THE STRUGGLE AND STRENGTH OF SEXUAL MINORITIES AND SUICIDALITY: A QUALITATIVE INTERPRETIVE META-SYNTHESIS

by

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I also wish to acknowledge those who struggle with who they are and those who struggle with suicide.

This work is dedicated to those who have died by suicide – may your stories help us to work towards overcoming suicide.

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ABSTRACT

THE STRUGGLE AND STRENGTH OF SEXUAL MINORITIES AND SUICIDALITY:

A QUALITATIVE INTERPRETIVE META-SYNTHESIS

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The researcher conducted a Qualitative Interpretive Meta-Synthesis (QIMS) of the intersection of sexual minority status and suicidality. Seven qualitative research studies were identified which included the stories of members of the gay, lesbian, bisexual, and transgender (GLBT) community (*n=96*). Five overarching themes were discovered: Internal Struggle, External Struggle, Isolation, Internal Strength, and External Strength. The Interpersonal Theory of Suicide was used to guide the interpretation of the findings of this QIMS in order to expand the understanding of suicide as it applies to the GLBT community. Implications for research, practice, and policy are discussed.

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INTRODUCTION

1.1 Rationale

1.1.1 Prevalence of the Problem

Suicide is a worldwide problem that has been at the forefront of many mental health and community organizations around the globe. The World Health Organization (2011) reported that in 2000, one million persons died by suicide and that at least 10 to 20 times that many people attempted suicide. Suicide is indeed the topic of much research of mental health and sociological professionals; however, the increasing volume of research appears to overlook the gay, lesbian, bisexual, transgendered, and transsexual, (GLBT[1]) population as a whole and as a part of society (Remafedi et al., 1998). Many of the studies found pertaining to suicide make no mention of sexual orientation as a factor whatsoever (e.g., Arria et al., 2009, Clum & Febbraro, 1994; Jeglic et al., 2007; Haas, Hendin, & Mann, 2003; Schwartz, 2006). When studies do include sexual orientation as a factor or demographic, there is typically a lumping together of the results from any participant who identified as being GLBT or classifying the results of all gay males, bisexual males, lesbian females, bisexual females, and transgendered individuals into the same category (e.g., Barrios et al., 2000; Haas et al., 2010; King et al., 2008; Mutanski et al., 2010; Rosario, Schrimshaw, & Hunter, 2005; Westefeld, 2001; Wilcox et al., 2010).

[1] GLBT is a shortened version of the full acronym for the sexual and gender minority community. The full acronym GLBTQIA is not used here because the QIA (i.e., queer, questioning, intersex, androgynous, and asexual) were not addressed in the literature included in this study, thus, the full version of the acronym was not employed unless otherwise stated. The acronym itself does not include every word used by sexual and gender minorities to describe themselves (e.g., genderqueer, two-spirit, metagender, omnisexual, pansexual). For a full discussion on this, see Meyer, 2010.

1.1.1.2 Lack of Research on GLBT Populations

Even though GLBT persons are at higher risk for suicide and suicide attempts, there is relatively limited research on the suicidality of persons who identify as gay, lesbian, bisexual, transgendered, or transsexual (Haas et al., 2010). Part of the issue may be a lack of reliable measures concerning sexual orientation (Heath & Euvard, 2007). Mutanski et al. (2010) point out that sexual orientation is not a demographic variable in most suicide and mental health studies and recommend that doing so may provide insight into the inequalities in mental health services for GLBT persons.

As stated above, many studies tend to lump together all members of the GLBT community as one demographic variable rather than separating each one out. This is especially important as persons who are questioning are largely understudied even within the GLBT community (Espelage & Swearer, 2008). Questioning persons are those individuals who are unsure about their sexual orientation or sexual attractedness, and such a distinction is important to make. Espelage and Swearer (2008) conducted a study on high school students' psychological outcomes based upon sexual orientation and noted that questioning youth had a higher likelihood of depression, suicidal thoughts, drug and alcohol use, and less support from parents. The importance of looking at each individual sexual orientation rather than at the GLBT community as a whole would provide much needed understanding of suicide among these individuals.

1.2 Purpose Statement

The primary purpose of this study was to explore the experiences of suicidality among gay, lesbian, bisexual, and transgendered individuals through Qualitative Interpretive Meta-Synthesis (QIMS). In doing so, the identification of themes that were discovered across the selected qualitative studies assisted in determining what commonalities exist. Through this discovery, greater insight and depth into the phenomenon of being a sexual minority struggling with suicidal thoughts and ideations was offered. This QIMS was guided by the theoretical

framework of the Interpersonal Theory of Suicide which contends that suicidality is comprised of one's perceived burdensomeness, thwarted belongingness, and acquired capability for suicide (Van Orden et al., 2010). This theory has been applied to several different populations, but has yet to be applied to the GLBT community.

1.3 Objectives

Specific objectives formulated to guide this study included to:

1. Determine what themes occurred across different qualitative studies in regards to sexuality and suicidality;
2. Determine what influence social supports have on suicidality of GLBT persons; and
3. Determine applicability of the Interpersonal Theory of Suicide to the GLBT population.

1.4 Definitions

- Bisexual – "A sexual orientation for a person who is attracted to some members of both sexes to varying degrees" (Meyer, 2010, p. 141).
- Gay – "The preferred term for a person who engages in same-sex relationships and identifies as a member of this [GLBT] community. It is preferred above the term 'homosexual' as homosexual has scientific meaning that apply specifically to same-sex behaviors and does not consider a person's identities and relationships. 'Gay' can refer to both men and women, although many women prefer the term lesbian" (Meyer, 2010, p. 142).
- Lesbian – "The preferred term for a woman who engages in same-sex relationships and identifies as a member of this [GLBT] community" (Meyer, 2010, p. 144).
- Suicide attempt – "(a) self-initiated, potentially injurious behavior; (b) presence of an intent to die; and (c) nonfatal outcome" (Van Orden et al., 2010, p. 576).
- Suicide – "those cases in which a suicide attempt results in death" (Van Orden et al., 2010, p. 576).

- Transgender – “An umbrella term, like ‘trans’ for individuals who blur the lines of traditional gender expression. Usually including transsexual and sometimes also including cross dressers. These individuals may or may not choose to change physical characteristics of their bodies or legally change their sex” (Meyer, 2010, p. 145).
- Transsexual – “… A term used to describe a person who lives in a gender that is different from the sex they were assigned at birth. Many transsexual people opt to undergo physical transformations such as surgery or hormone therapy so that their bodies more closely align with social norms for their gender identities” (Meyer, 2010, p. 145).

CHAPTER 2

REVIEW OF RELATED LITERATURE

2.1 Interpersonal Theory of Suicide

2.1.1 Theory Explanation

Within the vast research on suicide, the Interpersonal Theory of Suicide offers three assumptions concerning the causes of suicidality: thwarted belongingness (e.g., “I am alone”), perceived burdensomeness (e.g., “I am a burden”), and acquired capability for suicide. In the theory, it is explained that when thwarted belongingness and perceived burdensomeness exist together, it creates a desire for suicide which is separate from the third factor of capability for suicide. However, when all three are present in an individual, it creates an environment within a person for lethal, or near lethal, suicide attempts (Van Orden et al., 2010; Van Orden, Merrill, & Joiner, 2005).

2.1.1.1 Thwarted Belongingness and Perceived Burdensomeness

Within the construct of thwarted belongingness, Van Orden et al. (2010) provide two comprising dimensions: loneliness (e.g., “I feel disconnected from others”) and absence of reciprocal care (e.g., “I have no one to turn to and I don’t support others”). Within both dimensions are indicators that influence each sub-construct. For example, loneliness may be influenced by living alone, few social supports, non-intact family, seasonal variation, or number of friends. Absence of reciprocal care may be influenced by social withdrawal, loss through death or divorce, childhood abuse, or family conflict. The idea that social isolation has an effect on suicidality is not new; it has been noted as one of the “strongest and most reliable predictors of suicidal ideation, attempts, and lethal suicidal behavior” (Van Orden et al., 2010, p. 581). It is

important to note that thwarted belongingness is described as changing rather than stable by the theory's authors; in other words, a person's sense of connectedness, or loneliness, and one's sense of having relationships with reciprocated caring change throughout the lifespan and are not a fixed feature. Likewise, it is noted by Van Orden et al. (2010) that thwarted belongingness is a stand-alone factor; it is not indicative of a desire for death, but when it is found with perceived burdensomeness, suicidality may emerge.

As with thwarted belongingness, perceived burdensomeness has two dimensions: liability (e.g., "My death is worth more than my life to others) and self-hate (e.g., "I hate myself"). Liability can be identified by indicators such as expendability, belief that one is a burden on family, distress from physical illness, or distress from unemployment. Self-hate can be indicated by low self-esteem, self-blame and shame, or agitation – described by Van Orden et al. (2010, p. 584) as "experiencing a degree of self-hatred and anguish that is so elevated as to manifest physiologically." Just as thwarted belongingness changes over time within a person, perceived burdensomeness varies in severity across a lifespan according to time and changes in relationships. In the suicide notes of persons who died by suicide, it was found that they expressed feeling more burdensome than those who survived their suicide attempts (Van Orden, et al., 2010). As stated previously, the concurrence of both thwarted belongingness and perceived burdensomeness, rather than an occurrence of only one, leads to a desire for death in an individual. It is rightly noted that while both of these dimensions are inter-related, they are distinct (Van Orden et al., 2010, p. 585):

> One could argue, for example, that if an individual's need to belong is completely thwarted, perceptions of burdensomeness are not possible because human connections are a prerequisite for the development of perceived burdensomeness. We suggest that this is not the case because of the presence of perceptions of connections to others does not equate with meeting the need to belong. In other words, the construct of thwarted belongingness is not synonymous with lack of human

connections, and conversely, the need to belong is not fulfilled by the mere presence of perceptions of connections to others.

2.1.1.2 Acquired Capability for Suicide

In addition to a combined feeling of thwarted belongingness and perceived burdensomeness, in order for an individual to perform a lethal or non-lethal attempt of suicide, the capability to do so must exist. However, one's capability to perform a suicidal behavior is not inborn and therefore must be learned or acquired (Van Orden et al., 2010; Van Orden et al., 2005; Smith et al., 2010). This is accomplished, according to Smith et al. (2010, p. 871), by "repeated exposure to psychologically provocative or fear-inducing and physically painful life events." That is, non-lethal suicide attempts, trauma exposure, non-suicidal self-harm, and high pain tolerance are all factors that can influence a person's capability for suicidal behavior. Van Orden et al. (2010) identify two dimensions for acquired capability: lowered fear of death and an elevated physical pain tolerance; likewise, the theory's authors identify impulsivity, exposure to suicidality, combat exposure, and suicide attempts as indicators of risk for acquired capability. The development of an acquired capability is also a process. The individual must have a repeated exposure to events that cause a lowered fear of death and an elevation of tolerance to physical pain.

2.1.1.3 Lethal and Near-Lethal Suicide Attempts

Van Orden et al. (2010) hypothesize that having either or both a feeling of thwarted belongingness and perceived burdensomeness create in an individual the desire for death or passive suicidal ideation, rather than an active suicidal ideation. In order for an individual with a passive suicidal ideation to come to have an active suicidal ideation, the person must also possess a hopelessness about their feelings of both thwarted belongingness and burdensomeness, thus moving an individual's thoughts from passive – "I would be better off dead" – to active – "I want to kill myself" (Van Orden et al., 2010). Yet, without both perceived burdensomeness *and* thwarted belongingness, it is likely that an active suicidal ideation is not

present. In order for an individual to develop hopelessness regarding thwarted belongingness and perceived burdensomeness, the individual must believe that both feelings are not going to change for the better. In other words, a person's desire for suicide develops at the intersection of thwarted belongingness, perceived burdensomeness, and hopelessness that positive change related to belongingness and burdensomeness will not occur (Van Orden, et al., 2010).

Therefore, in light of an individual having thwarted belongingness, perceived burdensomeness, and hopelessness about those feelings, an individual must have been desensitized to the inborn fear of death and suicide in order to engage in suicidal behaviors. Once all of these constructs and dimensions are in place, an individual is more likely to engage in lethal or near-lethal suicide attempts (Van Orden et al., 2010).

2.1.2 Application of Interpersonal Theory of Suicide to GLBT Community

As previously discussed, the Interpersonal Theory of Suicide relies heavily on feelings of perceived burdensomeness and thwarted belongingness. Persons who identify as gay, lesbian, bisexual, transgender, transsexual, and transsexual may experience these two feelings at an exaggerated rate due to their sexual orientation or gender identity. Members of the GLBT community experience heightened levels of alienation, social exclusion, social stigma, internalized sense of self-shame, social stress, substance abuse, mental disorders, lower levels of support, and lower self-esteem than their heterosexual counterparts (Haas et al., 2010; King et al., 2008; Mutanski et al., 2010; Rosario, Schrimshaw, & Hunter, 2005, Westefeld et al., 2001). Each of the factors are included within the Interpersonal Theory of Suicide. The National Coalition of Anti-Violence Programs (NCAVP) found in their annual report on hate violence against the GLBT community that physical violence, verbal harassment, threat, and harassment occupied four out of the five most frequent types of anti-GLBT violence perpetrated in 2011 (NCAVP, 2012). Experiencing such acts of violence may also exacerbate the perceived burdensomeness, thwarted belongingness, and the acquired capability for suicide GLBT

persons might experience. Similarly, murders of GLBT persons rose 11% in 2011 from 2010 (NCAVP, 2012).

Therefore, it may stand that due to increased levels of experience for the GLBT community members on the constructs, dimensions, and indicators of risk, the Interpersonal Theory of Suicide is applicable to not only the general population, but specifically to the GLBT community. However, there was found no research concerning the GLBT community and the Interpersonal Theory of Suicide.

2.2 Suicidal Behaviors and Ideation in the GLBT Community

Despite a rise in concern and overall awareness of suicide within the GLBT community, and an overall higher rate of suicide within the community, there is relatively little research on the topic (D'Augelli et al., 2005; Haas et al., 2010; King et al., 2008; Rosario, Schrimshaw, & Hunter, 2005; Silenzio et al., 2007; Westefeld et al., 2001). Further, it is difficult to accurately document every single suicide of a GLBT person due to the nature of sexuality; there is not a reliable way to determine a person's sexuality (Haas et al., 2010). An individual may be struggling with their sexuality and may not tell anyone; may not have been "out;" their sexuality may be hidden by the family after a suicide; and the investigating coroner or medical examiner will likely not include such information on the death certificate. While many studies have attempted to perform a "psychological autopsy"[2] with suicide victim's families, friends and others, non-disclosure of sexual orientation proves this process difficult to rely upon (Haas et al., 2010). In the same way, several studies have difficulties in determining suicidality within the GLBT community due to a lack of definition and recruiting issues. Definitions within the community itself of sexual orientation and gender identity make it difficult to produce definitive

[2] A psychological autopsy "can be defined as *a procedure for the reconstructing an individual's psychological life after the fact*, particularly the person's life style and those thoughts, feelings, and behaviors manifested during the week preceding death, in order to achieve a better understanding of the psychological circumstances contributing to death (Clark & Horton-Deutsch, 1992: 144)" (Maris, Berman, & Silverman, 2000, p. 66).

and generalizable results in addition to difficulty in finding respondents willing to disclose their sexuality (King et al., 2008).

Stigma commonly associated with sexual orientation and gender identities, as well as individual and institutional discrimination, are factors that must be addressed in order to understand some of the issues surrounding research in the GLBT community (Haas et al., 2010; Westefeld et al., 2001). The “coming out” process is an important factor to also consider. A GLBT person experiences emotional and interpersonal stress due to rejection by family or friends that can affect suicidality; likewise, the effect of not coming out to family and friends can have negative emotional properties (Haas et al., 2010) as can living in an environment that is not tolerant of sexual minorities. A study was conducted that found GLBT adults who live in states without protective laws and policies in place were almost five times as likely to have two or more mental disorders as those who lived in states that had protective laws and policies (Haas et al., 2010).

2.2.1 Age-Related Risk Among GLBT

A common risk factor found in the literature was related to age within the GLBT community. Statistics related to prevalence within different age groups greatly varies and consideration of demographics and geographical location of the respondents must be taken into account. Within most studies, distinction is also made between those reporting thoughts of suicide and those reporting suicide attempts.

2.2.1.1 GLBT in Adolescence

Adolescence was found to be the most researched age group and was found to have the highest risk for suicidality. The attention towards GLBT youth and adolescents began with the seminal report by United States Secretary of Health and Human Services (HHS) Secretary in 1989, which showed that GLBT youth are two to three times more likely to attempt suicide than their heterosexual counterparts (Cochran & Mayes, 2000; Faulkner & Cranston, 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi, 2002; Russell & Joyner, 2001).

Kitts (2005) reported that 15 studies within the last 20 years showed a wide range of suicide attempts, 20 – 40 %, among GLBT adolescents. Similarly, it was found that most GLBT who attempt suicide make their first attempt before the age of 25 (Paul, et al., 2002).

In their random sampling of Massachusetts students, Faulkner and Cranston (1998) found that same-sex attracted students, when compared to their heterosexual counterparts, were 50% more likely to report having considered suicide within the last year—two times as many reporting attempting suicide, and eight times as many having attempted suicide four or more times. Likewise, another study states that since the 1989 HHS report, non-randomized studies found prevalence rates of thoughts of suicide from 48% to 76% and attempts at 29% to 42%, but that more recent studies place attempts among GLBT at 7% to 13% (Russell & Joyner, 2001).

2.2.1.2 GLBT in Adulthood and Late Adulthood

In his meta-analysis of studies in North America and Europe, Lewis (2009) claimed that rates of prevalence among GLBT adults ranged from 8 to 25% compared to their heterosexual counterparts' rates of 1 to 13%. Another study reported that across a lifetime, gay men – as compared to heterosexual men – are five times more likely to have attempted suicide (Cochran & Mays, 2000). While there are relatively few studies concerning sexuality minority status and aging, the risks found for GLBT persons who are in late adulthood or are elderly is elevated and has been found to be related to social support networks, absence of a romantic partner, loneliness, and internalized homophobia among other things (Grossman, D'Augelli, & O'Connell, 2002).

2.3 Significance of the Study

Suicidality amongst the GLBT community within the United States population is greatly understudied. As has been shown, the GLBT population has a greater risk for suicidality than its heterosexual counterpart. This is likely influenced by the challenges faced by GLBT persons due to increased vulnerability of the factors leading to suicidality (i.e., perceived

burdensomeness, thwarted belongingness, and acquired capability for suicide). Large studies have been conducted concerning suicide amongst the general population and there is a growing volume of work relating to suicide amongst the GLBT population; however, the Interpersonal Theory of Suicide is a lacking component in this growing body of research. Lack of research has created a gap in understanding of how all of the factors outlined in the Interpersonal Theory of Suicide interact with each other, if at all, for GLBT persons.

CHAPTER 3

METHODOLOGY

3.1 Design

This study is a Qualitative Interpretive Meta-synthesis (QIMS) that investigates the relationship between suicidality and minority sexuality across existing qualitative research. The purpose of performing a QIMS is to "create a synergy of qualitative findings" (Aguirre & Bolton, Forthcoming, p. 8). There are different ways in which qualitative research is synthesized (Sandelowski, Docherty, & Emden, 1997); two established formulas of qualitative synthesis include syntheses that employ quantitative (or aggregate) methods and those that employ qualitative (or interpretive) methods (Aguirre & Bolton, Forthcoming; Bondas & Hall, 2007; Sandelowski, Docherty, & Emden, 1997). For this study, the selection of the interpretive method developed by Aguirre and Bolton (Forthcoming) is particularly intentional.

Specifically, QIMS is defined as

> a means to synthesize a group of studies on a related topic into an enhanced understanding of the topic… wherein the position of each individual study is changed from an individual pocket of knowledge of a phenomenon into part of a web of knowledge about the topic where a synergy among studies creates a new, deeper and broader understanding (Aguirre & Bolton, Forthcoming, p. 8)

The particular procedures for conducting a QIMS are broken down into six steps after a research question is determined: sampling, theme extraction, theme synthesis, triangulation

(methods, sources, analysts, and theory), description of synergistic understanding, and credibility reporting (Aguirre & Bolton, Forthcoming).

3.2 Instrumentation

Within qualitative research, the researcher is the main instrument for the study. Therefore, here is a description of my credibility to conduct this qualitative interpretive meta-synthesis. At the time of this research, I have been enrolled in The University of Texas at Arlington Master's of Science in Social Work program for approximately two years and have served as an advanced direct practice intern at the Center for Clinical Social Work of The University of Texas at Arlington. While there, I engaged in delivering supervised counseling services to numerous clients, many of whom presented with suicidal thoughts and ideations. I have also undergone trainings pertaining to the treatment and delivery of services to individuals presenting with suicidal thoughts and ideations.

I also identify as a gay male and have identified as such for approximately five years. My experiences as a gay male and of coming out as a gay individual have included struggling with depression and suicidal thoughts. Likewise, I have also had close friends who died by suicide. Since I have such a personal connection with the topic of this QIMS, I relied upon triangulation with my chairperson, in order to ensure that my experiences and biases do not unduly influence the synthesis.

3.3 Sampling Process

The studies included in this QIMS were obtained through searches on PsycARTICLES, Academic Search Complete, Education Abstracts (H.W. Wilson), ERIC, Health Source: Nursing/Academic Edition, Legal Collection, LGBT Life, MedicLatina, MEDLINE, Military & Government Collection, Professional Development Collection, Psychology and Behavioral Sciences Collection, PsycINFO, Social Work Abstracts, TOPICsearch, and ProQuest Theses and Dissertations concerning suicidality, social supports, and sexual orientation. The following search terms were employed in various combinations:

1) suicid* (the use of an asterisk in the searches performed for this QIMS was employed in order to search for all the variations, e.g., suicide, suicidality, suicidal)

2) social supports

3) homosexuality

4) sexual orientation

5) gay men

6) lesbian

7) bisexual

8) questioning

9) sexuality

10) qualitative

Other criteria established for inclusion within the study included that the study is qualitative in nature, is written in English, and is a peer-reviewed journal article, thesis, or dissertation. Research using mixed methods or quantitative data were excluded from the study. All of the mixed methods studies that were found during the search did not include substantive qualitative information. Studies were reviewed by title, abstract, and detailed reading of article (See Figure 1 for a detailed quorum chart of the search process). There were 431 relevant studies that were screened by their title; and of those, all but 25, were excluded after they were deemed not relevant. The remaining 25 were retrieved for a detailed assessment. After the detailed review, some were excluded due to mixed methodology, lack of substantive discussion concerning suicide or suicidality, and lack of sufficient methodological adherence to the qualitative research method. This led to the final seven articles representing research from six different research studies. Upon selection of these, there was triangulation with the chairperson of the thesis committee to verify the selection for inclusion in this QIMS.

The final sample includes six studies reported in seven research articles published between 1998 and 2012. Two articles were found to present findings from the same research

study (McAndrew & Warne, 2010; McAndrew & Warne, 2012). The second article (2012) was included due to expanded reporting on one of the themes reported in the first article. This QIMS reports upon the experiences of sexual minorities and their experiences with suicidality (*n=96*). All research articles included in this QIMS deal with sexuality and suicidality, in addition to social supports and other mental health issues (e.g., depression, anxiety). The range of ages represented in the included studies is 14 to 82; the studies included mainly gay males. Two of the studies included some lesbian, bisexual, and transgendered persons. The races and ethnicities of the participants in the studies were diverse and included White European, American Caucasian, Hispanic, African American, Asian, Jamaican, and Bi-racial. Studies in this QIMS were conducted using several different methodologies including grounded theory, case study, consensual qualitative research method, basic interpretive qualitative design, and discourse analytic approach. For complete information regarding the demographics of studies included in this QIMS, see Table 3.1.

3.4 Triangulation

To ensure that this study meets the standard for trustworthy qualitative research (Patton, 1999), triangulation was employed. Triangulation is best described as a process by which the researchers engage in maintaining the trustworthiness of the research. Patton (1999) concisely explains:

> …triangulation is based on the premise that no single method ever adequately solves the problem of rival explanations. Because each method reveals different aspects of empirical reality, multiple methods of data collection and analysis provide more grist for the research mill. (p. 1192)

There are four types of triangulation: sources, methods, analysts, and theory (Patton, 1999); in QIMS, triangulation within the four types has additional levels (Aguirre & Bolton, Forthcoming) as demonstrated in this study: 1) source triangulation was present given that there were multiple participants in each of the included studies and there were multiple studies; 2)

method triangulation is present due to the use of varied data collection methods across the individual studies; 3) analyst triangulation was present within most of the included studies and a second layer was included with triangulation among the researcher and his thesis chairperson; and 4) theory triangulation was present due to the use of multiple theoretical approaches to qualitative research across the studies.

3.5 Theme Extraction and Data Translation

Once research articles that met the inclusion criteria were identified through triangulation with the Thesis committee chairperson, theme extraction took place by identifying the original themes as presented in the studies (Table 3.2). Presentation of themes in the original phrasing presented by the authors who conducted the individual studies is an important aspect in maintaining the integrity of the original authors' interpretations of their findings. The next step concerning this QIMS was data translation—the synergistic process of identifying themes across the different studies. This process entailed detailed reading and coding of the articles in order to identify themes that emerged across the studies to further the knowledge of the phenomenon. Finally, data translation was conducted through the description of synergistic understanding. In this process, the integration of the identified over-arching themes is brought together, with the assistance of the aforementioned types triangulation, to develop a description and deeper understanding of the phenomenon (Aguirre & Bolton, Forthcoming) that better informs health care professionals providing services to suicidal GLBT persons. The QIMS resulted in five themes across the six studies further enhancing understanding of suicidality as it relates to sexuality: Internal Struggle, External Struggle, Isolation, Internal Strength, and External Strength.

CHAPTER 4

RESULTS

4.1 Synergistic Translation

The themes that emerged from the translation of the six research studies are Internal Struggle, External Struggle, Isolation, Internal Strength, and External Strength. A discussion of each theme follows with supporting quotations. Table 4.1 illustrates how the themes extracted from the original studies translated into these five themes.

4.1.1 Internal Struggle

The first theme, Internal Struggle, speaks to the conflict felt by the participants inside their own inner self with being homosexual, e.g., recognizing one's difference from others, coming out, and internal homophobia. Internal struggle emerged clearly in all of the research articles. Within this theme there were three sub-themes: (1) knowledge of different-ness; (2) negative thoughts towards self; and (3) a wish to be heterosexual.

4.1.1.1 Knowledge of Different-ness

Many of the participants related a sense of knowing very early that they were different in some way from their peers: "It was when I was about seven or six, it was just an awareness, just an awareness I was different, but it was a long, long time before I put a word to it" (gay male[3]) (McAndrew & Warne, 2010, p. 95).

> When I was a little boy, I, I didn't have any awareness of my sexuality really . . . and then as I grew a little bit older I was always bullied at school and called poof and nancy

[3] Throughout this chapter, quotes with the sexual orientation or identity of the partipcipant were included where it was made available or known in the text. For example, with this quote from McAndrew & Warne (2010), all of the participants were described as "gay" and "male." However, not every quote used in this chapter was labeled in the original studies. Some studies only mention sex and/or gender, while others offer no demographic information.

> boy, you know, and the rest . . . this was at primary school. (gay male) (McAndrew & Warne, 2012, p. 350)

Though they were aware of being different, it was not until much later they were able to put a name to it:

> When I was in primary school, I had crushes on other boys . . . and I would be at home and I'd be thinking about sort of cuddling another boy or whatever, but I didn't equate that then with anything sexual. (gay male). (McAndrew & Warne, 2012, p. 350)

The knowledge of this different-ness contributed to a deliberate distancing of oneself from others for fear of being discovered and consequently rejected: "I think fear, really, to be honest. I isolated myself quite deliberately from others. I became aware this is how I am, I was obviously aware that other people might not like that and there might be consequences" (gay male) (McAndrew & Warne, 2012, p. 351). This fear of being discovered also contributed to negative thoughts about oneself. Many participants in the McAndrew and Warne (2012) study reported starting self-destructive behaviors and feeling disgust towards oneself.

4.1.1.2 Negative Thoughts Toward Self

After experiencing their self-knowledge of different-ness, participants reported developing a negative sense of self:

> It's more to do with me feeling awkward about myself, having these thoughts makes me defensive. . . . I'm just hiding myself away and I try to slip out at night, which is funny, sometimes and I run to the co-op and its quarter to 10 and it's got dark, and I think now I can slip out of the house. (gay male) (McAndrew & Warne, 2010, p. 96)

Likewise, participants reported that this played a part in having to be constantly aware of their surroundings, worried that they would be found out at any moment, adding to their internal struggle: "It almost feels like it's not what's meant to be, I can feel sort of exposed I don't feel safe I feel like I'm going to crumble if someone challenges me about it…" (gay male) (McAndrew & Warne, 2010, p. 96). This constant feeling of being watched played a part in

some participants' lack of self-care and self-destructive behaviors: "I started to get very self-destructive . . . I didn't care about myself . . . I was frightened, I didn't know who to turn to. It was just so tiring, pretending, mentally tiring" (gay male) (McAndrew & Warne, 2010, p. 96). Some participants also reported that they had difficulty accepting their own sexuality and that this sometimes contributed to a constant worrying:

> As one teen put it, 'Right now, I'm not really, I don't really accept it . . . it feels like there's a weight on me.' The other adolescent, speaking about the hardships of being gay, lamented, 'I wouldn't choose to be gay. I'm not going to lie. I really did try to be straight because I don't really want to live my life worrying about this and that'. (Diamond et al., 2011, p. 139)

4.1.1.3 A Wish to be Heterosexual

Another common experience in participants' internal struggle was a strong wish to no longer have same-sex attractedness and to be heterosexual. It was reported that this took a lot of emotional and mental energy to attempt this (Curry, 2009). Another common experience was from participants that God would help them to rid themselves of their homosexuality: "I used to try and hurt myself a lot thinking that if I punished myself that God would change me. He (God) would see that I was being authentic and that I really wanted to be straight" (gay male) (Curry, 2009, p. 103). Wishing to be heterosexual was reported to be a common experience amongst most gay persons: ". . . you'll never find a gay person who won't say that at one time in their life they wished they were straight or that it would just be so much easier if they were straight . . ." (Fenaughty & Harré, 2003, p. 15).

4.1.2 External Struggle

External Struggle, the second theme, describes the conflict felt by the participants with their social supports—or lack thereof, and within hostile environments. Within this theme there is the greatest connection with depression and suicide, as reported by the participants. While the discussion of Internal Struggle demonstrates how its subthemes can lead to strained and

distanced social supports before or when a GLBT person discloses or comes out, External Struggle demonstrates how post-disclosure stressors were also found to be present and emerged in three subthemes: negative social support interactions, negative mental health interactions, and negative environment.

4.1.2.1 Negative Social Support Interactions

Most of the participants in all of the reviewed studies reported that much of their internal distress was a direct result of negative external interactions with family, friends, and other social supports. One of the most common ideas put forth by the participants was a deep fear of losing social supports after coming out and an actual loss of or diminution of quality of their social supports, especially their school friends:

> I still sometimes get down because I just can't walk around and be myself. Everywhere you go somebody will say something . . . well, they don't really say it but they say it to my friends. They call them faggots and these other kinds of names, like sissy and this and that . . . People at school would say to me, 'Oh, I knew you were a faggot'—It's really frustrating because you can fight some people, but after a while you just get tired of fighting every day and it just becomes so much you have to deal with on your own and then nobody understands (Diamond et al., 2011, p. 140).

For many male participants, the father figure was reported as vastly important:

> I think this anxiety and apprehension was also to do with this lack of bonding with my dad; I felt vulnerable, no strong male role model, so I think that just kind of exacerbated the whole gay thing for me . . . (gay male) (McAndrew & Warne, 2010, p. 95)

Lack of fatherly support was also reported to be linked to self-harming behaviors:

> One strong incident that I can remember, I was 10, I remember being very angry with him [Dad] to the point that I put my fist through the kitchen window as he stood at the sink. I just thought I'm going to show you how angry I am . . . I can remember I wanted him to respond . . . a cry for his love ultimately. (gay male) (McAndrew & Warne, 2010, p. 95)

Some respondents even expressed difficulty in being able to talk with their family members about their homosexuality due to societal beliefs:

> Well, it was my usual thing er, em, feeling I've got so much to give, but isolating myself all the time because of my em, I suppose I could put it as feelings of guilt about being gay. Cos I was brought up in a time where it was just – well, as my mother told me, it didn't exist! So it was kind of difficult. (Robertson, 1998, p. 36)

The fear of rejection or loss was so powerful in some cases that it contributed to a constant monitoring of one's behaviors and speech for fear of the family discovering their homosexuality; this was found to be a forerunner to even more isolation from the participant's social supports:

> At one point I remember thinking that they (my friends) are going to think that I am some kind of girl or something, and I was terrified of that. And, I was always conscious of how I was acting or what I did, because I didn't want anyone to think I was some kind of girl…I remember when I was in high school there was a little joke when I was in junior high they would tell you like – depending on how you looked at them – they would say, "Oh you're gay," or whatever, and so I remembered how that person looked and I would never look like that. So that was totally in the back of my head never to look like that. (gay male) (Curry, 2009, p. 97)

For the younger participants who were still living at home, the fear of rejection was accompanied by a very real fear that, should their parents find out they were gay, they would be expelled from their home.

> There is no doubt in my mind when I was growing up that I would be probably thrown out – gotten rid of – that nobody would want me! There is no doubt in my mind. I always figured that if someone (in my family) found out (that I was gay), I would just have to kill myself. (gay male) (Curry, 2009, p. 94)

Some even related experiences of being expelled from their home after disclosure of their sexuality:

> […] I can remember lying back on my bed in October thinking oh my life's all sorted out, and the next day I get kicked out of my house so I had to leave college, the course that I loved more than anything…and then I had to come down (CITY) and I was in the YMCA and it was just the people in, in the YMCA weren't very nice people as well so on top of all that, you know, being kicked out, not speaking to your mother. (male) (McDermott, Roen, & Scourfield, 2008, p. 824)

Similarly, fear of losing their peer social supports was just as overwhelming:

> I was really afraid that my friends would find out I was gay, because if they did I mean what would happen? Would we still sit down at the same table for lunch? You know, would I still sit by them at football games…just things like that? Would I be invited to dinner with friends at restaurants? I really don't know how life would have been for me if I lost all that, because my friends thought I was a fag…that's what my friends would call homosexuals…or something like that. (gay male) (Curry, 2009, p. 97)

4.1.2.2 Negative Mental Health Interactions

Just as many participants reported negative interactions with family and friends, several also reported that when they sought mental health or health services, they had negative experiences with professionals in relation to their homosexuality:

> Thinking about the language that they use, they don't make room for you. Relationship stresses and sort of general passing the time of day sort of questions, how's your wife, what are they like, or who you went on holiday with, or you need to know. (Robertson, 1998, p. 38)

> Yes. Well, they tried to help me in many ways I'm afraid I found dreadful, but they tried. They obviously tried. . . they tried this thing that was absolutely awful, in those days, of putting you off being homosexual, you know, giving you electric shocks and things like that, they tried to change my mannerisms, to lengthen my stride, they actually tried to see if they could bring out any heterosexuality in me, and all this sort of thing, but it really didn't work, to put it in a nutshell. And I. . . and that seemed so pathetic, you know, I can't, you know, and so. . . (Robertson, 1998, p. 37)

4.1.2.3 Negative Environment

Both of the preceding sub-themes lay the groundwork for this final sub-theme under External Struggles. Due to the negative incidents with family members, friends, and mental health professionals, among many other experiences (e.g., societal discrimination, discrimination from strangers), the amalgamation of the negativity present in many GLBT lives creates an environment that begets more negativity. In this environment, GLBT persons live with negative comments, physical attacks due to their minority status, threats of physical harm and death, and lack of laws protecting them from harm – a life in which the walls are closing in

around them. Some participants described comments from their families: “My biological father got upset and physically attacked me. My mother was like, ‘What do you do, bump cootchies all night?”’ (lesbian female) (Diamond, Shilo, Jurgensen, D’Augelli, Samarova, & White, 2011, p. 138). While others described non-verbal communications:

> My mom doesn’t say anything negative, but I can see it in her face. When I bring up my girlfriend in conversation—me and my girlfriend have been going out for about a year and a half now and my mom, she knows—and she says that she doesn’t really have any feelings about it but just in her face, if I bring it up you can just see this sadness come over her. (female) (Diamond et al., 2011, p. 138)

Likewise, other participants shared of being given death threats:

> My mother is not even willing to talk to me about it openly or go to a PFLAG [Parents, Families, and Friends of Lesbians and Gays] meeting with me. She’s like ‘that’s disgusting, nasty. If you were a boy, I would have killed you by now.’ (female lesbian) (Diamond et al., 2011, p. 139)

Furthermore, societal and religious beliefs greatly influence social support reactions to homosexuality disclosure and the participants’ feelings towards themselves, further contributing to the negative environment:

> As one adolescent described, ‘They don’t like it because they are Christians. Gay people go to hell and burn there forever and ever.’ Another adolescent reported that her Muslim cousin told her, ‘Out of everything, that’s the worst sin! It is a sin in all religions—you are going to hell.’[female] Another described why he did not want certain members of his family to know he was gay. ‘I don’t tell my Jamaican side of the family.

> They would kill me.' [gay male] (Diamond et al., 2011, p. 140, bracketed information added)

Several participants also communicated that they had a very real concern for their own personal safety. Fear of physical abuse, sexual abuse, and murder were commonly expressed by many participants:

> There was a guy named Oscar and people would see him coming down, and the other guys would try to imitate how he walked. And all kinds of stuff they would do. They hit him. They did all kinds of stuff – just treat him bad – this was in junior high and high school. Literally (they did) all kinds of stuff. (gay male) (Curry, 2009, p. 100)

> There was one kid, a guy when I was a freshman, who was walking by a group of the football players, and they yelled at him, 'Hey fag. We're gonna kick your ass!.' I was like, 'Whoa, that's scary.' But, I always felt safe when I was with my girl-friends. So, I just made sure I was never alone without them I mean. But no one bothered with me, because I stayed away from the tough guys. (gay male) (Curry, 2009, p. 101)

> I found out I was gay at 17 and then I had a friend who was killed because he was gay . . . somebody didn't like it. They all thought he was straight and then somebody told them that he was gay and so they killed him . . . that made me feel depressed and I started seeing a therapist for it . . . I'm still seeing a therapist for it. (Diamond et al., 2011, p. 140)

Negative environment was also directly linked by participants to self-destructive behaviors and suicidal thoughts and ideations: "Well, you see I've always had this worry about em, I keep repeating this but I'm so unhappy about being homosexual. And I once tried to do away with myself" (Robertson, 1998, p. 37). "I tried to commit suicide because of my father's

well my parents' rejection of me. Some of the respondents had problematic alcohol use related to managing their sexuality" (Robertson, 1998, p. 37).

> Just before I left school I got myself in really a bad state … I got myself really down because I was having a load of trouble with people at school. And I think everybody thought they could take the piss because they got away with it. I was a right mess, I couldn't move some days, I just felt like, argh, and then I started cutting myself on my arm and I was just a mess. I was upset because of the way people were with me because I was gay and it just aggravates me so much. (gay male) (McDermott, Roen, & Scourfield, 2008, p. 821)

4.1.3 Isolation

The third theme, Isolation, speaks to the seclusion – whether imposed by the participants or by their social support networks – that can be experienced by GLBT persons. One participant described how his inner struggle led an intentional isolation:

> Feeling that life was just totally shit . . . really was horrible. It takes up virtually all of your energy just being depressed. It's a horrible place, but it's a safe place to be because you pull up all those drawbridges, barricade yourself in, and you don't let anyone get close. (gay male). (McAndrew & Warne, 2010, p. 96)

Another McAndrew and Warne (2010) participant described how despite having friends, he still felt isolated:

> I felt more alienated and isolated when I was in secondary school, even though I did have friends, mainly male friends, I sort of still felt, I was isolated from other people, more alienated and distant. A deep thing of dissatisfaction with myself . . . dislike of myself and I didn't feel comfortable with myself any more. (gay male) (p. 96)

One female adolescent described how she was isolated by others after she became a member of the high school football team: ". . . one they realized they couldn't stop me, they would hide

my uniform, send me to other end of the field to practice kicking . . . it was humiliating" (female) (Diamond et al., 2011, p.139).

Respondents also felt a sense of isolation knowing there was a lack of GLBT mentors in their geographical location that they knew: "Before I was out I found it quite depressing, because. . . Knowing there was other people, but I didn't know any of them in my area" (Robertson, 1998, p. 37). Another Robertson (1998) participant spoke to the fact that his or her internalization of societal discrimination led to his or her own isolation: "Oh, I [now] think I'm as valid as anybody else. I think I used to think it was quite a shameful sort of dark secret, and I thought we were probably the only people in the world that did this" (p. 37). Participants also described family members isolating them from having social supports:

> I didn't really have a lot of friends. My mother wouldn't allow it. I remember one time – it was really innocent too – I was staying over a friend's house and there was a bunch of us and they didn't really have too many beds. So, we shared a bed. We didn't do anything. We just slept there, and I told my mom that we slept on a bed, a futon or whatever, and she got pissed. She got so mad. She was like, "You don't do that!" She made a big deal about it. So there was some pretty intense anxiety over that (my family finding out I was gay) basically. (gay male) (Curry, 2009, p. 95)

4.1.4 Internal Strength

The fourth theme, Internal Strength, discusses the positive aspects of the participants' inner self that helped them to overcome the negative emotional and mental characteristics of their conflict with sexuality and struggles with suicidality. Discussion thus far has focused on the negative internal and external factors faced by GLBT persons in relation to suicidality. As with the negative experiences, both the internal and external realm were found to experience the positive. The internal strength theme was found to have two sub-themes: (1) positive coping skills and (2) positive self-view.

4.1.4.1 Positive Coping Skills

Some participants reported being proud of their homosexuality and it was found that this helped to mitigate the negative effects of their sexual minority status. McDermott et al. (2008) (pp. 825-826) provide an excellent example of this; in their study, conducted through focus group interviews, they communicate one such focus group discussion about positive coping:

> At the beginning of the extract, Lorraine gives the example of her gay male friend, an arts student, who suffers homophobic abuse, including homophobic graffiti on his home:
>
> Lorraine: He is completely comfortable with who he is. He's not bothered by what people say. But when they're getting to the stage that they are, doing things to his family home and stuff, it is very distressing for him …
>
> Researcher: […] Do you think a young man wouldn't find it distressing?
>
> Stuart: If a young man actually wan…
>
> Samuel: I think if they've reached that […] themselves they won't find it distressing.
>
> Lily: They don't find it distressing themselves. The stress comes from external sources from people who are giving them hassle because of it.
>
> Samuel: Yes, yes.
>
> Stuart: It's, um, everybody's personal thing though if they feel normal then they're normal and it doesn't really matter about what everybody else thinks.
>
> Researcher: Yes, yes.
>
> Stuart: So even if it is distressing they can still feel themselves.

Other participants identified additional coping skills in purposefully strengthening social supports:

> I became quite social after coming out. I spose, yeah . . . I always just needed to constantly find that affirmation, it wasn't just something that I could say okay I've had enough, you know. I constantly needed that every day . . . and it was also about my whole, my self-esteem and confidence just totally went up every time as well, and if I stopped or something they'd just go down again. (gay male) (Fenaughty & Harré 2003, p. 16)

4.1.4.2 Positive Self-View

Some participants reported that they were able to find positive mental and emotional energy by "coming to terms" with their sexuality:

> . . . and suddenly I had the confidence to say to myself, you are gay and you know it. That takes quite a lot of adrenaline pumping around in the body for a while! Just gets really. . . feels really good to be sure, but on the other hand it's a really big thing to be thinking yeah, this is right, this is true. And you suddenly think, oh, what am I going to... how am I going to cope with all this happening? What's going to happen now? (Robertson, 1998, p. 36)

Another participant explains how he overcame the issue of his negative interactions with others:

> It was a turning point. I just…it kinda hit me that, you know what, fuck 'em. I mean, you know if people don't like it or can't accept me – fuck 'em. If they do (accept me) great…if not, you know…forget it. And, it was just that kind of attitude…that fuck you attitude…and that's what did it. (gay male) (Curry, 2009, p. 110)

Likewise, another participant shares how his own self-acceptance helped him to defeat the fears he had of rejection:

> Anyway I just thought it was like a big buzzy, like it felt like a . . . like all of a sudden you have something about you that's really cool, oh cool I'm gay. I don't know it was just weird, I didn't really think about the whole my mum's going to hate me, or anything like that because, and I didn't really think about it, and I kind of thought they'd be okay about it. (gay male). (Fenaughty & Harré, 2003, p. 14)

4.1.5 External Strength

Lastly, external strength is the final theme; this tells of the positive social supports and environments experienced by participants that helped them to choose to live. This theme is comprised of two sub-themes: (1) positive social supports and (2) positive GLBT role models.

4.1.5.1 Positive Social Supports

Some participants stated that they experienced positive support from their families regarding their sexuality that helped mitigate negative experiences: "My mom accepts me for who I am . . . my family 'has my back' (i.e., will defend me). It was a relief when my mom reacted so understandably . . . My dad said that if anybody hurts me, he would kill them" (Diamond et al., 2011, p. 141). Another participant reported that even some help from his parents, as opposed to none, was beneficial in helping him through difficult times:

> . . . my parents had a hard time dealing with it, you know, but you hear stories and see examples of people who, um, don't have any of that support, quite the opposite they're thrown out, like people with really strongly religious backgrounds who are up against brick walls, whereas I had something to work with my parents, they've always been supportive even if they've been a bit difficult at times, and I can't imagine what it would be like otherwise, I mean it would just make you so much more alone, you'd have to be doing so much more by yourself . . . (gay male) (Fenaughty & Harré, 2003, p. 10)

Participants also cited positive support from school and their peers. One participant tells of the importance of having supportive heterosexual peers:

> . . . the support of other gay people is really important, and supportive straight people too, because they are people who aren't in the same boat as you, I think it was really important to tell straight people who I was and for them to accept me, I think that was really important because we live in a predominantly straight world. (gay male). (Fenaughty & Harré, 2003, p. 12)

4.1.5.2 Positive GLBT Role Models

Positive GLBT role models were reported to be instrumental in overcoming the negative effects of being a sexual minority. Participants in the Fenaughty and Harré (2003) study indicated that positive images of GLBT persons in the media helped them to realize that they were not alone: ". . . So I definitely knew that there were things out there which would provide opportunities, it wasn't like I felt like, you know, there's nowhere to go now and I'm all stuck by myself" (gay male) (Fenaughty & Harré, 2003, p. 8). Another Fenaughty and Harré (2003) participant reported that his brother having a gay friend helped him to realize that there are gay persons who are happy:

> . . . I knew there were stable gay people out there who lead full on lifestyles, and that they could be out and happy, and live like that and not be closeted. . . . like it provides you with an option, and, and um, a role model that you know, that there is something out there that you can live that lifestyle. . . . (gay male) (Fenaughty & Harré, 2003, p. 9)

Similarly, participants reported that having a positive support group of GLBT persons allowed them to keep connected:

> . . . we set up to meet them the next week, and went to the movies or something I can't remember. Um and we all, the group of us all instantly connected, and all became really

> strong, really close friends, we all instantly connected because we were all in the same situation realising our feelings coming out to friends, family that sort of thing you know, and just spent so much time together. (gay male) (Fenaughty & Harré, 2003, p. 13)

4.2 Closing Statements

In reviewing the themes which emerged from this QIMS, the theme Isolation was discovered. Especially upon reviewing the first two themes, Internal Struggle and External Struggle, they appeared to converge into and presented the theme of Isolation. Both Internal Struggle and External Struggle presented elements of participants being or becoming isolated. Upon review, Isolation appeared to be central to the experience of being a sexual minority and suicidal; therefore, it became its own theme.

CHAPTER 5

DISCUSSION

5.1 Application of the Interpersonal Theory of Suicide

Several participants reported the different factors associated with the Interpersonal Theory of Suicide that will be discussed in this chapter; the presence of these factors and the severity support that the GLBT community stands at risk for suicide at a greater rate. As discussed earlier, members of the GBLT community experience higher levels of isolation, social stigma, social exclusion, etc. (Haas et al., 2010; King et al., 2008; Mutanski et al., 2010; Rosario, Schrimshaw, & Hunter, 2005; Westefeld et al., 2001). By reviewing the studies and working towards a synergistic understanding of the factors related to GLBT persons and suicidality, five main themes were discovered. Further application of the Interpersonal Theory of Suicide to these themes is presented as many of the factors that comprise the theory were discovered in the studies.

5.1.1 Thwarted Belongingness

As discussed earlier, thwarted belongingness is the idea that one believes they are alone and contains the sub-constructs of loneliness (e.g., “I feel disconnected from others”) and absence of reciprocal care (e.g., “I have no one to turn to and I don’t support others”) (Van Orden et al., 2010). Both of those sub-constructs contain indicating factors. Within the negative internal and external struggles, participants in the study communicated feeling disconnected through having few strong social supports.

As was communicated by the participant in the Curry (2009, p. 94) study: “There is no doubt in my mind when I was growing up that I would be probably thrown out – gotten rid of – that nobody would want me! There is no doubt in my mind” (gay male). Likewise a lack of genuine relationships with parents and friends, as reported by participants, contributes to the disconnection and lack of someone to turn to. The importance of fatherly support may also come into play with a lack of belongingness, likewise, this fear of rejection a constant monitoring of behavior. The theme of Isolation which was discovered speaks volumes to feeling as the loneliness and absence of reciprocal care sub-constructs as the gay male participant in McAndrew and Warne (2010) stated, “. . . you pull up all those drawbridges, barricade yourself in, and you don’t let anyone get close” (p. 96).

5.1.2 Perceived Burdensomeness

Perceived burdensomeness is the idea that one believes they are a burden to those around them (Van Orden et al., 2010). It is also comprised of two sub-constructs: liability (e.g., “My death is worth more than my life to others) and self-hate (e.g., “I hate myself”). Participants within the included studies presented these concepts. In particular, one participant reported that he had “A deep thing of dissatisfaction with myself . . . dislike of myself and I didn’t feel comfortable with myself any more” (gay male) (McAndrew & Warne, 2010, p. 96). This dissatisfaction speaks directly to the self-hatred sub-construct as was noted above in this participant’s statement: “I started to get very self-destructive . . . I didn’t care about myself . . . I was frightened, I didn’t know who to turn to . . .” (gay male) (McAndrew & Warne, 2010, p. 96).

Concerning the liability sub-construct, Robertson (1998, p. 37) reported that: “Suicide attempts were usually related to family members discovering respondents’ sexuality and rejecting them.” As one respondent stated: “I tried to commit suicide because of my father’s well my parents’ rejection of me” (Robertson, 1998, p. 37). Similarly, Diamond et al. (2011, p. 138) reported that a participant said, “I don’t tell my Jamaican side of the family. They would kill me” (gay male). As reported above, one participant’s mother told her that if she had been born male

and was gay, her mother would have killed her: “She’s like ‘that’s disgusting, nasty. If you were a boy, I would have killed you by now’” (female lesbian) (Diamond et al., 2011, p. 139). Perhaps the most direct statement linking the participant’s sexuality with their liability was this gay male’s statement about what he would do if his family discovered his sexuality:

> There is no doubt in my mind when I was growing up that I would be probably thrown out – gotten rid of – that nobody would want me! There is no doubt in my mind. I always figured that if someone (in my family) found out (that I was gay), I would just have to kill myself. (gay male) (Curry, 2009, p. 94)

5.1.3 Acquired Capability of Suicide

The acquired capability for suicide is a person attaining the ability to perform a lethal or non-lethal suicide attempt (Van Orden et al., 2010). This ability is accomplished through repeated exposure to events that are physically painful and work to further remove the person emotionally from their body. Several participants reported self-injury and alcohol and drug use: “Some of the respondents had problematic alcohol use related to managing their sexuality” (Robertson, 1998, p. 37). Some reported self-injury: “One strong incident that I can remember, I was 10, I remember being very angry with him [Dad] to the point that I put my fist through the kitchen window as he stood at the sink” (gay male) (McAndrew & Warne, 2010, p. 95). Several of the participants were also suicide attempters, which has been shown to increase one’s capability of dying by suicide (Van Orden et al., 2010).

Some participants linked their need to constantly monitor their behavior to being self-destructive: “I started to get very self-destructive . . . I didn’t care about myself . . .” (gay male) (McAndrew & Warne, 2010, p. 96). This self-destruction sometimes took the form of self-cutting or other risk behaviors, which can be a part of the development of an acquired capability of suicide as it increases tolerance of physical pain (Van Orden et al., 2010); as one participant stated: “I was a right mess, I couldn’t move some days, I just felt like, argh, and then I started

cutting myself on my arm and I was just a mess" (gay male) (McDermott, Roen, & Scourfield, 2008, p. 821).

5.2 Limitations

There are a few limitations which need to be addressed for this QIMS. The first is the "lumping" issue addressed. Most of the studies did only study gay men (Curry, 2009; Fenaughty & Harré, 2003; McAndrews & Warne, 2010, McAndrews & Warne, 2012; Robertson, 1998). However the two remaining studies included lesbians, bisexuals, and transgendered n individuals (Diamond et al., 2011; McDermott, Roen, & Scourfield, 2008); this serves to "lump" all the members of the study together and may not provide the opportunity for all members of the sexual and gender minority community to discuss their own risk protective factors. Similarly, many of the articles included in this QIMS study gay men and there were no studies found to be concerning suicidality with other members of this community. There is also limited qualitative research in this area and thus limited the available studies included in this QIMS.

Another limitation to consider is that it is unknown what the current suicidality of each of the participants in the individual studies is. Some general information is noted in some of the studies as having participants that were suicidal in the past, as having attempted suicide in the past, and as having only suicidal ideations or thoughts but did not attempt suicide. However, little was shared as to their current relationship with suicidality. It is also a possibility that persons included in the individual studies may not have included persons with the most severe suicidal thoughts, ideations, or plans for suicide. Therefore, some of the participants may not have been suicidal at the time the research was conducted and may not offer a clear picture of persons currently struggling with suicidality.

Lastly, I was the author of this study and I have personal experience in my own life and in relationships with suicide and as identifying as a sexual minority. This limitation presented the possibility of bias because of my personal experiences. The triangulation of analysts in this QIMS was employed in order to address this particular limitation.

5.3 Implications

5.3.1 Introductory Statements

The purpose of this study was to explore the experience of suicidality among gay, lesbian, bisexual, and transgendered individuals. In performing this QIMS, five different themes have been explored that show that the GLBT experience of suicidality is anchored in internal and external forces that have both positive and negative aspects. The importance of each theme was shown in its own right to be connected to the GLBT encounter with suicidality. The presence of negative internal and external forces shed light on why GLBT persons may be at much higher risk for suicide than their heterosexual counterparts. The presence of positive internal and external forces shows that negative experiences can be lessened and lead to overcoming suicidality in GLBT persons. Because the research shows that GLBT persons are at higher risk for suicidality and other negative mental health events, the importance of this study is inherent. Increased risk calls for better services provided by health care and mental health professionals serving GLBT persons, more research of high quality needs to be conducted, and better public policy needs to be enacted.

5.3.2 Implications for Services

Many participants experienced negativity in receiving services from healthcare and mental health professionals. Services that are culturally informed appear to be needed as well as more GLBT practitioners who can empathize with patients and clients. While it is not plausible for each demographic to have their own practitioner, it is plausible to have more GLBT persons in order to create a more diverse and informed professional field. For non-GLBT practitioners, the social work value of culturally competent services appears to be imperative in order to provide patients and clients with a safe environment to disclose their sexuality should it be related to the reasons they are seeking services. Therefore, interventions that focus upon or include development of the positive aspects of GLBT life appear to be needed. Operating from

the strengths based perspective (Saleebey, 1997) could provide the groundwork for developing and discovering positive features of being a sexual or gender minority.

The importance of social support networks was also borne out from the results of this QIMS. Services that work to enhance or repair existing personal relationships or create positive relationships could prove to be helpful. Relationships between GLBT adolescents and their parents seem to provide opportunity for the highest risk due to the possibility of expulsion from the primary residence; thus leading to possible homelessness. Practitioners may also be able to work with schools and educators to provide culturally competent training for teachers and administrators in order to help provide safer environments for schools and improve relationships between GLBT youth and their peers.

5.3.3 Implications for Research

As previously discussed, research on the GLBT community is comparatively less than research on their heterosexual peers. Likewise, research that combines all members of the GLBT community as one entity appears to further impede greater understanding of each letter in the acronym. Research which individually studies gay men, bisexual men, questioning men, lesbian women, bisexual women, questioning women, transgendered persons, androgynous persons, transsexual persons, and intersex persons would greatly add to the ability of practitioners and policy makers to make better informed interventions and policies; and better inform what research would be most beneficial to the field of mental health of GLBT persons. Most research contains several demographic information concerning race, ethnicity, and gender among many others in that certain phenomenon are studied relative to those demographics – e.g., prevalence rates in females versus males. Therefore, it would stand to reason that future research should include the several sexual orientations and gender identity expressions as options rather than continue lumping them all together as “other.”

The establishment of an accepted definition of sexual orientations may also be helpful in producing future quality research. Much of the research discussed above relied on self-report

of sexual orientation – which can cause issues due to variance of definition from one person to the next. Likewise, many of the measurements used to determine sexual orientation (e.g., Klein Sexual Orientation Grid, Kinsey Scale, etc.) lack proper validity or reliability to be accepted (Heath & Euvard, 2007). The general negative environment in society of the may have an effect on recruitment of participants in research on GLBT persons; GLBT persons may not feel safe in coming out to researchers or for being studied because they are GLBT.

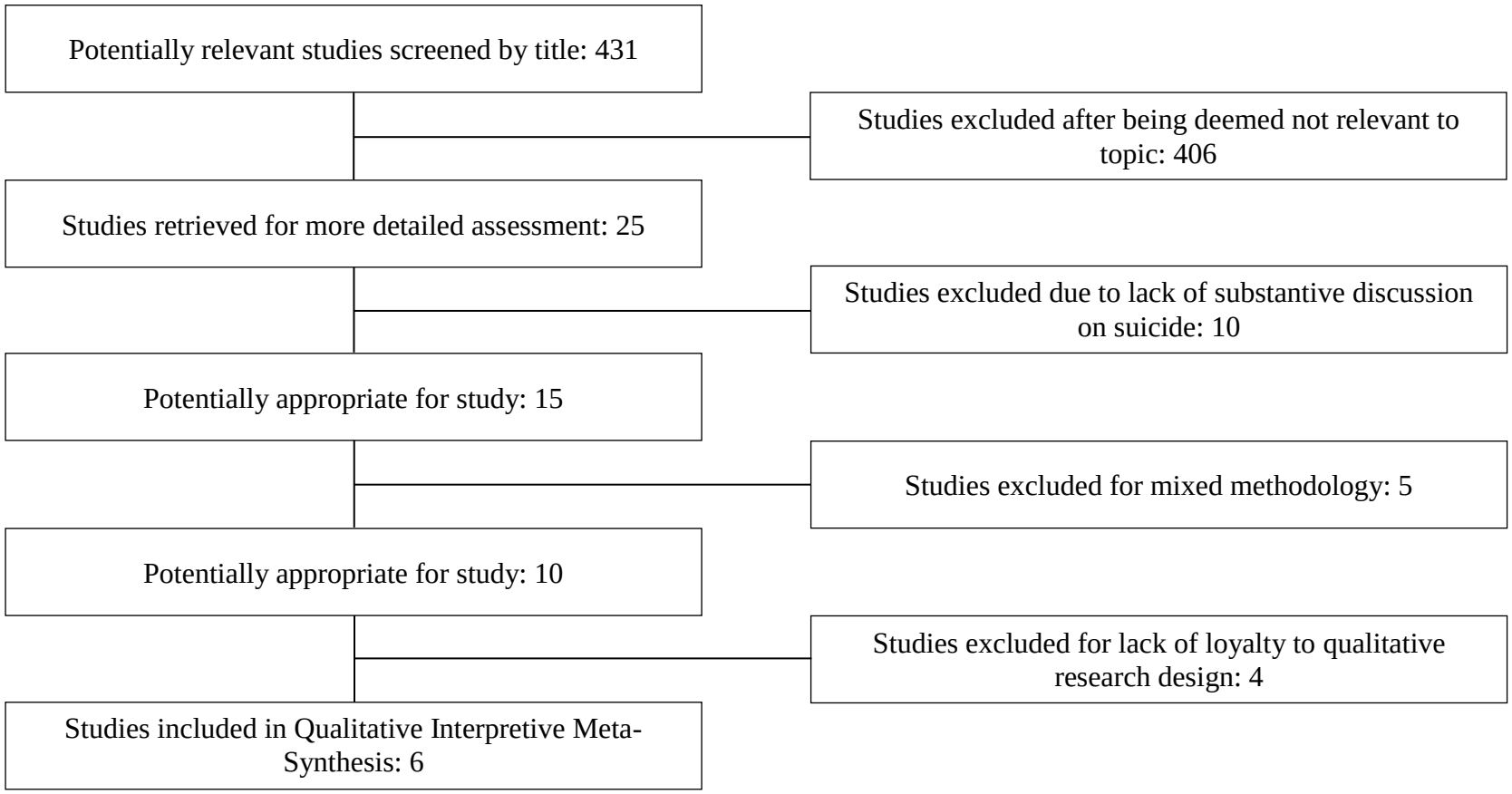
5.3.4 Implications for Public Policy

As homophobia and heterosexism were found to be detrimental and contribute to the overall harm of GLBT persons, it would stand to reason that better informed and culturally sensitive legislation and policies would create a more hospitable environment in larger society for GLBT persons and the community as a whole. There are still several states which do not include protective laws or policies for GLBT persons; meaning that in some states, GLBT persons can be still be fired or be denied housing simply because of their sexual orientation. Also, better and positive-minded education would be beneficial for not only GLBT persons, but for society at large in order to dispel negative stereotypes of GLBT persons.

APPENDIX A

FIGURES

Figure 3.1. Quorum Chart



APPENDIX B

TABLES

Table 3.1. Studies Included in Sample.

Authors	Tradition/Data Collection Method	N	Ages, Race/Ethnicity, Sex	Types of Participants	Sexualities of Participants
Curry (2009)	Basic interpretive qualitative design, interviews	6	22-29; 2 Hispanic, 2 Caucasian, 1 African American, 1 Asian; males	Gay men in South Texas	Gay
Diamond et al. (2011)	Consensual qualitative research method, interviews	10	15-19; 7 African American, 1 Jamaican, 1 Hispanic, 1 Bi-racial; 4 males, 1 pre-operative FTM trans man	Gay, lesbian, and bisexual young persons who were active in an adolescent medicine program and GLB agencies	Gay, lesbian, bisexual, gay Female-To-Male pre-operative transgender man
Fenaughty & Harré (2003)	Grounded theory, in-depth interviews	8	18-23; 4 New Zealand European/Pakeha, 1 South African Indian/New Zealander; 2 Maori/New Zealander; 1 Maori/Scottish and Chinese	Gay men involved in a university or community organization for gay men	Gay
McAndrews & Warne (2010)	Case study, psychoanalytically informed free association narrative interviewing	4	35-41; White British; males	Gay men from a voluntary organization which supports gay men	Gay
McAndrews & Warne (2012)	Case study, psychoanalytically informed free association narrative interviewing	4	35-41; White British; males	Gay men from a voluntary organization which supports gay men	Gay
McDermott, Roen, & Scourfield (2008)	Discourse analytic approach, interviews and focus groups	27	16-25; White British & Welsh; males, females, & transgender	GLBT young persons recruited through GLBT support groups	Gay, lesbian, bisexual, transgender
Robertson (1998)	Grounded theory, interviews and focus groups	37	14-82; Not reported; males	Gay men and a bisexual man involved in gay groups or active in gay venues	Gay

Table 3.2. Theme Extraction.

Authors	Original Themes
Curry (2009)	- Fear of loss of primary supports - Concerns for personal safety - Struggle to change sexuality - Personal resiliency factors
Diamond et al., (2011)	- Negative life events/stressors - Explicitly stated causes of depressive/suicidal symptoms - Positive life events/strengths - Desire for change - Experience of and attitudes toward counseling
Fenaughty & Harré, 2003	- Positive L/G/B stereotypes and representations - Positive family acceptance - School and peer support - L/G/B support network participation - High self-esteem - Coping mechanisms
McAndrews & Warne (2010)	- Knowing and not knowing - The centrality of the father - The loneliness of outsiderness - Leading a double life - Crime and punishment
McAndrews & Warne (2012	- Knowing and not knowing
McDermott, Roen, & Scourfield (2008)	- Homophobia and self-destructive behaviors - Avoiding homophobic shame · Routinization and minimization · Adult identities and individual responsibility · Proud identities
Robertson (1998)	- Coming to terms with one's sexuality - Family and social interactions - The development of self-worth and experiences of prejudice - Depression and suicide - Seeking help

Table 4.1. Translation of Themes

New Themes	Original Themes
Internal Struggle	- Knowing and not knowing (McAndrew & Warne, 2010) - Knowing and not knowing (McAndrew & Warne, 2012) - Leading a double life (McAndrew & Warne, 2010) - Crime and punishment (McAndrew & Warne, 2010) - The loneliness of outsiderness (McAndrew & Warne, 2010) - Struggle to change sexuality (Curry, 2009) - Avoiding homophobic shame (McDermott et al., 2008) · Routinization and minimization · Adult identities and individual responsibility
External Struggle	- The centrality of the father (McAndrew & Warne, 2010) - Fear of loss of primary supports (Curry, 2009) - Family and social interactions (Robertson, 1998) - Negative life events/stressors (Diamond et al., 2011) - Experience of and attitudes toward counseling (Diamond et al., 2011) - Seeking help (Robertson, 1998) - Explicitly stated causes of depressive/suicidal symptoms (Diamond et al., 2011) - Homophobia and self-destructive behaviors (McDermott et al., 2008) - Depression and suicide (Robertson, 1998) - Concerns for personal safety (Curry, 2009)
Internal Strength	- Avoiding homophobic shame (McDermott et al., 2008) · Proud identities - The development of self-worth and experiences of prejudice (Robert, 1998) - b (Fenaughty & Harré, 2003) - Coping mechanisms (Fenaughty & Harré, 2003) - Personal resiliency factors (Curry, 2009) - Coming to terms with one's sexuality (Robertson, 1998) - Desire for change (Diamond et al., 2011)
External Strength	- Positive L/G/B stereotypes and representations (Fenaughty & Harré, 2003) - Positive family acceptance (Fenaughty & Harré, 2003) - School and peer support (Fenaughty & Harré, 2003) - L/G/B support network participation (Fenaughty & Harré, 2003) - Positive life events/strengths (Diamond et al., 2011)

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