their assigned gender. Some participants held fast in their performance of gender expectations, believing they would be more successful in their social environments living as their assigned gender. GDAS also feared drastic repercussions

(e.g., "My life would be over") if their gender identity was revealed. One participant shared the concerns she was having when she was contemplating social transition, believing she would "lose all my friends, my family wouldn't speak to me, and that would be it." Identity concealment was sometimes necessary to preserve the safety of GDAS. Participants were cognizant of violence and other forms of discrimination faced by people with diverse gender identities and expressions and applied that awareness to their personal situations. Knowing their home community would not be accepting of their gender identity, GDAS perceived danger and feared for their personal safety. One participant reflected, "If I'd come out as trans. . . I don't know if I would have made it through my teens."

Participants indicated a desire to maintain privacy and secrecy surrounding their mental health challenges, sometimes exacerbating the challenges they faced. One participant shared how detrimental to their wellbeing it had been to continuously conceal parts of themselves, coming to the realization that "shame, doubt, and hiding things have been such a destructive force in my life." Another participant spoke of feeling like they were in disguise or hiding something when those around them were not aware of their suicide attempt survivor status. GDAS spoke of their double lives as sources of tremendous stress, often a driving wedge between them and their support networks.

Community (Dis)Connect

Connecting and, conversely, disconnecting with community represents a continuum of factors that impacted how GDAS experienced, interpreted, and responded to stigma. At the highest levels of connection, participants felt better able to manage challenges and distress. GDAS spoke of higher levels of disconnect as related to greater distress and less ability to manage distress, resulting in suicidal crises. All participants emphasized the importance of having access to peer support and community. In the absence of community connection, participants spoke of isolation in their gender identity as well as in their struggles with suicidal intensity. In the context of both of those facets of their experiences, GDAS spoke of feeling alone and though they did not really have a place in their communities. As GDAS expounded on connecting and disconnecting to community, some themes emerged in their descriptions. Isolation represents the

peak of community disconnect, while other themes move toward community connection: positive support, the internet as a lifeline, peer understanding, and intersectional convergence.

Disconnect into Isolation

At its most severe, community disconnect results in isolation, which manifested as a major component of the stories of all GDAS (11/11). The isolation GDAS experienced stemmed, in part, from their feeling “very alone” in their experience, like they were the only persons who were struggling with mental health or with gender identity. They also felt as though “there really isn’t a lot of support” and like “no one cares about” them; they described hopelessness and feeling like they had no one who would listen to them or support them. One participant spoke specifically of the isolation they experienced during early stages of their transition, during which they longed to connect to other trans people with whom they could share their experience and seek guidance, reflecting on the peak of their isolation as “when you’re binding, not taking hormones, and not really sure how to introduce yourself with your new name.”

Upon others in their social networks learning of stigmatized identity, many participants shared stories of rejection by family, friends, and peers. GDAS shared encountering rejection and victimization. One participant recalled her friends’ behavior when they found out she was transgender: “They basically left my life and didn't want to be friends anymore.” Some GDAS shared specific incidents in which they were victimized or rejected because of their suicide attempt. Upon returning to high school following a suicide-related absence, one participant was confronted with stigma from their peers, who said things to the GSAS such as, “why don’t you just go die?” and “why don’t you go try to kill yourself again?” Others reflected on the distance they felt from their support networks following a suicide attempt. GDAS recognized the fear behind much suicide stigma, understanding that people sometimes avoided the topic of suicide because they were uncertain of their capacity to handle it. The painful impact of multiple experiences of rejection by family, friends, and others was described as accumulating over time (“You can only take so much rejection.” “You can only take. . . the rug being pulled out from under you so many times.”) and how even expected sources of support can be perpetrators of rejection (“To not even have the support of the people who brought you into the world is really, really harrowing.”).

Connecting via Positive Support

Working against the arduous effects of stigma, isolation, and rejection, most GDAS (10/11) discussed the importance of having a source of positive support during their mental health challenges and, more broadly, in navigating their way through life. One spoke specifically of the way positive support countered their feelings of isolation, saying the way their “community rallied” for them was in “direct opposition” to their belief that no one cared about their suffering. Another GDAS reflected a major boon to their healing was “knowing you have people right there for you” and having “the emotional support backing you up.” Positive support often came from family members or friends, but sometimes from unexpected sources, such as tangentially connected persons who had been touched by suicide loss or experience, or from others within the gender diverse community. One participant spoke of his chosen family being his primary support system. He shared that because his chosen family is so strongly supportive, his tumultuous relationship with his mother became less devastating to him. This provides a poignant example of the power of positive social support in protecting against the detrimental impact of stigma.

The Internet as a Lifeline

Rejection and the discrepancies between their experiences and those of their peers led GDAS to seek out support and understanding from avenues other than their immediate social networks. For many (8/11), this meant finding peers through the internet. Some participants warned against the potential harms of the Internet, expressing the importance of critical discernment in online spaces. They recognized the dangers of misinformation and the possibility of stigmatizing interactions. Although GDAS remained cognizant of stigma-based content and interaction on the Internet, they also praised online communities as essential in fostering environments within which to gain knowledge and to express themselves authentically.

They discussed the internet as a vital tool for self-education and an avenue for connecting with a community of peers. Information and content they discovered on the Internet fostered a sense of belonging by exposing GDAS to the existence of other people with shared experiences. Online connection helped GSAS realize “there’s other people out there going through this” and that they were “not the only one” going through struggles like theirs. One

participant reflected on the accessibility of online communication to connect with other people with shared identities. They spoke of online dating sites as a key venue for community connection because they eliminate the necessity of potentially perilous self-disclosure and allow for open communication between individuals with shared identities.

Peer Understanding

Nearly all GDAS (10/11) described a point at which they were exposed to gender diversity for the first time. Upon this exposure, they discovered that they were not alone in their gender experiences and that transness was an option for them. They also spoke of meeting others with mental health challenges or suicide experience, which made them feel less alone and alleviated some of the personal responsibility they felt for their mental health struggles. Relatedly, participants spoke of learning about the suicide experiences of others, seeing for the first time that they could have a livable life despite their suicidality. Finding a community of peers was a pivotal experience for GDAS. They discovered others with similar experiences and came to realize that they were not as alone as they felt. Connection to peer communities provided a safe milieu for discussing experiences with suicide. Open discourse about suicidal experiences helped to reduce the sense of isolation for GDAS by providing them with the knowledge of others who have similar experiences. They expressed the importance of peer support because "they can offer some ideas and support that you've never even thought of," having gone through the experience themselves.

GDAS asserted the singularity of their experiences, saying "it's something that is hard to explain to someone who hasn't tried to kill themselves" and "nobody understands. The only way you really get trans" is if you are trans or are very close to someone who is trans." GDAS were better able to express themselves to peers with the comfort of being understood (or at least, heard). One participant described their experience speaking with peers with shared experience with a sense of feeling at ease with others because of shared understanding without the necessity of explaining or educating others, describing "an inner circle thing," in which "we get it" and they do not feel as though they must "explain all this shit" to someone without shared experiences.

Once connected to these communities, participants were exposed to concepts and language that helped them explore their identities and find the words to describe their experiences. Discovering language that represented their truth reduced the isolation felt by GDAS and facilitated authentic expression. They described learning about gender diversity as opening a “whole new world” as they discovered “descriptions and definitions” that “fit who I am.” “The lightbulb went off” as GDAS found language to “make sense” of their gender identities.

Intersectional Convergence

Understanding the stigma of both suicidal experiences and gender diversity, many GDAS (8/11) recognized the compounding stigma they faced based on their positions within those social groups. Some GDAS reflected on the disparities among those whose identities fall into marginalized multiplicity. One participant shared her reasons for disengaging with her church community following her transition: “The whole stereotypes stigma behind trying to commit suicide plus the transgender issue, and what people would think of me.”

GDAS found relief in seeing other people with shared experience, even if they were not directly connecting with those people. The knowledge of peers existing provided hope for GDAS. Frankie shared an important point of connection for his convergence of identities: a trans-specific suicide support group. Community connection was notably beneficial to those who felt like they had a community of intersectional convergence, wherein multiple aspects of their identities were shared.

Living Authentically or Not at All

The discovery of trans existence constituted a turning point for the GDAS, wherein they understood their gender expression as a path they could shape and transitioning as a viable option for them. Participants talked about reaching a breaking point at which they could no longer live as their inauthentic self (11/11). They saw their options as either coming out and living as authentic self or dying by suicide. GDAS spoke of this turning point with intensity, using language that invokes a sense of finality: “Fuck it! I’m done!” and “I can’t go on living like this anymore, the dual/secret lives.” One participant articulated that, as a trans person, “there comes a point [at which you] just can't. . . stay behind in the closet and just let your life be as it is.” One participant

disclosed her trans identity to her parents in her suicide note, sharing that she could not continue living as man, which is exemplary of the compelling need for authenticity.

Connecting to peer communities allowed for safe exploration of gender identity, as well as providing resources and information to aid the process of self-exploration. While this time of self-discovery was tumultuous for many, GDAS ultimately spoke of the experience as enlightening and positive, as well as a necessary component of eventually living fully as their authentic selves. Interactions with others who validated and understood their experiences enabled participants to begin moving from feeling trapped by stigma and embracing their authenticity. The realization that they could live as their affirmed gender and had options to begin on that trajectory prompted participants to seek euphoria and begin transitioning (6/11). Some performed small actions of affirmation that were mostly private but served as positive steps toward living as their true gender, to "secretly feminize myself," and things that "weren't overt, but private little signals" to themselves that they were taking steps toward living as their affirmed gender.

Some GDAS teamed up with peers who were also in the process of transitioning, seeking solidarity and safety in numbers. They recognized the risk in their gender presentation, saying "either we're going to have a great time or we're going to get killed," speaking to the very real threat of violence against trans people. They expressed feeling great relief when in the presence of other GD people, as this granted a sense of safety that was otherwise missing.

Finding a community with which they shared experiences facilitated finding language to understand and describe their identities as well as providing a vital source of social support (6/11). As GDAS sought gender euphoria, they faced the daunting feat of coming out to others in their social networks. They were often reliant on the stories of coming out that they had heard through peers or pop culture, which were largely negative. This period was characterized by increased awareness of stigma and by weighing the risks and benefits of transitioning and coming out. Ultimately, they saw transition and coming out as essential components of seeking authenticity.

GDAS (8/11) spoke about their experiences with coming out of the closet, remembering the difficulty of making the decision to disclose their gender identities to their social networks and reflecting that when they did come out, a "big weight" was lifted. Some GDAS made comparisons between their sexual orientation disclosure and their gender identity disclosure, making note that friends and family were more receptive to sexual orientation disclosure because they saw it as a less severe deviation from expected norms. One participant reflected on the difficulty in coming out as trans when family members had "already disowned you for being pansexual."

GDAS spoke of negative reactions to their coming out, from a somewhat passive rejection from a mother ("Do whatever you want, but don't expect me to accept it.") to deeply wounding statements of rejection ("She told me that I was never the daughter that she wanted me to be."). Participants also spoke of coming out as a suicide attempt survivor, recalling changes in the way people treated them following disclosure of their lived experience of suicide. These harmful responses to coming out were what many GDAS feared and experiencing that rejection contributed to distress and isolation. Conversely, when GDAS were met with acceptance and positivity upon coming out, they were compelled to come out to more people and continue reaching toward living openly.

As they began to embody their affirmed gender identity and to accept their suicide experiences, GDAS became more engaged with peer communities and sought understanding and support through others with shared identities. This community connection alleviated the isolation of GDAS and fostered opportunities to meet others with their unique convergence of intersectional identities, which they referenced as the ideal sources of support.

Looking Toward the Bigger Picture

Increased community involvement and peer support empowered participants to take in the bigger picture surrounding their experiences. They began to recognize their personal strengths and to begin overcoming self-stigma, leading to greater sense of agency and self-esteem, which allowed them to practice self-advocacy. As GDAS experienced validation and

acceptance in their social communities, they began sharing their personal stories and experiences and finding other ways to combat the ubiquitous stigma they had always experienced. Community belonging and peer support enabled GDAS to begin shifting perspectives toward the bigger picture and viewing their experiences within social and situational contexts, rather than feeling like they were inherently wrong or broken. Turning toward the bigger picture encompassed processes of recognizing strengths and overcoming self-stigma, sharing their story and combatting stigma, and changing systems and policy.

Recognizing Strengths and Overcoming Self-Stigma

Understanding and acknowledging society-level issues facilitated a shift in how most participants thought about stigma: They recognized—at least part of the time—the problem as originating in the social environment and not within themselves (11/11). GDAS shared this perspective in comments such as, “Even as much as I think I’m the problem, look at all the stuff that’s going on,” referring to repressive political climates and social attitudes: “It’s society’s fault.” This new focus on external factors facilitated self-acceptance, allowing GDAS to separate societal stigma about their identities from their own concept of self-identity. GDAS (9/11) spoke of how their journey toward overcoming self-stigma, holding their own authenticity as priority over the comfort others.

GDAS spoke of doing “a lot of work around not feeling bad,” referring to unlearning internalized stigma, which was part of beginning the journey of self-acceptance. One shared, “I’m not so far in the closet that I can’t see my feet,” reflecting on the impact of concealing their identity on their overall outlook. Coming out of the closet allowed GDAS to see themselves as within a social context that could be accepting of their identities. Ultimately, GDAS prioritized their personal truth and became less concerned with the reactions of others. One participant shared an example of her re-introduction to a social environment: “I went as who I’m supposed to be. I did get some looks, but I just blew it off ‘cause I know who I am. If they can’t accept it, well that’s their problem, not mine.” The new attitude reflected in that excerpt alludes to increased self-esteem and resilience in facing stigma.

Participants expressed the importance of retaining agency and autonomy in their gender expression, their right to suicide, and in the treatment they sought. As GDAS overcame self-stigma, they felt more empowered to advocate for themselves across various settings. Some participants shared instances of self-advocacy in treatment settings in which they voiced their needs and preferences. The possibility of suicide served as a kind of safety net for some participants, who saw suicide as an option if their fears about losing their support after sharing their reality or beginning gender transition. Agency was also discussed in the context of gender expression and living authentically, relating the retention of personal autonomy to self-worth and overcoming self-stigma: “Everyone is their own person and deserves the right to their own body.”

Sharing Story and Combatting Stigma

As GDAS detached stigmatizing attitudes from their self-perception, they recognized that one avenue to alleviating suffering was through sharing their story, thus serving to combat the stigma associated with their experience. Most participants (9/11) reflected on the empowerment associated with openly sharing their story. As one participant illustrated, talking about taboo subjects more helps normalize them and remove some of the negativity associated with those subjects: “It’s putting it out there. The more you talk about quinoa, the more people are going to eat quinoa.” Gordon’s reference emphasizes the normalizing effect of a subject that is centered in public discourse. Though suicidal experiences for GDAS may be more of a taboo topic than quinoa, the assertion is the same: The more we talk about it, the easier it is to talk about and accept. Also important to some GDAS was showing others that they’re “not some weird freak,” but “a regular person,” “a regular human being.” Some saw sharing their story as an avenue for combatting stigma and normalizing the suicidal suffering.

Unexpected positive consequences of GDAS openly discussing suicidal experiences included making social connections they would not have otherwise made. Tatum reflected on being unaware of how infrequently suicide is discussed “until I started talking to a bunch of people about suicide.” Sharing their experiences opened the door for conversations with others who share similar experiences, which would not have been kept private.

Changing System & Policy

With enhanced understanding of social contexts shaping their experiences, participants expressed the need for systematic and policy changes. Some of those changes were related to the overall acceptance of trans people as a valid and worthy group, while others spoke specifically about suicide-related institutional problems. All of them agreed that sharing the stories of their experiences and opening the dialogue surrounding these problems would only serve to move the needle in a helpful way toward alleviating the disparities in suffering of gender diverse people. Some GDAS spoke about institutional barriers to full inclusion, pointing to the "medicalized and shaming" language used to describe suicidal suffering and gender and sexual diversity. They connected these institutional factors with contributing to the overall environment of stigma and exclusion of gender diverse people with lived experience of suicide. One GDAS stated, "the system is not set up to help you," and that "you're chastised for being where you are," emphasizing the deficit in quality resources for GDAS.

One GDAS referred to anti-trans policies as "the last bullet in a bunch of trans peoples' heads" because of their devastating impact. Another participant pointed to the relative safety provided by inclusive policies, indicating they came out only after the federal legalization of same-gender marriage. The growing awareness of transgender existence and issues contributed to noticeable shifts in policy and environment. GDAS expressed the criticality of fundamental human rights and how ensuring those basic rights can serve as a protective factor.

Summary of Findings

Taken together, these findings represent a journey through a pervasive environment of stigma, which contributed to the suicidal suffering of GDAS. Self-perceptions of GDAS were shaped by self-stigma, which fueled isolation and a sense of personal ineptitude related to their unique experiences. At its most intense, suicidal experience occurred in the presence of feeling different and socially disconnected, low levels of community connection or social support, and the stress of living a double life. When experiencing these overlapping conditions, GDAS felt alone and unable to manage their pain. GDAS displayed the greatest levels of resilience with the convergence of community connection, feeling different, living authentically, and seeing the

bigger picture. With the confluence of those factors, GDAS were able to manage their distress through intrapersonal and interpersonal resources, such as reaching out to supportive others for help before or during a crisis and utilizing coping skills they had acquired. This resilience placed GDAS at lower risk of suicide because their perceived ability to manage their challenges was improved and they had a sense of belonging in their community. See **Figure 3.1** for a graphic representation of these findings.

Discussion

Existing within an environment of identity-based stigma shaped the experiences of GDAS in myriad ways and served as a constant backdrop for their social interactions and their interpretations of those interactions. The environment of stigma contextualizes all GDAS experiences and is the source of considerable minority stress for GDAS. This stigma and its manifestations comprise minority stress theory's (Meyer, 2003) concept of distal minority stress and foster feelings of being different from others in their environment. Stigma surrounded not only gendered aspects of their lives, but also their experiences with suicide. The compounding stigma experienced by GDAS exacerbated deleterious effects of minority stress, consistent with extant literature which highlights intersectionality and the cumulative impact of minority stressors (Pilling et al., 2017; Schimanski, 2018; Johnson et al., 2020; Williams et al., 2018). For example, gender diverse BIPOC experience more discrimination than their White counterparts (Evelyn et al., 2022; Busby et al., 2020). Gender diverse individuals with disabilities also experience greater discrimination than those without disabilities (Cramer et al., 2021). Experiencing discrimination on the basis of multiple components of their identities is associated with increased suicidal ideation and attempt in gender diverse populations, reflecting the compounding impacts of intersectional stigma (Cramer et al., 2021; Battalen et al., 2021; Maksut et al., 2020). Because experiences with stigma have the potential to be so detrimental to mental health challenges, interventions involving education and stigma reduction among general communities and within specific settings could greatly benefit GDAS. Such educational initiatives would address the roots of stigma within and outside of our communities and work toward building and enhancing gender affirming practices.

A pervasive force in their lives, stigma impacted the sense of self for GDAS, leading them to feel “different” and driving a wedge between them and social others. Feelings of otherness grew out of observations of stigma and a general lack of representation of their identities. Understanding they were dissimilar to others and having little or no reference to gender diversity contributed to self-stigma and isolation. Recognized as a major stressor for gender diverse individuals is attempting to discover one’s true identity in the absence of gender diverse knowledge or role models, which has been described as “navigating a TGNC identity in the dark” (Austin et al., 2016, p. 221). Leslie Feinberg (zie/she) alludes to zir own gender journey in *Stone Butch Blues*, the 1993 novel regarded as a groundbreaking work about the complexities of gender (Feinberg, 1993). A particularly salient excerpt portrays the limitations of our societal discourse about gender: “Who was I now—woman or man? That question could never be answered as long as those were the only choices; it could never be answered if it had to be asked” (Feinberg, 1993, p. 241). This quotation also points to the isolation that can develop as a result of this discourse, suggesting the desolate position of not having language or concepts to relate one’s identity. Recognizing the self in others has been associated with decreased isolation and enhanced comfort with their own identity (Austin et al, 2016). Having previously interacted with trans people and even just knowing that trans people exist can be so influential to mental health that it can drastically reduce suicide among trans individuals (Testa et al., 2014). Fostering community connections among GDAS can provide peer support and identity representation, which, in turn, could facilitate identity exploration in a safe milieu and offer opportunities for mentorship and peer guidance.

Suicide stigma was also a prevalent feature in the stories of GDAS and was construed as amplifying their distress and contributing to negative self-worth. This finding is consistent with literature exploring attempt survivors’ experiences with mental health services, which finds common experiences of inadequate services (Aboussouan et al., 2022), negative experiences with providers (Hom et al., 2020) and that involuntary hospitalization can increase stress from stigma in attempt survivors (Xu et al., 2018). Suicidality is stigmatized in society overall as well as in GSD communities (Williams et al., 2018; Schimanscki et al., 2018), so individuals may be likely

to conceal their experience with suicidality in both settings to avoid ostracism or rejection (Batterham et al., 2013; Schimanski et al., 2018; Williams et al., 2018). Identity concealment may be particularly appealing to individuals who belong to multiple oppressed groups (McIntyre et al., 2014). If many individuals hide their gender identity or experience with suicide, others may not be aware that they have a shared stigmatized identity: thus, exacerbating social isolation. GDAS are a pivotal population to reach due to the staggering association between history of suicidal behavior and eventual suicide death (Joiner, 2005) and because of the high rates of suicide exposure in this population (Cerel, 2016; Cerel et al., 2021). Stigma reduction campaigns tailored to GD communities could enhance GD understanding of suicidal experiences and promote interest in activities that could promote community well-being, such as suicide prevention gatekeeper training for GD individuals.

Interactions with stressors of the environment contributed to interpersonal stressors, like fear of rejection, and prompted GDAS to manage stigma through concealing their stigmatized identities from their social networks and feeling as though they were living a double life. For GDAS, identity concealment widened the gap between themselves and their social networks, increasing disconnect from their community and exacerbating feelings of thwarted belongingness, which is consistent with other research involving GSD adults (Salentine et al., 2020). Living a double life increased minority stress and contributed to the development of perceived burdensomeness through the belief that one is so flawed that they are a burden on their families (Battalen et al., 2021).

Minority stress has been associated with suicidal thoughts and behaviors across various GSD populations, such as trans veterans (Tucker et al., 2019), GSD youth and adults in the U.S. (Cogan et al., 2021; Salentine et al., 2020; Peterson et al., 2021; Cramer et al,. 2021; Progovac et al., 2021; Battalen et al., 2021; Pellicane & Ciesla, 2022; Schweizer & Mowen, 2020; Price-Feeney et al., 2020; Austin et al., 2020), LGBT adults in Thailand (Kittieerasack et al., 2021), GSD people in Brazil (Malta et al., 2020), and trans women in Iran (Nematollahi et al., 2021). Similar relationships between minority stress and suicidal experiences have been found with GSD attempt survivors (Schimanscki & Treharne, 2019; Williams et al., 2018). Results of this study

contribute to the growing body of literature emphasizing the complex interplay between minority stress and suicide.

Long regarded by scholars as a critical step in identity development, coming out is thought to enhance connection to the GSD community through identifying oneself as a member of the community and allowing others in the community to recognize the shared identity (Cass, 1979), thereby increasing social support and community connection (Perrin et al., 2019). A GDAS person may be *out* to all, part, or none of the members of their social networks. The coming out process is ongoing and must be engaged with all new relationships and settings; individuals must regularly make decisions as to whom to disclose gender identity and sexual orientation (Ryan, et al., 2015). For example, a person who is out to their friends and within social settings needs to assess the safety of coming out in professional settings or within unfamiliar social groups; risks and benefits must be weighed for each new identity disclosure (Orne, 2019).

The intersectional nature of occupying space in multiple marginalized identity groups leads to a compounding stigma which contributes to greater mental health disparities. For example, some groups within the GSD population exhibit a higher burden of mental health challenges, including suicide, such as BIPOC GSD people (Sutter et al,. 2016), bi- and queer-identified persons (Maksut et al., 2020; Peterson et al., 2021), people with disabilities (Cramer et al., 2021), and those with suicidal experiences (Schimanski & Treharne, 2019; Pilling et al., 2018). GDAS spoke of difficulties meeting peer support needs with those who match their unique intersection of gender diverse and attempt survivor identities, leading to difficulties finding connection, belonging to a community, and feeling isolated. This finding coincides with literature that has found GSD spaces and mental health spaces to be siloed and each stigmatizing of the other, which drastically reduces opportunities for social support (Pilling et al., 2017; Schimanscki & Treharne, 2019; Williams et al., 2018). Where the stress of feeling different, living a double life, and community disconnect overlap, the risk for suicidal intensity is highest. Efforts to prevent suicide and provide relief from suicidal suffering among GDAS communities should emphasize stigma reduction and community connection, with a particular focus on spaces wherein those with intersectional stigma experiences can feel safe and free to live openly.

The most influential protective factor against suicidal behavior is having a supportive social network, including peer support and family belonging (Parra et al., 2021; Austin et al., 2020). Peer support has been emphasized as a crucial source of protection from the impacts of stigma and helpful in building resilience and facilitating recovery; this may be especially true when individuals are able to locate peers with shared identity convergence, like GDAS (Hom et al., 2020; Williams et al,. 2018; Bockting et al., 2013; Schimanski & Treharne, 2019; Fenaughty & Harré, 2003; Pilling et al., 2017). As community connection grew and GDAS had access to more positive and peer support, their feelings of singularity shifted from being a negative aspect of their identity to a source of pride and strength. This process of movement away from self-stigma and toward identity pride facilitates personal growth and the development of self-esteem (Perrin et al., 2019). With more frequent validating and affirming social interactions enhancing their self-esteem, GDAS felt more capable of presenting their authentic self in public.

The presence of peer support and affirmation empowered GDAS to begin to overcome self-stigma to realize their identities are not inherently wrong but construed as such by social environments. They recognized their strength as survivors and their unique place in a community of shared experience and identity. This important shift compelled GDAS to combat stigma through sharing their stories and advocating for themselves and others. A major component of GDAS' desire to combat stigma included sharing their stories to increase representation and acceptance of gender diversity, suicide attempts, and the convergence of both, which is consistent with findings from other studies with this population (Pilling et al., 2017; Williams et al., 2018; Fenaughty & Harré, 2003; Johnson & Rogers, 2020; Schimanscki & Treharne, 2019). The suggestions offered by participants in this study align with suggestions from other research: GDAS in this study spoke of high-level factors in systems and institutions that could enhance wellbeing of their community, such as inclusive health care policies, better training for mental health service providers (Hom et al., 2020; Johnson & Rogers, 2020; Aboussouan et al., 2022), more positive representation in the media (Johnson & Rogers, 2020; Pilling et al., 2017), and ensuring the voices of their community are heard (Schimanscki & Treharne, 2019; Johnson & Rogers, 2020). The concurrent presence of living authentically, feeling different, the bigger

picture, and community connection build the highest resilience for GDAS, through which they were able to use their internal and interpersonal resources to manage suicidal intensity when it arises. See **Figure 3.2** for an illustration of the journey of GDAS through stigma to authenticity. Findings from this study suggest important implications for reducing suffering and improving well-being among GDAS.

Limitations

There are some limitations to consider with this study. One consideration is the homogeneity of the sample of this set, which lacks diversity and therefore lacks important intersectional perspectives. There were also no demographic data associated with these interviews, so in-depth analyses considering important demographic variables like race, education, and income, were not possible. The participants in this dataset self-selected for participation in a public advocacy project and self-disclosed gender diverse identities, so their stories may differ from others who are not openly sharing their experiences. Because the *Live Through This* project is meant for public consumption, some GDAS may have omitted information they deemed too private to share in such a public venue. Because this study utilized secondary data, the researchers were unable to shape interview questions or contact participants for further interviews to probe complexities of stigma experiences. With these considerations in mind, this project offers a uniquely rich insight into the stigma experiences of GDAS.

Implications

Important implications arise from the findings of this study. GDAS pointed to the power of policy to contribute to or protect from suicidal suffering. They recognized that when their rights were protected, they felt more able to be themselves and were better able to manage the impacts of stigma. Advocating for inclusive legislation that protects individuals from discrimination based on their gender identity and expression is an imperative action for social workers and others working toward a better environment for GDAS. GDAS also endorsed shifting the language we use to talk about their identities, suggesting that person-centered, strengths-based language is much more in alignment with their experiences and that positive language can be an empowering tool, whereas stigma-based vocabulary perpetuates stigma and marginalization.

Another critical point of intervention is media portrayal of suicide in gender diverse communities, which many GDAS described as bleak and inaccurate. They want to see more holistic representations of gender diverse people and less stigmatizing coverage of suicide. Awareness of others with similar experiences provided hope for GDAS. Exposure to others with diverse gender identities empowered GDAS in their own identity exploration and acceptance and reduced their feelings of aloneness. They found solidarity and inspiration in the stories of other attempt survivors.

GDAS appreciated the inclusive communities formed through the Internet. Many indicated that without the Internet, they would not have made the peer connections that so heartily bolstered their social support. This points to the need for spaces in which GDAS can connect with peers and safely share their suicidal struggling without fear of unwanted consequences. A major component in providing these safe spaces is ensuring appropriate resources are available if participating GDAS become distressed. Referrals to resources such as crisis hotlines, GSD-specific crisis services, and warmlines should be readily available in physical and online spaces.

Stigma reduction interventions are another avenue for improving social environments for GDAS. Beyond shifting to positive messaging in media, stigma reduction interventions are designed to engage in critical discourse through education, raising awareness of personal biases, confronting stigma-based beliefs, and increasing contact with stigmatized groups (Brown et al., 2003; Nyblade et al., 2019; Corrigan, 2011). Strategic stigma change programming that centers contact between GDAS and key community members can be more interactive than education alone, providing greater engagement and investment toward stigma change (Corrigan, 2011). Other mechanisms of stigma reduction interventions include information-based approaches, skills-building approaches, and counseling approaches, which may offer more sustained results when combined with strategic contact (Brown et al., 2003). Stigma reduction interventions targeting education, health, and mental healthcare systems at multiple levels to center the experiences and needs of GDAS could greatly improve social environments for GDAS and reduce damaging effects of stigma. Training on the unique experiences and needs of GSD

people should include all levels of client-facing staff because anyone who has client contact can stigmatize (Nyblade et al., 2019).

Increased standards for suicide assessment and management training across health and social systems should reflect a nonjudgmental, person-in-environment approach that encompasses accurate assessment of suicidal intensity and emphasizes client autonomy when developing plans to enhance client safety. Interventions should be developed to ensure safety while understanding the potentially deleterious effects of involuntary hospitalization on GDAS. Assessments should consider aspects that may be unique to GDAS, such as experiencing gender invalidation, family rejection, or being exposed to violence in the GD community. Safety planning should incorporate resources for GDAS such as chosen family members, tailored services (e.g., Trans Lifeline), and local organizations that provide support for the GD community.

Gatekeeper suicide prevention training in GSD communities could reduce suicide stigma in those communities and enhance social support for those who are suffering. Gatekeeper suicide prevention trainings for key members of GSD communities could provide a better understanding of suicidal suffering and skills to help others in the community who are suffering or in crisis. Better preparedness for addressing suicidal suffering may increase comfort in discussing suicide and therefore create a safer space for GDAS.

Further qualitative research focusing on specific elements of stigma encountered could inform stigma reduction efforts and identify areas of clinical concern for working with GDAS. Future research would benefit from a larger sample of diverse GDAS. Incorporating the perspective of diverse voices is essential to understanding the complexities in lived experience of stigma and improving the lives of GDAS.

Conclusion

GDAS experienced stigma as a ubiquitous force that impeded their wellbeing, as something with which to cope and, eventually, resist. Within the environment of stigma, experiences of stigma were reflected by themes of (a) feeling different, (b) living a double life, (c) community (dis)connect, (d) living authentically, and (e) looking toward the bigger picture. Various positions in the convergence of these themes represented points of intensified suicidal suffering

or highest levels of resilience. Stigma reduction across ecological levels is a primary recommendation from these findings.

CHAPTER 4

INTEGRATING FINDINGS

Findings from both studies differed in specific content describing manifestations of stigma but suggested similar experiential narratives overall. The dynamically interconnected interactions described by gender and sexually diverse suicide attempt survivors (GSDAS) in their stories included a complex interplay between overlapping constructs of feeling different, openness, social support, and the bigger picture, which all occurred within a climate of stigma. See Figure 4.1 for an illustrative depiction of the processes. The following chapter expands upon these integrated findings, compares and contrasts findings across samples, situates the findings among extant literature, and offers implications for research, practice, and policy.

For GSDAS, the social world was riddled with stigmatizing messages and interactions about their identities (i.e., attempt survivor, gender identity, sexual identity), which was discussed as a pervasive and ubiquitous force that informed their perceptions and beliefs about themselves, others, and the world around them. Sources of stigma included media representation, religious teachings, family attitudes, environmental observations, and discourse across social arenas. Positioned in a minority identity group, GSDAS faced the burden of minority stressors that hindered overall wellbeing (Meyer, 2003). The deleterious impacts of stigma on GSDAS fluctuated depending on positionality within the constellation of connected constructs of feeling different, openness, and supportive community.

Situated within the climate of stigma and providing a layer of adversity or protection was a theme of community and support. At the negative (adverse) end of the connection continuum was ostracism, or disconnection from community and support. GSDAS described feeling alone and unwanted. Loneliness and lack of belonging felt by GSDAS were primary contributors to their suicidal suffering, which reflects the IPTS association between thwarted belongingness and

suicidal desire (Joiner, 1995; Van Orden et al., 2010). Components of community that influenced ostracism and isolation included direct observations and experiences of enacted stigma, such as being bullied by peers based on GSD or suicide attempts, hearing negative remarks about GSD or suicide from their families or others in their social environments, and being rejected by family or friends. Retaining negative perceptions of their place within the social world sometimes contributed to an assumption or fear that they would never find a social community that would genuinely accept and support them. Hopelessness about belongingness and burdensomeness is connected to emotional suffering and increases the risk of developing suicidal thoughts and behaviors (Van Orden et al., 2010). At the positive (protective) end of this category, community connection was high, and participants perceived ample social support. Social interactions with identity affirmation and positive support may decrease feelings of hopelessness for GSDAS, protecting against suicidality (Fenaughty & Harré, 2003).

Feeling different was a common phenomenon across samples and possessed a paradoxical quality in which feeling different could be perceived as positive (e.g., “I am unique and special.”) or negative (e.g., “I am different from everyone else.”). At the negative end, GSDAS felt the weight of identity-based stigma in ways that led to feelings of inferiority and *other*ness. The sense of being *othered* intensified the thwarted belongingness in participants. At times, distress associated with their stigmatized identities was intense enough to lead them to believe they were a burden to their loved ones, reflecting the perceived burdensomeness that is associated with the desire to die (Joiner, 1995; Van Orden, 2020). At the positive (protective) end of the *feeling different* spectrum is the perception of one’s minority identity as unique or special, rather than inferior. The shift from positive to negative attribution is resultant from self-acceptance and community consciousness, which come from increased access to and belonging within identity-based communities (Perrin et al., 2019). As GSDAS were exposed to communities within which they are welcomed and surrounded by like others, they have greater access to peer support and identity affirmation. Group affiliation can assist in the reconceptualization of difference from a negative attribute to a positive one and is associated with the development of

identity pride (Perrin et al., 2019). Identity pride is posited to increase self-acceptance and self-esteem, enhancing resilience and overall well-being in minority populations (Perrin et al., 2019).

An important factor in recovery and in accessing community and support is *openness* about stigmatized identity status. The climate of stigma within which GSDAS existed necessitated the management of stigma's impact. A prime technique for managing stigma interactions is concealment of a stigmatized identity (Quinn & Chaudoir, 2009), which was a tactic employed by many GSDAS. Coming out and staying in the closet are fraught with social and personal consequences, burdening GSDAS with recurrent situations that require decisions about outness and concealment (Orne, 2011). The concept of strategic outness suggests a complex set of practices and strategies used on a daily basis to manage who knows about their identity and how and why others learn about it (Orne, 2011). Cited as a source of considerable stress, GSDAS had to constantly consider conflicting reasons for identity concealment or disclosure. Participants concealed their stigmatized identity when they anticipated stigma as a means of keeping themselves safe from rejection and victimization. At the peak of identity concealment, GSDAS may have been protected from stigma-fueled interactions in the social world, but they were also cut off from peer communities. Conversely, living openly in their stigmatized identity facilitated peer connection because they were more easily located as members of the identity group with which they would be affiliated, but also posed the risk of being more easily identifiable as targets of stigma. Despite the risks associated with heightened visibility of one's stigmatized identity, coming out has the potential to reduce self-stigma and combat public stigma through increasing familiarity and reducing feelings of difference and otherness (Corrigan et al., 2013). Moreover, being able to live openly as one's authentic self can increase self-esteem and enhance well-being (Corrigan & Matthews, 2003; Austin et al., 2020).

As GDSAS interacted with positive and affirming social environments, they were able to shift their focus from personal flaws to the bigger picture, understanding their experiences as occurring within a complex environment of stigma and social forces. This reconceptualization of stigma and their place in the social world empowered GSDAS to more fully embrace their identities and find opportunities to combat stigma and give back to their communities. Further,

community consciousness fostered identity and group pride, contributing to enhanced self-esteem (Perrin et al., 2019). Keeping sight of the bigger picture provided hope for participants and fostered resilience. GSDAS resilience was highest where outness, identity pride, and the bigger picture met against a backdrop of community connection. At this particular intersection, GSDAS perceived greater personal ability to utilize personal and social resources to alleviate suicidal distress and move through suicidal crises.

Existing within an environment of stigma was a common theme across samples, but there were some differences between groups. For example, older GSDAS spoke in-depth about lacking GSD representation and knowledge as a critical component of their suffering. GDAS also reflected on this aspect of existence more than did SDAS. An awareness of shifting attitudes surrounding GSD was noted by participants, but they recognized there is still a long way to go in terms of social acceptance of GSD. In the documentary film *Disclosure: Trans Lives on Screen* (Feder, 2020), GLAAD director of trans media Nick Adams discussed the reality of trans isolation in the social world:

> We're not raised, usually, in a family where other trans people are around us. So when we're trying to figure out who we are, we look to the media to figure it out, because just like the 80% of Americans who say they don't know a trans person, that's often true of trans people as well. We don't know a trans person when figuring out who we are. So, we're looking to the media to figure out, 'Who's like us?'

Social distance between GSDAS and others like them perpetuated feelings of otherness they were experiencing, sometimes inducing hopelessness surrounding their possibility of ever being able to live openly and authentically. Hopelessness regarding thwarted belongingness stemmed from minority stressors and contributed to suicidal suffering (Salentine et al., 2020; Testa et al., 2017). For GDAS, identity exploration and transitioning were exceptionally difficult in the absence of exposure and interaction to other GD persons. This finding coincides with Austin's (2016) study suggesting the intense struggles of "navigating a TGNC identity in the dark" (p. 221), which encompassed a journey in which GD individuals moved from uncertainty to knowing, recognizing aspects of their identity in others, exploring their identity, struggling for authenticity, and a gradual process of evolving self-acceptance. The invisibility and discrediting of GD life is reflected by trans actor and activist Laverne Cox:

> I think for a very long time the ways in which trans people have been represented on screen have suggested that we're not real, have suggested that we're mentally ill, that we don't exist. And yet, here I am. Here we are. And we've always been here.
>
> Laverne Cox, in *Disclosure: Trans Lives on Screen* (Feder, 2020)

Laverne's observation also points to the interconnectedness of GSD stigma with mental illness stigma. GSDAS spoke about GSD identity considered as a mental illness, which contributed to their notion of self as other. Some felt this reduced their experiences to stereotypes or attributed their suffering to an aspect or consequence of their GSD identity. GDAS in this study spoke more frequently of the connection between stigma surrounding GSD and mental health challenges, noting the language society uses as especially detrimental. They struggled with the pathologizing of GSD in the medical and mental health institutions, recognizing this as a root source of stigma against GSD, mental illness, and suicidality (Austin, 2016; Goodyear et al., 2021; Herek, 2010; Corrigan, 2014; Pilling et al., 2017).

Intersectionality was discussed as a contributor to suffering among GSDAS. Compounding stigma based in multiple stigmatized identities is associated with increased prevalence of distress, anxiety, depression, and suicidal thoughts and behaviors (Layland et al., 2020; Green et al., 2021; Tejera et al., 2019). Specifically, interactions between multiple minority stress experiences are associated with perceived burdensomeness, thwarted belongingness, and cumulative risk for those with intersectional stigmatized identities (Green et al., 2021; English et al., 2022; Layland et al., 2020; Pellicane & Ciesla, 2022). GSDAS discussed challenges in finding community and peer support at the narrow convergence of their intersectional identities; this concept was discussed more among GDAS than among SDAS. Difficulty in finding intersectionally affirming communities contributed to feeling alone in their struggles and left them feeling cut off from communities from which they expected to find support. This adds to literature suggesting similar difficulties experienced by GSD people with mental illness (Pilling et al., 2017; Johnson & Rogers, 2020) and with suicidal thoughts and behavior (Schimanski & Treharne, 2019; Williams et al., 2018), who face stigma in discrimination in the broader social context as well as within GSD communities.

Combatting the harmful impact of intersectional stigma were safe spaces in which intersectional convergence was reflected and validated by peers. The ability to authentically express

oneself provided relief from stigma stress and facilitated self-acceptance for GSDAS. Participants emphasized the importance of peer understanding in their ability and willingness to disclose their identities and be open about their experiences. Willingness to discuss suicidal experiences is a crucial factor in reducing suicide risk because disclosure facilitates intervention and nondisclosure inhibits help-seeking (Frey et al., 2016; Schimanscki & Treharn, 2019). Peer support is frequently associated with increased resilience and more positive well-being overall (Busby et al., 2020; Bockting et al., 2013; Parra et al., 2021; Johnson & Rogers, 2020; Dorrell et al., 2020). Safe spaces provided important social support through community consciousness, peer support, and identity affirmation, which are posited to enhance identity pride and build resilience for GSD persons (Perrin et al., 2019).

Limitations

This dissertation has some limitations to consider. First, the data for these studies were gleaned from an advocacy project and intended for public consumption. For that reason, participants shared only what information they were comfortable with being available on the Internet, so some details may have been omitted. Further, their voluntary participation and self-identification as suicide attempt survivors may reflect only those who are already living openly in their stigmatized identities and findings may not reach across other groups within the population. Another limitation concerns the demographic diversity of the sample. Further, lacking measures of demographic data disallowed for investigation of particular experiences across race and ethnicity, socioeconomics, geography, and other details that could provide valuable contextual information. Further, GSD identities included in this sample were limited: most of the transgender sample comprised trans men and women with fewer nonbinary identities, and most of the cisgender sample identified as lesbian, gay, or bi, with few exceptions.

Use of secondary data limited theoretical sampling and prohibited following up with participants to continue generating knowledge with GSDAS. Interview data from the project were not collected for research purposes and interviews were openly guided toward sharing experiential aspects of being a suicide attempt survivor. Interviews were conducted conversationally as part of the interviewer’s style and to make participants more comfortable.

Because interview data were collected for the project and not with the intention of research, I was unable to probe for complexities of stigma experiences, which left some gaps in the conceptualization of GSDAS navigating life and stigma.

Implications

Findings from this study enhance our understanding of the experiences of stigma within GSDAS, which are an understudied population and a pivotal group to reach to begin addressing suicide disparities. The voices of participants add to our knowledge the authentic experiences of interacting with stigma in the context of life as a GSDAS, the value of which cannot be understated. Inclusion of GSDAS within scholarly discourse broadens our understanding of social exchanges and individual experiences impacting suicidal suffering and recovery to inform research, policy, and practice. Recommendations for interventions across ecological levels to address the stigma identified by GSDAS are discussed in the following section and summarized in Figure 4.2. Before diving into intervention recommendations, I will discuss implications for further research.

Research

To address conceptual gaps, further qualitative research is recommended to explore the complex nuances of the lived experiences of intersectional stigma for GSDAS, how they interact with that stigma, and the how that stigma impacts their mental health and overall wellbeing. Another important task for future research is collecting data with a diverse sample of GSDAS along with demographic and identity-related data to help assess differences across groups. It is essential to reach GSDAS with identities that are subject to in-group stigma, such as nonbinary genders and nonexclusive sexual orientations. Research should also actively recruit Black, Brown, Indigenous, and other People of Color (BIPOC) to investigate and explore the intersectional experiences of BIPOC GSDAS. Further research including strengths-based perspectives can greatly enhance our ability to increase resilience and promote positive outcomes for GSDAS.

Policy

Legislation that explicitly protects individuals based on gender identity expression and sexual orientation can decrease stigma its impacts. Studies have found better mental health outcomes in GSD persons where policies are inclusive and explicitly protect their rights (Richardson et al., 2022; Saewyc et al., 2020). Policy advocacy is recommended as a means by which to reduce suicide disparities and suffering among GSDAS. Policies at varying levels have the power to impact life for GSDAS.

Relevant policy at the local, state, and federal levels includes comprehensive anti-discrimination legislation that explicitly includes SOGIE as protected classes. Other targets for policy advocacy at these levels include increased funding allocation for resources and programming that address mental health and suicide among GSDAS and improved access to GSD affirming healthcare in general. City-level fairness ordinances that protect GSD people within city limits are also important, especially when the state does not have such legislation. Advocating for inclusive policies at all levels of government is an important step toward building a better social world for GSDAS.

Relevant policies at an organizational level (e.g., schools, healthcare) include comprehensive anti-bullying and anti-discrimination policies that explicitly protect students and staff from harassment based on sexual orientation, gender identity, and gender expression (SOGIE). GSDAS indicated the protective effects of such policies and found daily existence to be less stressful when such policies were in place. Findings from this dissertation indicate a dearth of education related to GSD and suicide in the school systems described by participants. Increasing funding for resources and programming related to mental health and suicide in schools may reduce internalized stigma and could greatly improve individuals' comfort in disclosing their suffering, seeking help, and helping others. GSDAS facing compounding stigma may face heightened levels of stress and may be reluctant to openly share their challenges, so reducing this stigma is an important vector for improving their mental health and overall wellbeing.

Social Work Education

Findings from this dissertation can inform social work education policies. GSDAS indicated insufficient cultural sensitivity regarding the unique experiences, challenges, and needs of GSD persons. GSD training should be incorporated into social work educational curricula to prepare social work practitioners for working with GSDAS. Additionally, GSDAS indicated discouraging interactions with mental health providers, suggesting deficiency in education related to suicide and suicidal suffering. Social work education could bolster the competency of social work practitioners through requiring incorporation of suicide risk assessment and management curricula into social work programs. Social work's strong holistic and person-centered perspectives can uniquely enhance conceptualization of suicidal suffering and provide important insights to others involved in care.

Practice

Findings from this dissertation suggest important implications for social work practice. Addressing the roots of suicidal suffering in GSDAS requires action at all levels of social interaction. In the following section, I will make recommendations for interventions across ecological levels.

Macro-Level Interventions

Macro-level interventions target systems for change and should focus on reducing stigma about GSD and suicide and enhancing affirming social environments to improve the well-being of GSDAS. Important targets of macro-level intervention are health and mental healthcare systems, wherein many GSDAS have had negative experiences. These systems are also influential in the conceptualization of GSD and suicide. Working within systems to de-pathologize and promote affirmation of GSD can promote stigma reduction. GSDAS identified pathologizing language surrounding their GSD identities and their suicidal suffering as contributing to the stigma they experienced. They described medical language as shaming and connected it to their exacerbated feelings of otherness. Using individuals' preferred language is an important component to respecting their autonomy and affirming their identities.

Schools serve an important role as the primary social environment and source of considerable stress for many GSDAS. Schools can reduce some of this stress by encouraging a culture that affirms GSD and protects the rights of GSD students. Affirming GSD cultures within schools can be developed by adopting comprehensive anti-bullying and anti-discrimination policies that explicitly protect students based on SOGIE, GSD-inclusive curricula, and accessible safe spaces for GSD students. All cadres of school personnel should participate in training designed to help them understand the unique experiences and needs of GSD students and promote positive social interactions between adults and GSD students at school. Accessible safe spaces for GSD students include student-led clubs that bring together students who identify as GSD and those who want to provide allyship. Other forms of safe space in school include actively posting inclusive and affirming signage, consistent adherence to anti-bullying policies, and school personnel displaying some symbol of GSD acceptance (e.g., “LGBTQ+ Friendly” signs or small pride flags in the offices of faculty). These small gestures can greatly increase feelings of safety and acceptance for GSD students. Supportive school cultures can increase GSD students’ sense of belongingness and protect them against GSD stigma in the larger social environment.

Stigma reduction is a crucial component of improving wellbeing among GSDAS. Interventions targeting social stigma can help reduce self-stigmatizing beliefs about their GSD and attempt survivor identities. Efforts to reduce suicide stigma increase help-seeking and suicide disclosure (Downs, 2012; Blanchard et al., 2018; Blocker & Miller, 2013). Clinical work with GSDAS can incorporate social perspectives and work through internalized stigma in order to reduce self-stigma and increase self-esteem (Díaz-Mandado & Periáñez, 2021; Tsang et al., 2016). Further, stigma reduction interventions can facilitate in improving social acceptance and affirmation of GSDAS through educating families and others about gender and sexual diversity and suicide, encouraging empathy for GSDAS and increasing understanding of their lived experiences.

Mechanisms through which stigma reduction can be implemented vary by approach and by target audience. Categories of stigma reduction interventions include information-based approaches, skills-building, contact-based approaches, and counseling approaches (Brown et al.,

2003). Information-based approaches, which involve communicating fact-based information about GSDAS, are appropriate for macro-level stigma reduction efforts, as they have potential for reaching wide audiences. These interventions communicate accurate information through written media, in videos, classroom-style presentations, and media campaigns (Brown et al., 2003). Information- and contact-based stigma approaches are most appropriate for macro interventions. The other mechanisms are well-suited for individual and small group interventions and will be discussed in the next section.

Contact-based stigma reduction interventions bring together GSDAS and members of the public. Best practices for strategic stigma change, a contact-based intervention model that addresses public stigma through contact between people in a stigmatized group and targeted community members, are defined by the acronym "TLC3: targeted, local, credible, continuous contact" (Corrigan, 2011, p. 824). Contact involves planned interactions between GDAS and key groups of local community members to change stigmatizing public attitude, targeting members of those key groups and identifying negative behaviors to change into affirming behaviors. The credibility principle is concerned with how well the contact persons embody the considerations of the stigma reduction program, such as GSDAS who are actively utilizing promoted resources. Finally, continuous contact is encouraged because the effects of varied contact over time may be much more powerful than one-time contacts (Corrigan, 2011).

Live Through This (www.LiveThroughThis.org) is a wonderful example of a contact-based stigma reduction program. The project increases virtual interaction between the general public and suicide attempt survivors by sharing their stories and their portraits. See Figure 4.3 for a screenshot of the *Live Through This* homepage, which provides an aesthetically pleasing and user-friendly platform for engaging in virtual contact with GSDAS. This type of project can serve as a nonthreatening way for people to increase contact with GSDAS. Further, the online base of *Live Through This* also exemplary of how social work can embrace the power of technology to enact social change. Expanding this kind of work to reach more GSDAS and to highlight the experiences of GSDAS can help reduce stigma against GSDAS.

In addition to serving as a mindfully curated repository for rich descriptions of the lived experience of suicidal suffering, *Live Through This* provides SAS with an online peer community that creates a safe space for SAS to share their suicidal suffering. GSDAS shared the lifesaving value of the Internet as a social tool to decrease isolation and connect them with peers. The Internet and the online safe spaces contained within it provided vital social support for GSDAS. For GSDAS who were otherwise isolated from others with shared identity, the Internet afforded them the opportunity to connect with peers who could understand their experiences. Online safe spaces represent another avenue for social workers to foster connection among GSDAS. In safe spaces, GSDAS expect the freedom to speak openly about their suicidal suffering without fearing unwanted consequences. Development of online safe spaces to foster peer connection and support should be informed by GSDAS. Because of the painful nature of suicidal suffering, users of online safe spaces may experience crises that require intervention, so referral resources should be easily accessible and posted in multiple locations in online safe spaces to enhance safety for GSDAS who are in distress.

Meso-Level Interventions

Meso-level interventions involve groups of people across multiple settings within which GSDAS interact. Interventions could include tailoring services for GSDAS, outreach efforts to connect GSDAS to available resources, fostering positive connection in GSD communities, or partnering with local GSD-serving organizations. Stigma reduction efforts at this ecological level could provide an important foundation for improving social support for GSDAS.

Meso-level stigma reduction efforts should focus on reducing stigma among GSD communities, with emphases on in-group stigma and suicidal suffering. Many GSDAS suggested more intense feelings of rejection when they experienced SOGIE-based stigma from other GSD individuals, which strained community connection and exacerbated isolation. Further, GSDAS discussed suicide stigma within GSD communities and indicated that stigma as a significant source of stress. Mechanisms for stigma reduction at this level include skills-based and counseling-based approaches. Skills-building interventions address stigma by teaching coping skills and strategies for resolving negative attitudes and include activities like role-play, imagery,

scripting, reframing, and group desensitization. Counseling approaches provide support for positive behaviors and can be delivered in family or group therapy sessions or in support groups. These approaches should be combined with information- and contact-based approaches for the most effective stigma reduction (Brown et al., 2003).

Consideration of tailored services designed for inclusion and affirmation of GSD is critical in improving help-seeking and utilization of those services. Multiple studies have found immense value in tailored services, with many participants reporting they would not be comfortable using crisis intervention services that were not explicitly affirming of GSD (Goldbach et al., 2019; Fulginiti et al., 2021; Fulginiti et al., 2020; Chang et al., 2021; Mereish et al., 2022). Increasing access to and availability of safe spaces for GSDAS can promote well-being, especially considering the reluctance of GSDAS to seek support outside of those spaces (Johnson & Rogers, 2020; Goldbach et al., 2019; Zhang et al., 2018).

Community and peer suicide prevention training could greatly promote the capacity of GSDAS community members to manage suicidality and to help peers who may be experiencing suicidal crises. Ferlatte et al. (2019) found robust readiness and interest among GSD persons in supporting suicidal peers. Suicide prevention gatekeeper training for GSD community members could be a magnificent avenue for reducing suicidal suffering and increasing peer support for GSDAS. Such training would provide GSD persons with better understanding of suicide and with the skills needed to help someone in crisis.

Partnering with local GSD organizations to assess needs and strengths of the GSD community would be beneficial in connecting GSDAS to local resources and to identifying areas of growth for the local GSD community. Initiatives to support and empower GSDAS should be prioritized in reducing suicidal suffering. Examples of those initiatives include support groups, legal clinics, and resource brokering to connect GSDAS to available support services.

Micro-Level Interventions

Micro-level interventions encompass those involving individuals and interpersonal groups, like the primary support systems of GSDAS. Interventions to reduce suicidal suffering and enhance social support for GSDAS include counseling approaches, skills-building

approaches, and efforts to support networks and connect GSDAS to peers. Social workers in direct-care settings may have greater opportunity to utilize micro-level interventions than those in other settings. Social workers can provide accurate information about GSD and about suicide to help individuals and their families understand the unique needs and experiences of GSDAS. Information-based interventions can reduce stigma-based attitudes and beliefs and shape GSDAS' self-perceptions.

Social workers should apply the person-in-environment perspective to their assessments and case conceptualizations in order to understand the experiences and needs of GSDAS. Another critical role of social workers is resource brokering, in which they can help connect GSDAS to supports, services, and other resources. Resources provided to GSDAS should be confirmed as GSD-affirming whenever possible so GSDAS can avoid further stigmatizing interactions.

Clinicians may be particularly influential in helping GSDAS reduce suicidal suffering and enhance resilience. Clinicians should be mindful of minority strengths models and the components that interact to build resilience to harness the strengths of GSDAS. Clinical work with GSDAS may include helping them conceptualize their experiences within a holistic perspective, acknowledging the impacts of stigma, raising community consciousness, and working through internalized and self-stigma. Another clinical focus that could benefit GSDAS is coaching on effective communication, which could prepare them for identity disclosure situations and consequences thereof. Additionally, GSDAS could benefit from skills-building approaches wherein they learn reframing and relaxing techniques and coping skills to mediate the impacts of stigma. Such interventions could also take place in group settings, like therapy or support groups, which would have the added benefit of fostering peer connection and building community consciousness.

Conclusion

GSDAS are burdened with intersectional stigma and related adverse outcomes. The ubiquitous climate of stigma experienced by GSDAS shaped their interactions with their social world and contributed to suicidal suffering. Compounding stigma from belonging to stigmatized

identity groups intensified suffering and worsened challenges for GSDAS, who identified stigma-based deficits in available supports across social and institutional domains. Suicidal suffering was reduced when GSDAS were able to situate themselves within supportive social environments, which aided them in overcoming self-stigma and generating identity pride. These supportive social environments were especially beneficial when they included others with shared identity (i.e., other GSDAS), as those conditions defined a “safe space” within which GSDAS could authentically exist and receive nonjudgmental support. Suicidal suffering was least intense when GSDAS accepted their own stigmatized identities and felt connected to their communities, accepted their own identities. The lived experience of stigma for GSDAS can greatly impact their mental health and overall well-being. To decrease the deleterious impacts of stigma-based minority stress, interventions should focus on allocating funding for GSDAS-affirming services, reducing stigma in public discourse and in communities, and combatting stigma with hopeful and positive representation of GSDAS.

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	Social Constructivism		Queer Theory
Ontology	Multiple realities are constructed through social interaction.	Research seeks multiple perspectives on an experience versus one objective truth. ***What are the experiences of stigma for gender diverse attempt survivors (GDAS)?***	Multiple realities are constructed through social interactions based on power/identity struggles.
Epistemology	Knowledge is socially co-constructed.	The social environment and social identities impact the way we experience and know the world. ***How do social interactions and positions shape the experiential world of GDAS?***	Knowledge is constructed through social structures, power, and oppression. Start with assumption of inequity.
Axiology	Individual values are honored and negotiated.	Diverse values and perspectives are honored. ***What are commonalities across diverse perspectives? What stands out as unique or anomalous?***	Diversity in values and perspectives is emphasized.
Methodology	Inductive analysis, literary writing styles.	Sharing stories of inequity to enhance understanding and promote equity. ***What can we learn from these stories of stigma that can improve conditions for GDAS?***	Research aims to document inequity and to call for action.

Figure 1.1. ***Philosophical Assumptions and Interpretive Frameworks***
Guided by social constructivism (Berger & Luckmann, 1969) and queer theory (de Lauretis, 1991), this research assumes socially constructed realities are rooted in power/identity struggles and experiences are impacted by social positions and interactions. Diverse perspectives and values are honored with the recognition that individual values may vary but should not be diminished. This research aims to enhance understanding, promote equity, and improve conditions for SDAS.

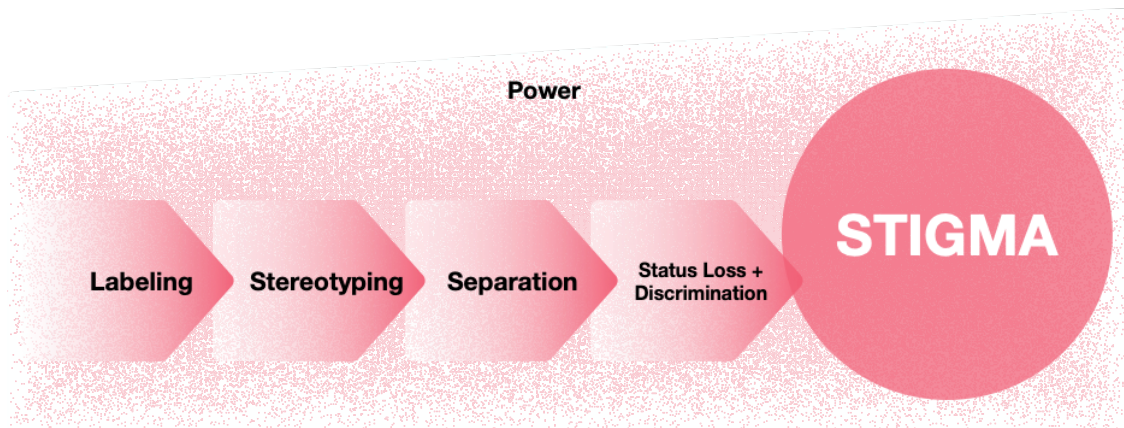

Figure 1.2. ***Stigma Theory***
Stigma is developed in a the context of power and involves interrelated components of (1) identifying and labeling differences, (2) associating differences with negative stereotypes, (3) separating "us" from "them," and (4) status loss and discrimination (Link & Phelan, 2001).

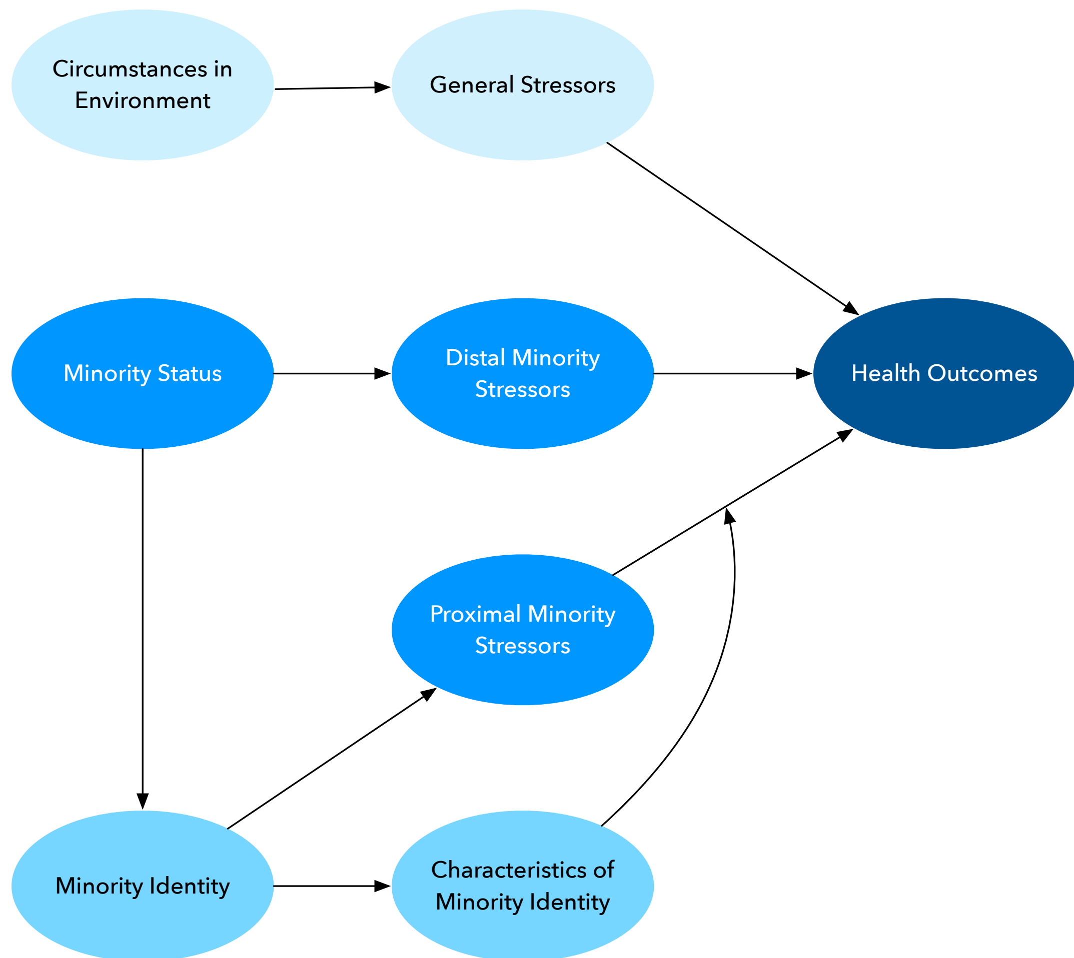

Figure 1.3. ***Minority Stress Theory***
Minority stress theory offers a theoretical explanation of how minority-specific stressors can contribute to disparate healthcomes in those minority populations.

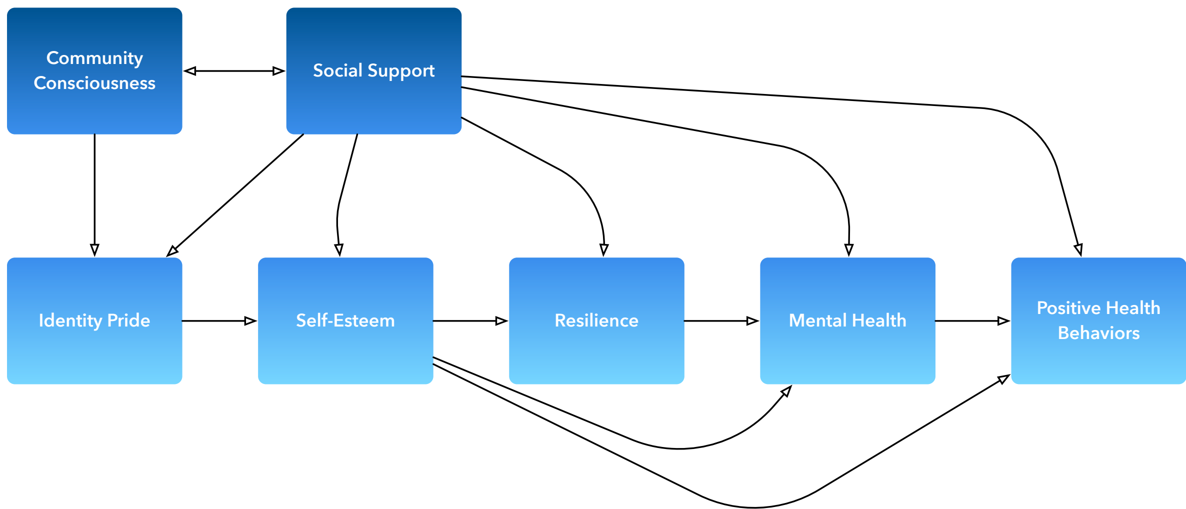

Figure 1.4. ***Minority Strengths Model.***
The Minority Strengths Model (Perrin et al., 2019) emphasizes strengths of minority identity status, incorporating factors of social support and community consciousness and critical components of minority strength, through which identity pride, self-esteem, resilience, mental health, and positive health behaviors are developed and enhanced.

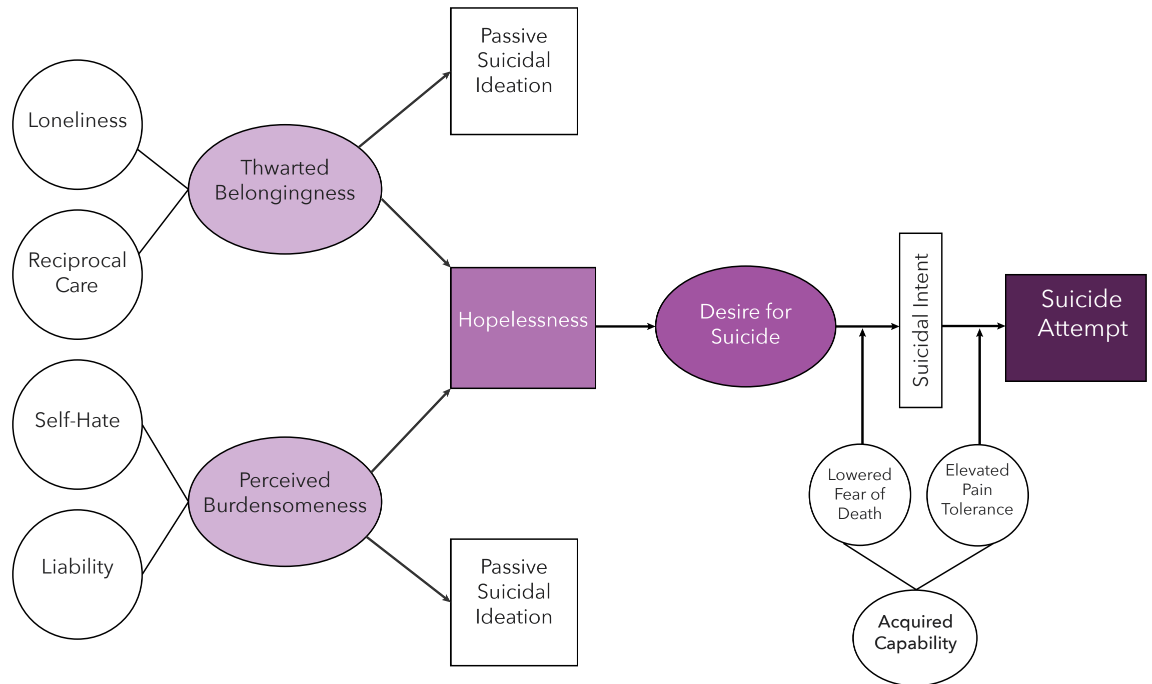

Figure 1.5. *Interpersonal Psychological Theory of Suicide*
The Interpersonal Psychological Theory of Suicide (Joiner, 1995; Van Orden et al., 2010) posits the development of the desire to die occurs in the presence of thwarted belongingness and perceived burdensomeness with hopelessness about those unmet social needs. When the desire for suicide is accompanied by an acquired capacity to act toward ending one's life, suicide attempts occur.

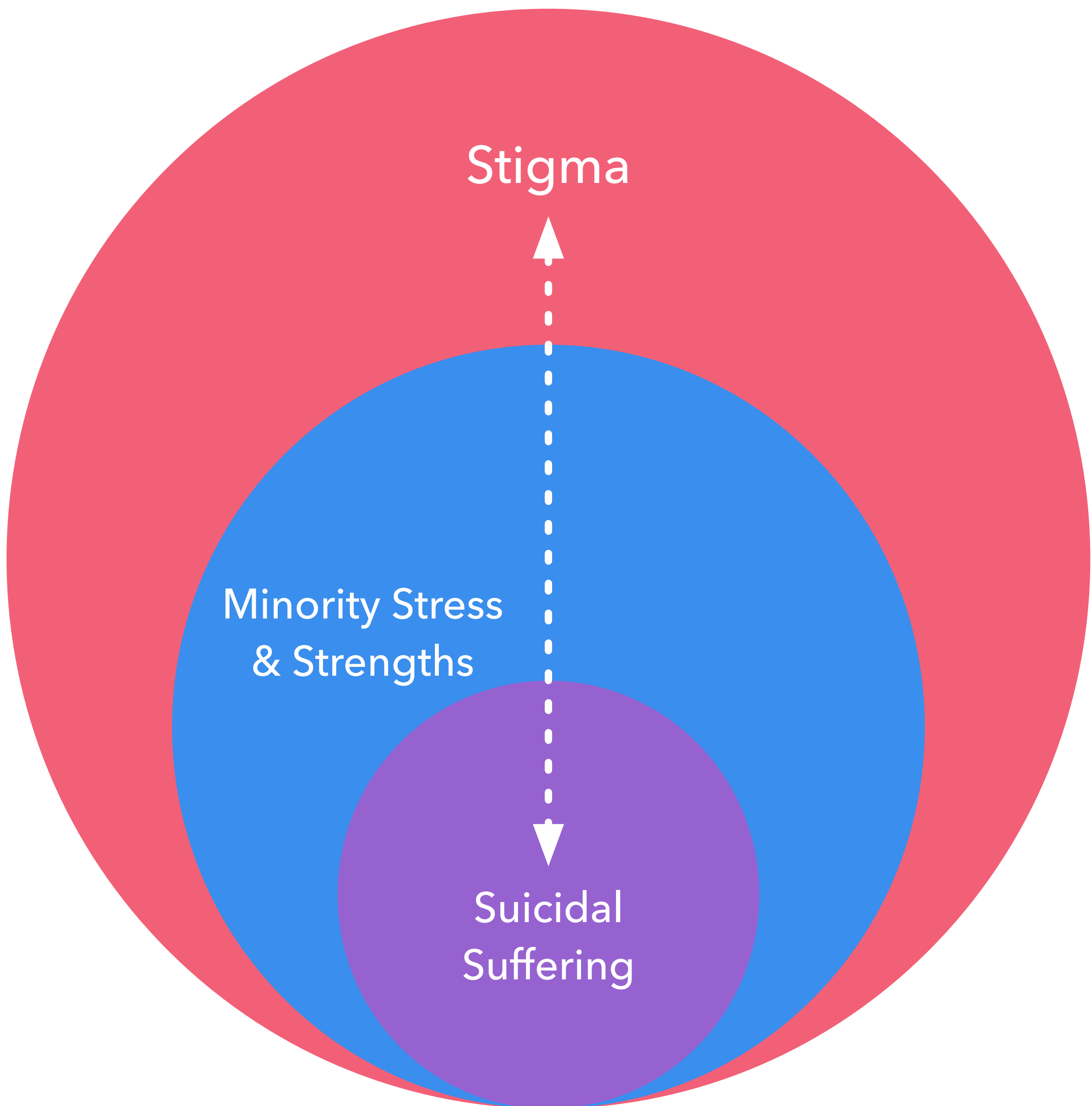

Figure 1.6. ***Conceptual Model of Theoretical Frameworks***
The integration of theories toward understanding experiences of stigma in the stories of GSDAS incorporates perspectives across ecological levels. At the micro level is suicidal suffering and individual experiences with stigma. Meso level interactions are framed by minority stress and strengths theories. Macro level factors are included in theoretical frameworks of stigma theory and minority stress and strengths models.

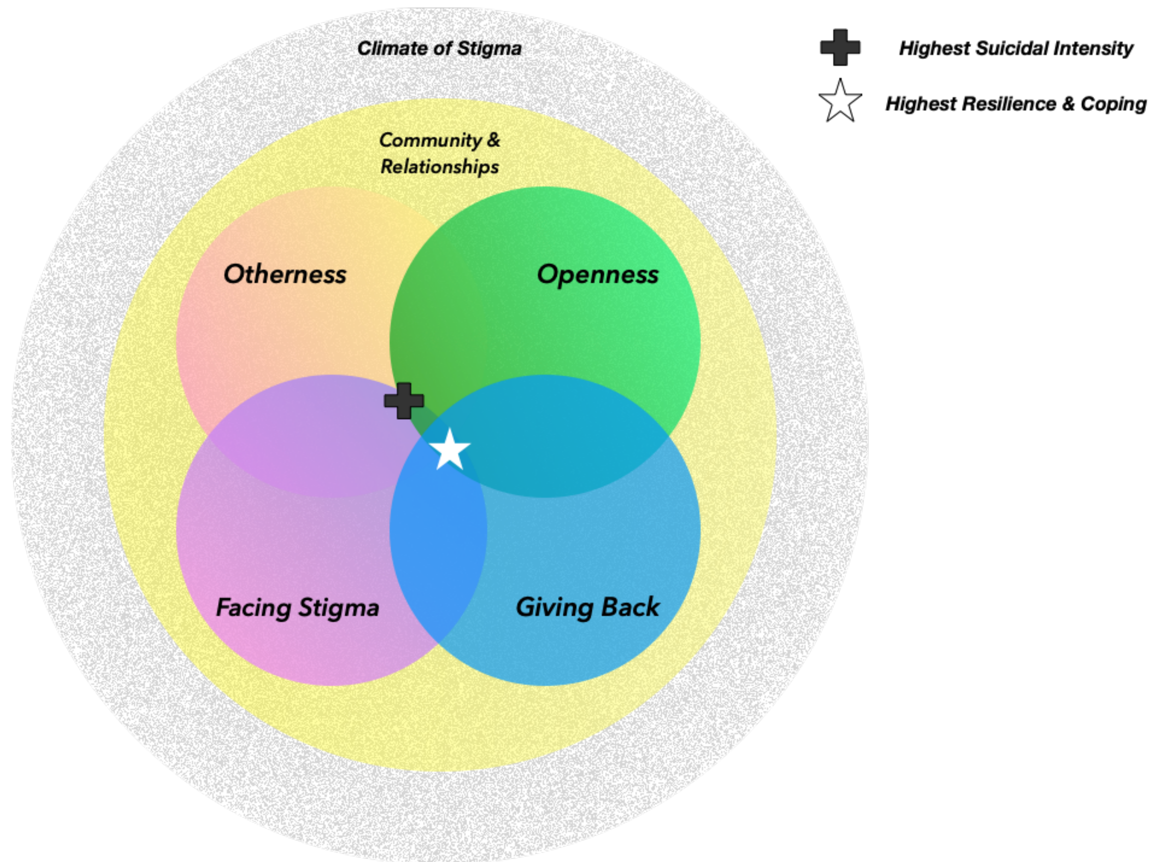

Figure 2.1. ***Stigma in the Stories of SDAS***
Within their suicide stories, participants discussed aspects of stigma and the ways in which they interacted with that stigma. Apparent themes in the narratives depicted the nuanced and often conflicting natures of existing and navigating life as SDAS. interconnected themes of (a) otherness, (b) facing stigma, (c) openness, (d) community and relationships, and (e) giving back emerged from an climate of stigma and contributed the overall experiences—positive and negative—of SDAS. In the overlap of high otherness, low openness, high stigma, and low social connectedness, suicidal suffering was most intense and SDAS were at the highest risk of attempting suicide. In the overlap of low otherness, high openness, low stigma, and high social connection, SDAS exhibited greater resilience and increased ability to cope with distress and suicidal thoughts when they did occur.

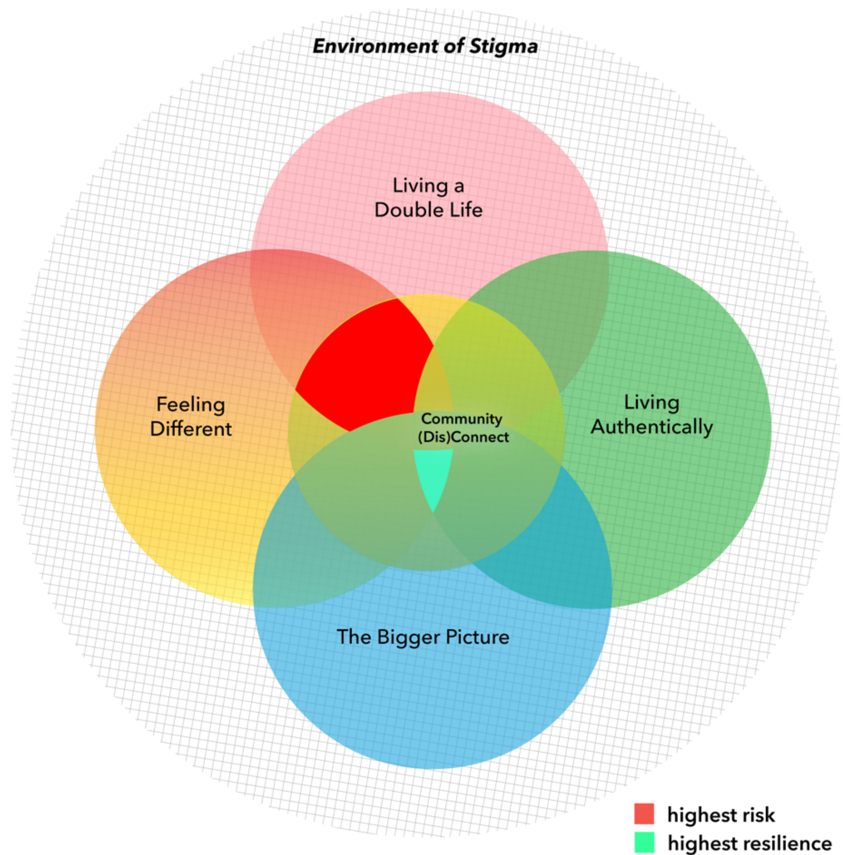

Figure 3.1
Through Stigma to Authenticity

The overlapping circles in this figure represent the complex themes described by gender diverse attempt survivors in their stories of suicide: themes that speak to the experiences with stigma of GDAS: (a) existing in an environment of stigma, (b) feeling different, (c) living a double life, (d) community (dis)connect, (e) living authentically or not at all, and (f) looking toward the bigger picture. For these GDAS, suicidal intensity was strongest with the presence of feeling different and living a double life when they lacked social support. Resilience in GDAS was highest in the presence of living authentically, community connection, feeling different in a positive way, and looking toward the bigger picture.

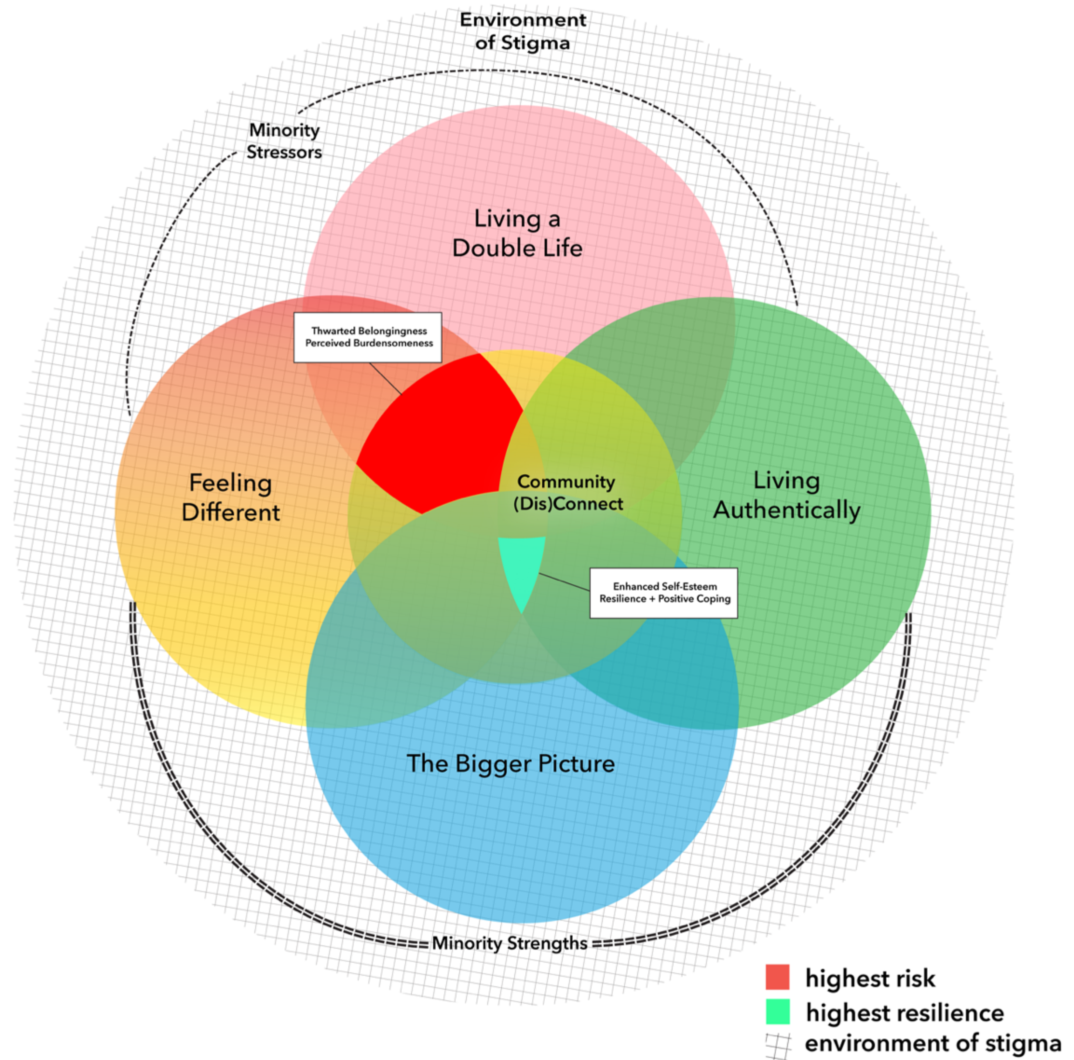

Figure 3.2
Theoretical Description of Findings
The environment of stigma contextualizes all GDAS experiences and is the source of considerable minority stress for GDAS. Where the stress of feeling different, living a double life, and community disconnect overlap, the risk for suicidal intensity is highest. The concurrent presence of living authentically, feeling different, the bigger picture, and community connection build the highest resilience for GDAS, through which they are able to use their internal and interpersonal resources to manage suicidal intensity when it arises.

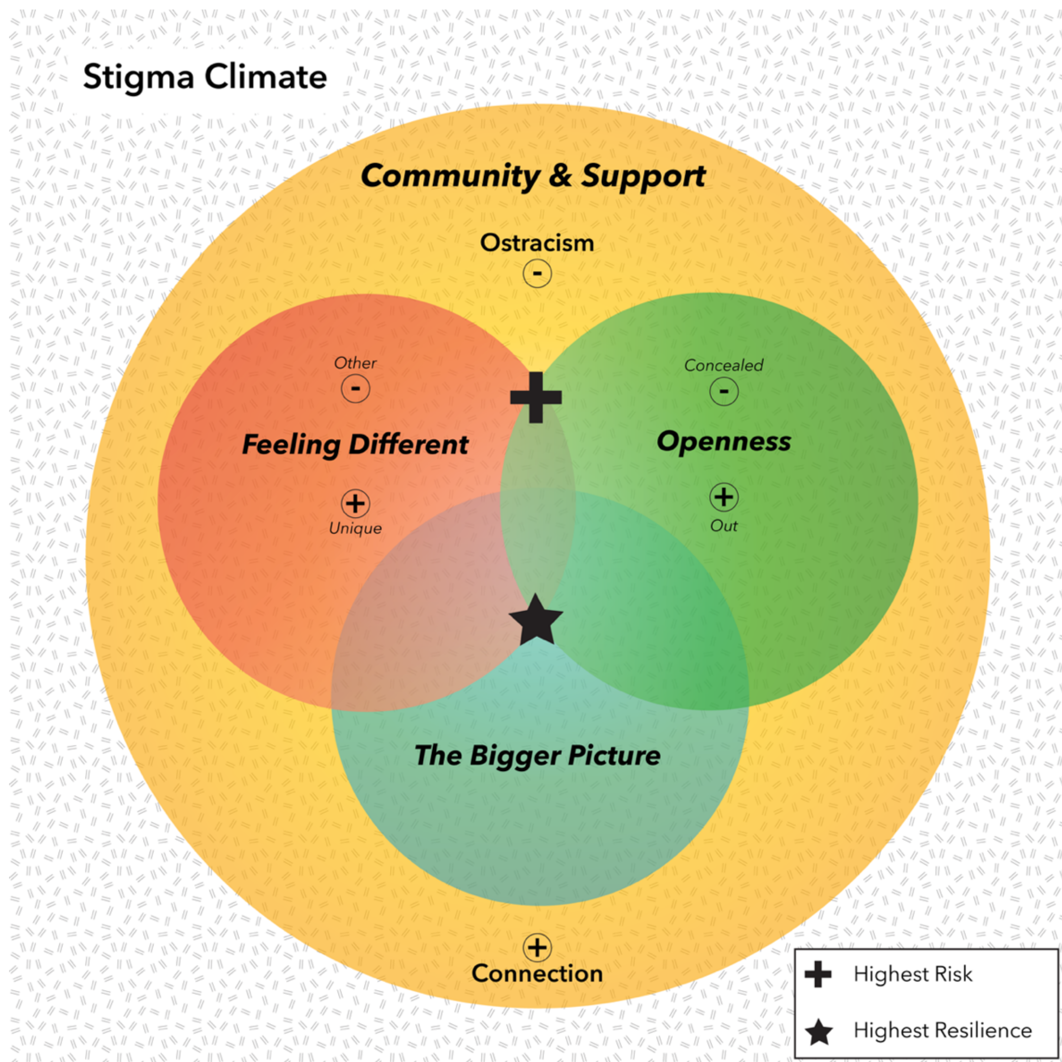

Figure 4.1. ***Integrated Findings***
Findings from across both studies differed in specific content and stigma interactions but indicated similar processes overall. The dialectical interplay of feeling different, openness, and community support exacerbated suicidal suffering and contributed to risk or fostered resilience and protected from GDAS from suicidal crises.

Micro ↑ … ↓ Macro	Level	Intervention Recommendation
Micro	Individual	o Psychoeducation (GSD, Suicide) o Person-in-environment assessment and case conceptualization o Clinical focus on internalized and self-stigma o Preparing for GSDAS identity disclosure o Critical consciousness raising o Increase community connection
	Interpersonal/Familial	o Family therapy, psychoeducation o Effective communication coaching o Support groups o Peer support o Online safe spaces for GSDAS
	School	o Comprehensive anti-discrimination and anti-bullying policies that explicitly include SOGIE o GSD-inclusive and affirming curricula in schools o Mental health and suicide training in schools o Safe spaces o Training for school personnel on SOGIE and suicide
	Healthcare	o Depathologize and promote affirmation of GSD o Training for all staff on SOGIE and suicide (including bias reduction) o Comprehensive trauma-informed suicide and self-harm assessments and suicide risk focused interventions o Implement best practice guidelines for GSD patients o Tailored interventions for GSDAS
	GSD Communities	o Increase accessibility of safe spaces and create MH safe spaces o Trauma-informed counseling with focus on suicide prevention o Suicide prevention gatekeeper trainings o In-group stigma reduction o Initiatives to support and empower GSDAS (e.g., support groups, legal clinics, academic and career resources, resource brokering)
	Community/City/County	o Training for law enforcement about GSD and suicide o Local fairness ordinances o Education and information for city departments and agencies about unique needs of GSDAS o Greater funding for GSD initiatives and community organizations o GSD stigma reduction o Suicide and mental health public messaging
	State	o Anti-discrimination legislation that explicitly protects people based on SOGIE o GSD training for licensed professionals o Suicide risk assessment and management training for licensed professionals o GSD and suicide trainings for client-facing staff o Increase funding for GSD programming and resources
Macro	Federal	o Anti-discrimination legislation that explicitly protects people based on SOGIE o Increase access to and availability of GSD affirming health and social services o Inclusion of SOGIE questions in national data collection initiatives o Promote positive representation of GSD in media o Promote hopeful messaging about suicide attempt survivorship in media

Figure 4.2. ***Intervention Recommendations***
Summary of intervention recommendations.

Figure 4.3. ***Screenshot of LTT homepage***
A screenshot of the landing page for the *Live Through This* advocacy project.

Appendix A: Biography

Sara Williams (she/her) is a PhD candidate in the Kent School of Social Work and a certified social worker in the state of Kentucky, where she has been practicing clinically since 2016. Sara is an award-winning researcher in the areas of suicide prevention and gender and sexual diversity. Her dissertation research focuses on the intersection of gender and sexual diversity and lived experience of suicide. Her areas of interest have ranged from individual experiences of suicide to social factors contributing to elevated suicide prevalence among gender- and sexually- diverse persons. This work is based on the conviction that to alleviate the intense suffering that frequently leads individuals to consider and attempt suicide, we must address social factors that are contributing to suffering and preventing gender and sexually diverse folx from living the life they want to live.

In addition to research, Sara's work involves awareness and training efforts that enhance people's understanding of gender and sexual diversity and improves suicide risk assessment and management services. She provides suicide prevention trainings for community members through the Louisville Mayor's Office for Safe and Healthy Neighborhoods and works closely with the State Suicide Prevention Coordinator on prevention efforts. Sara also serves on suicide prevention and diversity boards and committees with the American Foundation for Suicide Prevention, the American Association of Suicidology, Trauma-Resilient Communities, and the University of Louisville. Sara has served as co-chair for the Active Minds group on campus — which promotes mental health awareness and well-being among college students— as well as helping to plan the UofL Out of the Darkness Campus Walk for suicide prevention for the past 6 years.

Sara believes that to address the issues in our society, we have to address social injustices and interactions at all levels, and as a loss survivor with lived experience of suicide, Sara is determined to spread knowledge and hope wherever possible. Her goal is to promote a world of inclusion, connection, and safety for everyone in all aspects of her work.

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  - Summer 2021. Online.
  - Spring 2021. Online.
  - Summer 2020. Accelerated (6-week intensive) session. Online.
  - Spring 2020. Online.
- SW 641: **Social Justice and Injustice in Social Welfare Policies.** Core curriculum in MSSW program.
  - Summer 2020. Online.
  - Fall 2019. Online.
- SW 307: **Diversity, Oppression, and Social Justice Practice.** Core curriculum in BSW program.
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- October 24, 2017
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Kent School of Social Work, University of Louisville
- Development of study protocol and other documents for IRB applications
- Managing IRB applications, amendments, and reports for various Center projects
- Development of figures, graphics, etc. for research projects
- Development of research training manuals for Center staff and students

RESESARCH SUPPORT COORDINATOR
Louisville, KY | *May 2021 – Present*
Kent School of Social Work, University of Louisville
- Conducting literature searches and reviews
- Assisting faculty with development of study protocol and other documents relevant to IRB processes
- Development of reports and other documents for internal and external publication
- Development of figures, graphics, etc. for research projects

CO-INVESTIGATOR
Louisville, KY | *February 2022-Present*
Kent School of Social Work, University of Louisville
The State of Mental Health for LGBQ Inmates in Federal Prisons
- Conducting literature searches and reviews
- Development of study protocol and analysis plans
- Data analysis and reporting
- Development of reports and manuscripts for publication

CO-INVESTIGATOR
Louisville, KY | *May 2018 – Present*
Department of English, University of Louisville
Trauma-Informed Writing Pedagogy
- Conducting literature searches and reviews
- Development of study protocol and intervention materials
- Development of reports and other documents for internal and external publication
- Development of figures, graphics, etc. for research-related projects

CO-INVESTIGATOR
Louisville, KY | *2021-Present*
Funded by the Cooperative Consortium for Transdisciplinary Social Justice Research
Transgender Individuals with Chronic Illness and Disability
- Participating in study conceptualization and design
- Qualitative coding
- Preparing manuscripts for publication
- Preparing materials for conference presentations

CO-INVESTIGATOR
Louisville, KY | *2019 – Present*
Funded by the Cooperative Consortium for Transdisciplinary Social Justice Research
Understanding HIV Risk and Resilience among Adolescents who have been Orphaned by HIV/AIDS in Hai Phong, Vietnam Using Photovoice and Social Network Analysis.
- Conducting literature searches
- Participating in study conceptualization and design
- Qualitative coding
- Preparing manuscripts for publication
- Preparing materials for conference presentations
- Participation in conceptualization and design of Arts-Advocacy project

DOCTORAL RESEARCH FELLOW
Louisville, KY | *May 2018 – June 2019*
Cooperative Consortium for Transdisciplinary Social Justice Research, University of Louisville
- Working with interdisciplinary faculty and students
- Planning of professional development events and the Consortium's annual Symposium
- Managing social media and external marketing
- Preparing documents and reports for internal and external audiences
- Assisting in identifying funding opportunities and preparing proposals

SENIOR RESEARCH ASSOCIATE
Louisville, KY | *June 2016 – May 2018*
Department of Psychiatry and Behavioral Sciences, University of Louisville
NIH-funded psychotherapy dissemination study on computer-assisted Cognitive Behavioral Therapy for adults in a primary care setting
- Recruiting patients for participation in study, conducting informed consent process
- Ensuring timely collection of data from participants and working with others to enter and review data
- Developing and maintaining systems to track patient flow, study progress, and clinic activity
- Overseeing and implementing solutions to problems that arise related to study flow and patient concerns
- Leading and participating in grant team meetings, focus groups, and other professional meetings

- Generating documents and systems to maintain data, preparing enrollment projections and progress reports
- Providing training on depression and cognitive-behavioral therapy to medical providers

RESEARCH ASSISTANT
Louisville, KY | *October 2015 – June 2018*
University of Louisville
An interpretive phenomenological analysis exploring lived experience of suicide among gender and sexual minority suicide attempt survivors.

- Conducting literature searches
- Participating in study conceptualization and design
- Qualitative coding
- Preparing manuscripts for publication
- Preparing materials for conference presentations

SOCIAL WORK (CLINICAL) PRACTICE

OUTPATIENT CLINICAL THERAPIST
Louisville, KY | *February 2021 – May 2021*
Maryhurst Renewal
Outpatient Clinical Therapist

- Providing individual psychotherapy to individuals across the lifespan
- Conducting intakes, assessing mental health, and providing diagnoses
- Developing and implementing treatment plans for clients
- Collaborating with professionals from other disciplines to improve client outcomes
- Participating in individual and group supervision to improve and develop skills as a clinician

SENIOR RESEARCH ASSOCIATE
Louisville, KY | *June 2016 – May 2018*
Department of Psychiatry and Behavioral Sciences, University of Louisville
NIH-funded psychotherapy dissemination study on computer-assisted Cognitive Behavioral Therapy for adults in a primary care setting

- Performing screening evaluations and clinical assessments to ensure study participants meet all inclusion criteria
- Conducting semi-structured interviews to ensure accurate diagnoses of enrolled study participants
- Providing Cognitive Behavioral Therapy to study participants
- Participating in Cognitive Behavioral Therapy supervision

THERAPY PRACTICUM STUDENT
Louisville, KY | *August 2015 – April 2016*
University of Louisville Counseling Center

- Providing individual psychotherapy to students
- Conducting intakes, assessing mental health, and providing diagnoses
- Developing and implementing treatment plans for clients
- Collaborating with professionals from other disciplines to improve student outcomes
- Participating in individual and group supervision to improve and develop skills as a clinician
- Participating in planning and implementation of Counseling Center’s spring event

SERVICE

COMMITTEE MEMBER
February 2021 - Present
American Foundation for Suicide Prevention, Kentucky Chapter

- Policy Committee
- Project 2025 Committee

- Education Committee

FACULTY SEARCH COMMITTEE
Fall 2020 - Spring 2021
BSW Tenure Track Faculty Search, Kent School of Social Work, University of Louisville
Engaging in faculty hiring process with tenure track faculty, administrators, and other professionals.

SUICIDE PREVENTION EDUCATOR
June 2016 – October 2021
Ambassador Institute, Mayor's Office for Safe and Healthy Neighborhoods, City of Louisville
Developing education curriculum designed for community members to engage with content and gain skills and knowledge in suicide prevention; delivering suicide prevention presentations in quarterly Institutes; consulting with program managers, community leaders, and other educators.

APPOINTED COMMITTEE MEMBER
Fall 2019 - Present
Provost's Student Wellbeing Committee, Suicide Prevention Subcommittee, University of Louisville
Working with staff and faculty from across the University on provost-appointed committee to examine student student wellbeing and provide recommendations to enhance wellbeing and increase suicide prevention efforts on campus.

ADVISORY BOARD MEMBER
Fall 2019 - Present
Louisville Trauma Resilient Community Initiative
Working with stakeholders in Louisville to promote community resilience.

ADVISOR
Fall 2018 – Spring 2021
Active Minds, University of Louisville Chapter
Providing guidance to undergraduate and graduate student members of Active Minds, a student organization dedicated to raising mental health awareness among college students.

COMMITTEE MEMBER
2018 - 2021
LGBT Inclusivity Committee, American Association for Suicidology
Working with an interdisciplinary team of suicide prevention experts, students, clinicians, advocates, and community members to promote gender identity and sexual orientation diversity and presence at the annual national conference.

COMMITTEE MEMBER
2017 - 2021
Diversity Workgroup Committee, American Association for Suicidology
Working with an interdisciplinary team of suicide prevention experts, students, clinicians, advocates, and community members to promote diversity and inclusiveness in the organization.

CO-FOUNDER, ORGANIZER
Louisville, KY | *2016 - 2018*
University of Louisville Out of the Darkness Suicide Prevention Campus Walk
Planned and executed first annual Campus Walk (event exceeded fundraising and attendance goals); coordinated with national, community, and campus organizations; promoted event; organized and co-hosted event with other co-founder; developed and led committee for subsequent years

GRADUATE STUDENT MENTOR
Louisville, KY | *August 2016 – May 2017*
Kent School Student Association
Providing guidance and mentorship to Masters-level Social Work students at the Kent School of Social Work, University of Louisville.

CAMP COUNSELOR & VILLAGE LEADER
Golden Pond, KY | *June 2004 – Present*
Camp MARC – Annual summer camp for adults with intellectual and developmental disabilities
As camp counselor, working with adults with intellectual and developmental disabilities to provide a therapeutic and enriching camp experience for campers; as village leader, responsible for directing and mentoring counselors and ensuring the safety and wellbeing of campers.

PUBLICATIONS

Srivastava, A., Prost, S.G. & **Williams, S.M.** (2022). Mental health among lesbian, gay, bisexual and other non-heterosexual adults in United States prisons. *Current Psychology*. https://doi.org/10.1007/s12144-022-03777-6

Harris, L.M., **Williams, S.M.**, Nyerges, E.X. & Bloomer, R. (2022). Beyond #FreeBritney: Teaching Social Workers about Surrogate Decision Making through the Spears Case. *Journal of Social Work Education. DOI: 10.1080/10437797.2022.2119065*

Antle, B.F., Harris, L.M., Wright, J.H., Eells, T., Logsdon, A., **Williams, S.M.**, Katz, R., Cappicce, A., & Owen, J. (2021). Barriers to implantation of a technology based mental health intervention in a rural setting. *Contemporary Rural Social Work Journal, 13*(1). https://digitalcommons.murraystate.edu/crsw/vol13/iss1/2

Antle, B.F., Owen, J., Wells, M.J., Eells, T.D., Harris, L.B., Cappiccie, A., Wright, R.B., **Williams, S.M**., & Wright, J.H (2019). Dissemination of Computer-Assisted Cognitive-Behavior Therapy for Depression in Primary Care. *Contemporary Clinical Trials 78*, p. 46-52. https://doi.org/10.1016/j.cct.2018.11.001

Williams, S.M., Frey, L.M., Stage, D.L., & Cerel, J. (2018). The unique experiences of a dual identity: Exploring lived experience in gender and sexual minority suicide attempt survivors. *American Journal of Orthopsychiatry 88*(6), p. 691-700. http://dx.doi.org/10.1037/ort0000334

IN REVIEW AND IN PROGRESS

Srivastava, A., Prost, S.G., & **Williams, S.M.** (In Review). The State of the Data: Mental Health Among Sexual Minority Persons in the United States Federal and State Prisons.

Harris, L.M., Bloomer, R., **Williams, S.M.**, Osezua, V., Sato, D., Nguyen, T.D., Byun, K., & Hambrick, M. (In Review). “Our World Our Say”: Using photovoice to explore and respond to youth-identified systems risks in Vietnam. *Children and Youth Services Review.*

Bloomer, R., **Williams, S.M.** (In progress). “Equip me with the tools I need to be successful”: Cultivating realms of support for adjunct social work instructors.

Harris, L.M., Bloomer, R., **Williams, S.M.**, Osezua, V., Sato, D., Thang, N.D., Byun, K., & Hambrick, M. (In review). “The law is not strong enough to protect children”: Using photovoice to identify systems risks among youth orphaned due to HIV/AIDS in Vietnam.

NATIONAL CONFERENCE PRESENTATIONS

Bloomer, R., Brown, A., **Williams, S.M.** (2022). Critical consciousness building in youth OST spaces: A Photovoice project. Roundtable presentation. American Public Health Association Annual Conference.

Srivastava, A., Prost, S.G., & **Williams, S.M.** (2022). The State of the Data: Mental Health Among Sexual Minority Persons in the United States Federal and State Prisons. Oral paper presentation. American Public Health Association Annual Conference.

Williams, S.M., Stage, D.L., Frey, L.M., Harris, L.M., Antle, B.F., Gattis, M.N., & (2022). Stigma in the Suicide Stories of Gender and Sexually Diverse Attempt Survivors. Paper presentation. Suicide Research Symposium.

Harris, L.M., Bloomer, R., **Williams, S.M.**, Osezua, V., Sato, D., Thang, N.D., Byun, K., & Hambrick, M. (2021). "Our World, Our Say": The Use of Photovoice for Youth-Driven HIV Advocacy Efforts in Vietnam. Paper presentation at the International Congress of Qualitative Inquiry. May 2021. Urbana-Champaign, IL.

Williams, S.M. & Frey, L.M. (2020). The disclosure cycle: Coming out and suicide-related disclosure. Paper presentation at the American Association of Suicidology Annual Conference. April 2020. Portland, OR. (Accepted, unable to present due to COVID-19 pandemic restrictions.)

Williams, S.M., Frey, L.M., Antle, B.F., Barbee, A., & Frame, C. (2020). Love Notes: Developing healthy relationships and reducing suicidality. Poster presentation at the American Association of Suicidology Annual Conference. April 2020. Portland, OR. (Accepted, unable to present due to COVID-19 pandemic restrictions.)

Purdy, L.M., **Williams, S.M.,** Randall, J.M., & Harris, L.M. (2019). The impacts of lived experience as a youth in the child welfare system on direct care staff. Paper presentation at the International Congress of Qualitative Inquiry. May 2019. Urbana-Champlain, IL.

Williams, S.M. & Frey, L.M. (2019). Exploring college student typologies based on suicide experience, knowledge, and attitudes. Poster presentation at the American Association of Suicidology Annual Conference. April 2019. Denver, CO.

Williams, S.M., Brown, M., Cerel, J., Frey, L.M., Kheibari, A. (2018). Loss survivor perceptions of suicide: Comparing the United States and Japan. Paper presentation at the American Association of Suicidology Annual Conference. April 2018. Washington, DC.

Kheibari, A., Brown, M., Cerel, J., Frey, L.M., & **Williams, S.M.** (2018). Are suicide attitudes different in suicide attempt survivors? Paper presentation at the American Association of Suicidology Annual Conference. April 2018. Washington, DC.

Williams, S.M., Frey, L.M., Stage, D.L., & Cerel, J. (2017). The unique experiences of a dual identity: Exploring lived experience in gender and sexual minority suicide attempt survivors. Poster presentation at the American Association of Suicidology Annual Conference. April 2017. Phoenix, AZ.

Frey, L.M., Stage, D.L., Cerel, J., Sanford, R.L., Nadler, S., & **Williams, S.M.** (2017). In their own words: New research using attempt survivor narratives to inform professional practice. Panel presentation at the American Association of Suicidology Annual Conference. April 2017. Phoenix, AZ.

INVITED PRESENTATIONS

Williams, S.M. (2021). (Invited Presentation) Gender and Sexual Diversity in Social Work Practice. Trager Institute. Louisville, KY. November 2, 2021.

Williams, S.M. (2021). (Invited Presentation) Suicide Assessment and Management. Trager Institute. Louisville, KY. September 21, 2021.

Williams, S.M. (2021). (Invited Presentation) Gender and Sexual Diversity: Embracing diversity and Enhancing Wellbeing. Kentucky Alternative Education Summit. Eastern Kentucky University. July 23, 2021.

Williams, S.M. (2021). (Invited Presentation) Gender and Sexual Diversity in Social Work Practice. Field Education Supervisors Spring Conference. May 21, 2021.

Williams, S.M. (2021). (Invited Presentation) Gender and Sexual Diversity: Expanding Inclusion & Promoting Resilience. Coalition for the Homeless. May 20, 2021.

Bloomer, R. & **Williams, S.M.** (2021). (Invited Presentation) Trauma and Resiliency in Child Care and Youth Development Settings. Presentation for Play Cousins Collective, Louisville, KY. April 27, 2021.

Williams, S.M. (2021). (Invited Presentation) Preventing suicide and promoting resilience in gender and sexually diverse youth. CCC/PACS Virtual Conference: "What We Don't Know Can Hurt." April 8, 2021.

Williams, S.M. (2021). (Invited Presentation) Coping in a crisis: Suicide prevention and coping during COVID-19. One Love Louisville; Mayor's Office for Safe and Healthy Neighborhoods. Jan 26, 2021.

OTHER PRESENTATIONS

Williams, S.M. & Bishop, L.B. (2017). Computer-assisted cognitive-behavioral therapy for depression in primary care. Internal Medicine Grand Rounds. University of Louisville. Nov 1, 2017. http://www.louisvillelectures.org/imblog/2018/depression/primary/bishop

Gordon, B., Ambers, J., Buszkewicz, K., & **Williams, S.M.** (2017). Mental health and aging: Panel presentation and discussion. Mental Health and Aging Conference, Institute for Sustainable Health and Optimal Aging. Oct 25, 2017. Louisville, KY.

Williams, S.M. (2017). Youth suicide prevention. Educate, Connect, and Equip Youth Conference. Jul 22, 2017. Jeffersonville, IN.

Frey, L.M. & **Williams, S.M.** (2016). Youth suicide prevention—Suicide Prevention for Parents. Jefferson County Public Schools. Aug 2, 2016, Louisville, KY.

CREATIVE PROJECTS

Harris, L.M., **Williams, S.M.,** Osezua, V., Byun, K. Bloomer, R. & Sato, D (2020, March 21). Our World Our Say Photovoice Project [Video file]. https://www.youtube.com/playlist?list=PL3uBODfFB1KFXEnAmYH4MCGhMWlZdeFfU

Byun, K. Harris, L.M., **Williams, S.,** Osezua, V., Scoggins, C., Coleman, L., Bloomer, R. & Sato, D. (2020, Feb 21 – 2020, April 24). Our World Our Say Exhibition #2: Understanding HIV Risk and Resilience Among Adolescents Who Have Been Orphaned by HIV/AIDS in Hai Phong, Vietnam [Art-Advocacy Exhibition]. https://www.tk-21.com/TK-21-LaRevue-no105?lang=fr#Our-World-Our-Say-Exhibition-1

Byun, K. Harris, L.M., **Williams, S.,** Osezua, V., Scoggins, C., Coleman, L., Bloomer, R. & Sato, D. (2020, January 10 – 2020, February 6). Our World Our Say Exhibition #1: Understanding HIV Risk and Resilience Among Adolescents Who Have Been Orphaned by HIV/AIDS in Hai Phong, Vietnam [Art-Advocacy Exhibition]. https://louisville.edu/art/exhibitions/all/our-world-our-say

AWARDS & RECOGNITION

Banner Bearer, Kent School of Social Work & Family Science. December 2022 Commencement, University of Lousville.

Emergent Researcher Award. Day, M.L. & Williams, S.M. (2019-2020). Trauma-Informed Writing Pedagogy: A pilot study of an evidence-based training initiative. Conference on College Composition & Communication. Funding: $5,600.

George Orley Student Mental Health Advocate Nominee (2020). Outstanding student leadership in the area of campus mental health. Nominated by Sandy Robertson, DNP, APRN, PMHNP-BC, Aesha L. Uqdah, PsyD, HSP, Laura M. Frey, PhD, LMFT, and Geri Morgan, MSW.

Best Student Poster Presentation (2019). For poster: Exploring college student typologies based on suicide experience, knowledge, and attitudes. American Association of Suicidology Annual Conference, Denver, CO.

Outstanding Graduate/Professional Student of the Year (2018). University of Louisville Student Involvement. University of Louisville: Louisville, KY.

CERTIFICATIONS & TRAININGS

- **Certified Trainer.** Assessing and Managing Suicide Risk (AMSR): Core Competencies for Substance Use Disorder Professionals. Certified in March 2021.
- **Certified Trainer.** Assessing and Managing Suicide Risk (AMSR): Core Competencies for Health and Behavioral Health Professionals Working in Outpatient Settings. Certified in October 2020.
- **Certified Trainer.** Assessing and Managing Suicide Risk (AMSR): For Direct Care Staff Working in Outpatient Health and Behavioral Health Settings. Certified in October 2020.

- NAVIGATE: Helping Families Navigate Suicide Risk, University of Louisville Center for Family and Community Well-Being, 2019
- LGBT Health and Wellness Competency Certificate, University of Louisville, 2016
- QPR (Question, Persuade, Refer) Gatekeeper Training, 2015
- Cognitive-Behavioral Therapy Seminar, 2015
- Mental Health First Aid (Adult), 2015
- Youth Mental Health First Aid, 2015
- Promoting Positive Behavior in Schools, 2014
- Darkness to Light Stewards of Children, 2013

PROFESSIONAL MEMBERSHIPS

- Society for the Scientific Study of Sexuality, member since September 2018
- American Association of Suicidology, member since October 2015
- National Association of Social Workers, member since August 2014

MEDIA SPOTLIGHTS

King, N. (2020). Our World, Our Say: Hite exhibition showcases photography of Vietnam youth affected by HIV. UofL News. Published January 15, 2020. Retrieved from https://www.uoflnews.com/section/arts-and-humanities/our-world-our-say-hite-exhibition-showcases-photography-of-vietnam-youth-affected-by-hiv/

Hebert, M. (2018). Gender and sexually diverse suicide attempt survivors: Findings from a recent phenomenological study. Aired October 9, 2018. *UofL Today with Mark Hebert.* Retrieved from https://soundcloud.com/uofl/10-09-18-ult-prost-lennon-frey-williams

Ward, T. (2018). March to prevent suicide held at UofL. WLKY News. Published April 8, 2018. Retrieved from https://www.wlky.com/article/march-to-prevent-suicide-held-at-uofl/19714221

Bassett, T. (2017). Suicide prevention. *Take it from Tara* on Crescent Hill Radio. July 17, 2017. Louisville, KY. Retrieved from https://www.facebook.com/CrescentHillRadio/videos/1733288653361077/?hc_ref=ARTCedCpA8JMlgiTZcUwc1JMJ_PMvnKfR6ZqFzRT7qhM415HEg2Ty_3GBQHdJpo8H0k&pnref=story

Massengill, D. (2017). Students walk for suicide awareness. *The Louisville Cardinal, 92*(27), p. 6. Published April 11, 2017. Retrieved from https://issuu.com/louisvillecardinal/docs/april_4__2017

WDRB (2017). U of L students hold 'Out of the Darkness' suicide prevention walk. Aired April 9, 2017. WDRB: Louisville, KY. Retrieved from http://www.wdrb.com/story/35107440/u-of-l-students-hold-out-of-the-darkness-suicide-prevention-walk#.WOsftUfd_2Y.facebook

WAVE3 News (2017). UofL hosts suicide awareness walk. Published April 9, 2017. WAVE3: Louisville, KY. Retrieved from http://www.wave3.com/story/35107943/uofl-hosts-suicide-awareness-walk

McGee, C. (2016). Inaugural suicide prevention walk raises more than triple its goal. University of Louisville News. Published April 25, 2016. Retrieved from http://uoflnews.com/post/uofltoday/inaugural-suicide-prevention-walk-raises-more-than-triple-its-goal/