

**Title:** 'Protective Determinants in Suicidal Ideation within Lesbian, Gay, Bisexual and Transgender (LGBT) Communities'

## **Abstract**

**Background:** LGBT people have an elevated risk of suicidal ideation and suicide as compared to the overall population. Risk factors and Protective determinants provide an insight into must be understood to create an evidence-based suicide prevention model and evidence-based assessment and treatment for LGBT people experiencing suicide ideation. Minimal research in this field exists to date, highlighting the need for illumination of these key issues for mental health nursing practitioners.

**Aims:** To ascertain the protective determinants of suicide ideation in the LGBT population based on the extant published evidence base surrounding this issue in the context of healthcare generally and mental health nursing practice, specifically.

**Methods:** A systematic review of five theoretically sampled articles pertaining to suicidal ideation in the LGBT community. This was undertaken in accordance with the 2009 PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) Implementation Framework Guidelines.

**Findings:** Data sets were synthesised using an inductive thematic analysis. Five core salient themes emerged from the data, collated from the extant published literature, which made it possible to identify protective determinants of suicidal ideation in the LGBT population. These salient themes were identified as a) resilience b) specific personality traits c) mindfulness and self-esteem d) social support and positive role modelling and e) the need for culturally competent healthcare provision, of which mental health nurses are an integral part.

**Conclusion:** The findings of the systematic review revealed the need for mental health nurses and adjunct healthcare staff to reflect on their interactions with the LGBT population, particularly where suicidal ideation or tendency is either directly articulated or suspected. Facilitation and support of vulnerable members of society could potentially be driven by increasing awareness of these specific vulnerabilities in clinical practice.

## **Introduction**

Suicide is a serious global problem that affects hundreds of thousands of people each year (WHO, 2018), and is one which affects LGBT people disproportionately. Although death records do not routinely include the individuals' sexual orientation, meaning that there is no reliable way to determine exact rates of deaths by suicide in the LGBT population (Haas, 2015), it has been found that LGBT individuals have an elevated risk of suicide ideation and suicide compared to overall population (Liu et al, 2012; King, 2008; Silenzio et al, 2007). Suicide attempt rates have been estimated to be between 20-53% within the LGBT population (McDaniel et al, 2001; Grant et al, 2011).

This finding is unsurprising given that LGBT individuals are at a higher risk of a range of mental health problems, including depression and anxiety (King, 1998), self-harm (Liu et al, 2012), and alcohol and substance abuse (Marshall et al, 2009). Studies suggest that poor mental health and suicidality among LGBT people is influenced by a range of complex factors. Sexual and gender minorities continue to face social, legal, economic, cultural and other barriers that put the mental health of these sexual minorities at risk (Meyer, 2003). Discrimination, for example, may act as a social stressor in the development and maintenance of poor mental health among LGBT people (Chakroborty et al, 2011).

Discrimination towards LGBT individuals can affect employment, housing, and access to health care as well as the quality of the healthcare provided (Marshall et al, 2009). In fact, many LGBT people have experienced homophobic comments and embarrassed responses (and occasionally prejudice) from healthcare professionals (Marshall et al, 2009; Stonewall, 2012).

Suicidal thoughts and behaviours are complex and influenced by interacting personal, social, psychological, cultural, biological and environmental factors. There is no singular underlying explanation why someone might attempt or die by suicide. Suicide, however is preventable and ongoing research on suicide prevention is needed to reduce suicide rates and support people affected by suicide.

An important step in developing suicide prevention models is to identify and understand both risk and protective determinants (Wang et al, 2007). Much has been written on the heightened risk factors for suicide among the LGBT population (Mereish, 2012; Cabaj, 2000; Meyer, 1995). There is, however, a paucity of research around suicide and protective determinants for LGBT people. Protective determinants buffer individuals from suicidal thoughts and behaviour (White, 1998). To date, protective determinants have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective determinants is, however, equally as important as researching risk factors, and given that there are LGBT-specific risk factors, it is logical that there will be LGBT-specific protective determinants (Moody et al, 2015: 268). This systematic review, then, fills a gap in knowledge by drawing together the literature on LGBT suicide and protective determinants to be able to synthesise, evaluate and present the findings in this area.

## **Background Literature**

This systematic review examines and reviews the extant published research on protective determinants of suicidal ideation amongst LGBT individuals. LGBT, for the purpose of this paper, will refer to individuals who are Lesbian, Gay, Bisexual, and Transgender (Stonewall, 2018).

Suicide is a global concern for mental health and the identification of risk factors and protective determinants remain essential in the development of effective suicide prevention models. The World Health Organization (WHO) (2018) operationally defined suicide as “act of deliberately killing oneself” and reports that close to 800,000 people worldwide die by suicide every year.

Suicide in the United Kingdom (UK) represents a high proportion of these deaths. The Samaritans (2018) report that in 2017 alone, there were 6,213 suicides. Alongside this, the House of Commons Briefing Paper: Suicide Prevention, Policy and Strategy (Mackley, 2018) reported that in the UK in 2017 alone, there were 5,821 recorded suicides. The discrepancy in these figures itself demonstrates that not all suicides that take place are formally recorded as such since the determination of cause of death cannot always be conclusively made. Historically, the delineation between suicide and misadventure has been documented as being difficult to categorically ascertain (O'Donnell and Farmer, 1995). The House of Commons' demographic statistics, translate to a suicide rate of 10 deaths per 100,000 of the UK population (Mackley, 2018).

Beginning to analyse and synthesise suicidal ideation as a specific phenomenon, it ought also to be recognised that there is a distinct variability in its demographic presentation. For example, although females are more likely to attempt suicide, males are more likely to succeed in their attempts (Overholser et al, 2012). This is largely attributable to the fact women are less likely to use immediately lethal means, such as hanging or shooting, and are statistically more likely to use less immediately lethal means such as self-poisoning. Sociologically, many factors influence these statistics, including

the social constructions of hegemonic masculinity and femininity and the reinforcement of these gender roles, which often prevent men from seeking support (Southworth, 2016).

In developed countries over the counter medications have low lethality in an attempt to reduce the risk of death by such methods (Appleby, 2000). Research also indicates that women are more likely to articulate their emotional distress and to seek support from friends and family Choo et al (2010). Also, following the death of or separation from a partner (which is considered a risk factor), women in western cultures are more likely to maintain social and familial connections, which act as protective determinants against the relative risk of suicidal ideation (Scourfield & Evans 2015).

In the UK, men are more than three times as likely to take their own lives as women. In particular, men aged 45-49 are at the highest risk of suicide (Samaritans, 2018). The suicide rate for males in the UK was 15.5 deaths per 100,000, while the UK female suicide rate in 2017 was 4.9 deaths per 100,000 (Office of National Statistics, 2017). This gender disparity in suicide has grown in the past 35 years (ONS, 2017). That is, while the rate of suicide among UK women has halved since 1981, the rate amongst men has only fallen by a quarter in the same time period (ONS, 2017). Although the number of suicides in the UK remains high, it is worth noting that the suicide rate among men is at its lowest in 30 years (Samaritans, 2018; Mackley, 2018). This is not, however, universal, with suicide amongst men in Scotland increasing in 2017 for the third consecutive year (Samaritans, 2018). What can be extrapolated from these statistics is that different populations and demographics face differing risks and protective determinants in relation to suicidal ideation. Understanding these is pivotal in any focused study of communities within this broader context, where suicide rates are even statistically higher. This is necessary to provide fully evidence-based approaches to suicide prevention in practice, where mental health nursing plays a pivotal role in the potential reduction of these statistics.

### **Considering Risk Factors**

As noted, rates of suicide among different populations are affected by a range of factors, both personal and structural. One type of such factor that is considered in suicide prevention is the risk factor. Mościcki (1997: 509) defines a risk factor as a 'characteristic, variable, or hazard that increases the likelihood of development of an adverse outcome which is measurable, and which precedes the outcome'. There are many risk factors that have been identified throughout the field of suicide prevention and a prior suicide attempt is the single largest risk factor for suicide (WHO 2018). As well as previous suicide attempts, there are a range of risk factors that have been noted in research and practice. These include: mental disorders; alcohol/substance abuse; physical illness; feelings of hopelessness and isolation; impulsive or aggressive tendencies; relational, social, work or financial loss; and easy access to lethal methods are all identified risk factors (Centre for Disease Control and Prevention, 2017). The link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well known, and has been noted to be particularly strong in highly developed countries (such as those considered in this project) (WHO, 2018). These are risk factors across the whole population, but may present more frequently among certain demographics. That is, while these disorders can be understood as personal risk factors, there is also a structural element to these factors as some groups are disproportionately represented in relation to these disorders. As such, a risk factor may be particularly pertinent with regards to members of this group. One relevant example to note for this study is that Lesbian and Bi women are disproportionately prone to alcohol misuse which is a significant risk factor for suicide (Diamant et al, 2000).

While people who die by suicide may not present with any long-term disorders or other continued risk factors, there may be more temporary risk factors that also need to be considered. The WHO (2018) notes that many suicides happen in moments of crisis due to an inability to deal with life stresses, such

as financial or relationship problems or acute pain and illness. Individuals have different ways of coping with life challenges, and strong family relationships and connections also help to balance out difficult or negative life issues (this will be discussed below in relation to protective determinants).

### **LGBT Individuals**

LGBT is an acronym for lesbian, gay, bisexual and transgender people (Stonewall, 2018). Lesbian refers to women who have an emotional, romantic or sexual orientation towards women; gay refers to men who have an emotional, romantic or sexual orientation towards men (and can also be used as a generic term for lesbian and bisexual women); bisexual refers to someone who has an emotional, romantic or sexual orientation towards more than one gender; and transgender refers to a person whose gender does not fit with the sex they were assigned at birth (Stonewall, 2018). Within much research, however, the term LGBT is much more inclusive than the acronym suggests, utilised instead as an umbrella term for a variety of sexual and gender minorities (Byne, 2014).

LGBT people are considered a 'marginalised community' (Rosenstreich, 2010). As such their lived experiences often differ from their heterosexual counterparts, and are often not easily apparent in mainstream health practice and research. LGBT people often face stigma and discrimination, which, as noted above, can lead to increased stress (Meyer, 2003). Many LGBT-specific venues are bars and clubs, meaning that socialising with other LGBT people often revolves around alcohol consumption (Emslie et al, 2017) and can lead to higher levels of alcohol abuse (McNair et al, 2016). Moreover, in some parts of the LGBT subculture, drug use is a key part of sexual activity, also known as chemsex, raising the potential for gay and bisexual men, in particular, to develop substance misuse disorders (Race et al, 2017).

LGBT people are often more isolated from familial bonds due to rejection by their family or because of their closeted status. This is particularly notable in relation to ageing LGBT populations (Stein et al, 2010) who often return to a closeted status when entering nursing or residential environments. Moreover, legal acceptance and rights for LGBT people are relatively recent, meaning that aging LGBT populations may be more reticent to open up about their sexuality or may still struggle with internalised shame and homophobia (Grossman, 2006). This may be particularly strong in those who were out before homosexual sex was partially decriminalised by the Sexual Offences Act 1967. Moreover, while LGBT people have more legal rights and social acceptance than previously, with, among other things, same sex marriage being legalised in the Marriage (Same Sex Couples Act) 2013, research shows that homophobia and transphobia still play a key part in LGBT people's lives (Warriner, 2013). Therefore, it is important that the context of LGBT lives, with the particular risk factors and protective determinants associated, is thoroughly understood and researched to provide an evidence-based suicide prevention model for LGBT people.

### **Policy, Practice & Procedure in Mental Health Nursing**

The assessment of suicide risk is a complex task for all mental healthcare professionals, of which mental health nursing is an integral part and approaches to suicide assessment integrate a constellation of personal demographics, psychiatric symptoms, and situational factors (Packman et al, 2004). Risk and protective determinants play a critical role in assessment for suicide prevention. For mental health nurses, the identification of risk factors and protective determinants provides critical information for the effective assessment and management of suicidal ideation in specific individuals.

The World Health Organization (2018) report, 'Preventing Suicide: A Global Imperative', provides a global evidence base on suicide and parasuicide as well as actionable steps for countries based on their available resources and the situational contexts they have available in being able to move forward in suicide prevention. This report incorporates a wide range of prevention strategies including: monitoring; access to means restriction; advice on media guidelines; stigma reduction; raising of public awareness; training for health workers, educators, and police and other gatekeepers; as well as crisis intervention services and postvention support and facilitation for those who have attempted suicide.

In recent decades, suicide prevention in the UK has developed and expanded as concerns around increasing suicide rates in parts of the UK have been illuminated in practice. The Preventing Suicide in England (2016) strategy is the third progress report of the cross-government outcomes strategy to save lives by reducing suicide. This report asserted that suicide is a largely preventable cause of death and highlights the need to increase England's efforts to reduce suicide rates. This strategy aims to achieve the recommendation of reducing the national suicide rate by 10 per cent by 2020/21. Key emphasis will be placed on; reducing access to means; providing suicide prevention training to the UK's transport network; learning and investigations within NHS settings; providing better information and support to those bereaved or affected by suicide; supporting the media in delivering sensitive approaches to suicide and suicidal behaviour; supporting research, data collection and monitoring; and improving data collection at both local and national levels (PSE, 2016).

The Five Year Forward View for Mental Health (2016) also made recommendations that local authorities have multi-agency suicide prevention plans in place by 2017, which also incorporate mental health nursing as an integral component of care. These plans ought to be designed to target high-risk locations and support high-risk groups, in relation to suicide prevention and reduction. The Samaritans have developed specific media guidelines on the reporting of suicide (2013). These guidelines provide a comprehensive media advice service for journalists and programme makers, to support safe and informative coverage of suicide and self-harm. This is important as the literature reveals consistencies between the media coverage of suicide and increases in suicidal ideation amongst vulnerable people.

In tandem with these initiatives, it ought to be noted that guidance and support is also being established to reduce incidence rates of homophobia, in order to prevent rather than treat suicidality in LGBT individuals. For example, in 2016, the Government Equalities Office announced a £3 million programme to tackle homophobic, biphobic and transphobic bullying in schools.

### **Assessing Specific Suicide Risk**

Beyond the context of policy, it is important to understand the practice of suicide prevention. There are many tools for assessing suicide risk including The Scale for Suicide Ideation (Beck 1979), The Suicide Intent Scale (Beck 1974), The Suicidal Affect Behaviour Cognition Scale (SABCS) (Harris 2015), The Suicide Behaviours Questionnaire (SBQ) (Linehan 1981), and The Reasons For Living Inventory (RFL) (Linehan et al, 1983).

The Suicide Intent Scale (Beck 1974) is a scale which consists of 15 questions which are scaled from 0-2 that consider both the logistics of the suicide attempt as well as the intent. The scale has high reliability and validity. The SABCS (Harris 2015) is a six-item self-report measure based on both suicide and psychological theory, developed to assess current suicidality for clinical, screening, and research purposes. There is substantial empirical evidence confirming the importance of assessing suicidal affect, behaviours, and cognition as a single suicidal construct (Harris, 2015). The SBQ (Lineham 1981)

developed a four questions questionnaire that can be completed in approximately 5 minutes. Answers are on a Likert scale that ranges in size for each question. This assessment tool is designed for adults and results tend to correlate with other measures, such as the SSI (Lineham 1981). This assessment of suicide risk is popular because it is easy to use as a screening tool, but at only four questions, fails to provide detailed information (Range & Knott 1997). Lineham's RFL Inventory (1983) is theoretically based, and measures the probability of suicide based on the theory that some factors may mitigate suicidal thoughts. It was developed in 1983 by Linehan et al. and contains 48 items answered on a Likert scale from 1 to 6. The measure is divided into six subscales: survival and coping beliefs, responsibility to family, child concerns, fear of suicide, fear of social disapproval, and moral objections. Scores are reported as an average for the total and each sub-scale. The scale is shown to be fairly reliable and valid, but is still mostly seen in research as compared to clinical use. Although none of these assessment tools is without limitation, a combination of these tools support practitioners in their assessments of suicide risk in presenting patients. It is important, however, to continually develop, extend and apply specific knowledge of suicide to ensure that the practice of using these tools, or developing new tools, is both evidence-based and most importantly, effective in its application to practice.

### **Framing Mental Health Nursing Practice alongside Individual Risk**

In the context of mental health nursing, it is important to assess specific risk factors. It is essential for clinicians to be able to identify risk and establish mechanisms of accessing protective determinants as an integral part of supporting people in practice. Individual risk is assessed through interview and/or assessment tools in order for the mental health nurse to establish a truly representative overview of risk factors and potential protective determinants. The Five P Formulation (Weerasekera, 1997) is an assessment tool which provides a framework for producing a narrative that helps the mental health professional and individual understand the problem/problems and assess the level of risk following this. The Five Ps refer to: 'presenting problem, the problem which the person is faced with; 'predisposing factors', any factors that have contributed to the person's problem over their life time; 'precipitating factors', any factors that may have triggered suicidal ideation; 'perpetuating factors', any factors that are maintaining the problem; and 'protective' factors, factors which lessen or help the person cope with the problem (Weerasaka, 1997). This framework explains the underlying mechanism of the presenting problem and proposes hypotheses regarding action to facilitate positive change.

In addition to risks for everyone, Meyer's Minority Stress model (2003) suggests that because of the sustained stigma, stress and discrimination faced by LGBT individuals, this group face additional stress, when compared to their heterosexual counterparts. This theory has resonance for suicide prevention strategies in relation to their capacity to provide tailored approaches to marginalised groups. Consensus from research conducted in this area shows that minority individuals face a higher degree of stress related to their minority identity, and that minority stress is associated with poorer health outcomes (Mereish, 2012; Cabaj, 2000; Meyer, 1995). A limitation of The Minority Stress Theory is that it focuses solely on the negative experiences of LGBT individuals despite acknowledging that this group have fundamentally unique coping strategies, including taking strength from their resistance to negative discrimination and adversity (Goldbach & Gibbs 2015).

Coping strategies specific to LGBT individuals include: employing cognitive strategies, such as imagining a better future; problem solving strategies, such as changing schools or seeking new friend groups in response to stress; and LGBT-specific strategies, such as getting involved in LGBT-focused groups or seeking out resources and activities specific to that community Goldbach & Gibbs 2015). As

such, mental health nurses must assess the risk factors specific to this group whilst not underestimating the ways LGBT people can and do mitigate the potency of these risk factors.

### **Protective Determinants**

Alongside risk factors, medical and therapeutic practice in relation to suicide prevention must also be based on an understanding of protective determinants. Suicide protective determinants are factors that either lower the risk or prevent the risk of suicide (Rutter et al, 2008). There are a number of recognised risk factors in reducing the risk of suicidal ideation and suicide, including the availability of physical and mental health care resources, feelings of connectedness to others, family, community, and social institutions, problem-solving and skills, individual coping ability and regular contact with caregivers (CDC 2017).

Protective determinants vary amongst individuals and cultures, may change over a period of time, and what may be a protective determinant for one person may be a risk factor for another. An example of this may be that for one person, having children can be a protective determinant attributable to care obligations or because they do not believe that others could provide the level of care that they could. For others, having children may be a source of stress and they may believe that the children will be better off without them, and therefore this would be a risk factor rather than a protective determinant. Another example of this is the provision of reciprocal care (not limited to children, but also to other adults or elderly relatives). Joiner (2005) asserts that reciprocal care is a protective determinant, but for others, the obligation to provide care may increase stress or anxiety and be a specific risk factors of suicidal ideation. This highlights the need to continually assess both risk and protective determinants during the treatment of individuals.

### **Methodology and Methods**

Literature for inclusion in this systematic review were identified following the methodology set out above. Discover, CINAHL, MEDLINE, PsycINFO, Embase, The Cochrane and the BMJ databases were searched using the occurrence of the combination of 3 keywords 'suicide', 'LGBT', and 'prevention' in the title, abstract, or keywords of the publication for English language, peer reviewed articles published between 2008 and 2018. The process can be seen in a clearer form in PRISMA 2009 Flow Diagram (Figure 1) and Study Selection Parameters (see Table 2). The initial search of Discover identified 76 articles (n=76) using the key words only. Date limitation parameters were stipulated, resulting in 74 articles identified; the peer review limitation was added and resulted in 17 articles identified; and following the final limitation of English-language only articles, 17 articles remained potentially identifiable for inclusion.

The initial search of CINAHL identified three articles; date parameter limitations were applied and three articles remained identified for potential inclusion. Finally the peer review limitation was added and this identified 2 articles for potential inclusion; both of these articles were in English and therefore met the final criteria. The initial search using MEDLINE using only key words identified six articles; following date limitations, six articles were identified; and, finally, when the peer review limitation was added, six articles were identified; all were written in English. The initial search using PsychINFO using keywords only identified 17 articles; following the date limitation there were 16 potentially identifiable and after the peer review limitation was added, there were 16 articles identified; all were written in English. The initial search using Embase using only key words identified 10 articles; with the date limitations added, there were 10 identified; and after the peer review limitation was added, there were 10 articles identified; all were in English. The initial search of The Cochrane Library using only key words identified 1 article which met the criteria regarding limitations. The initial search of the BMJ

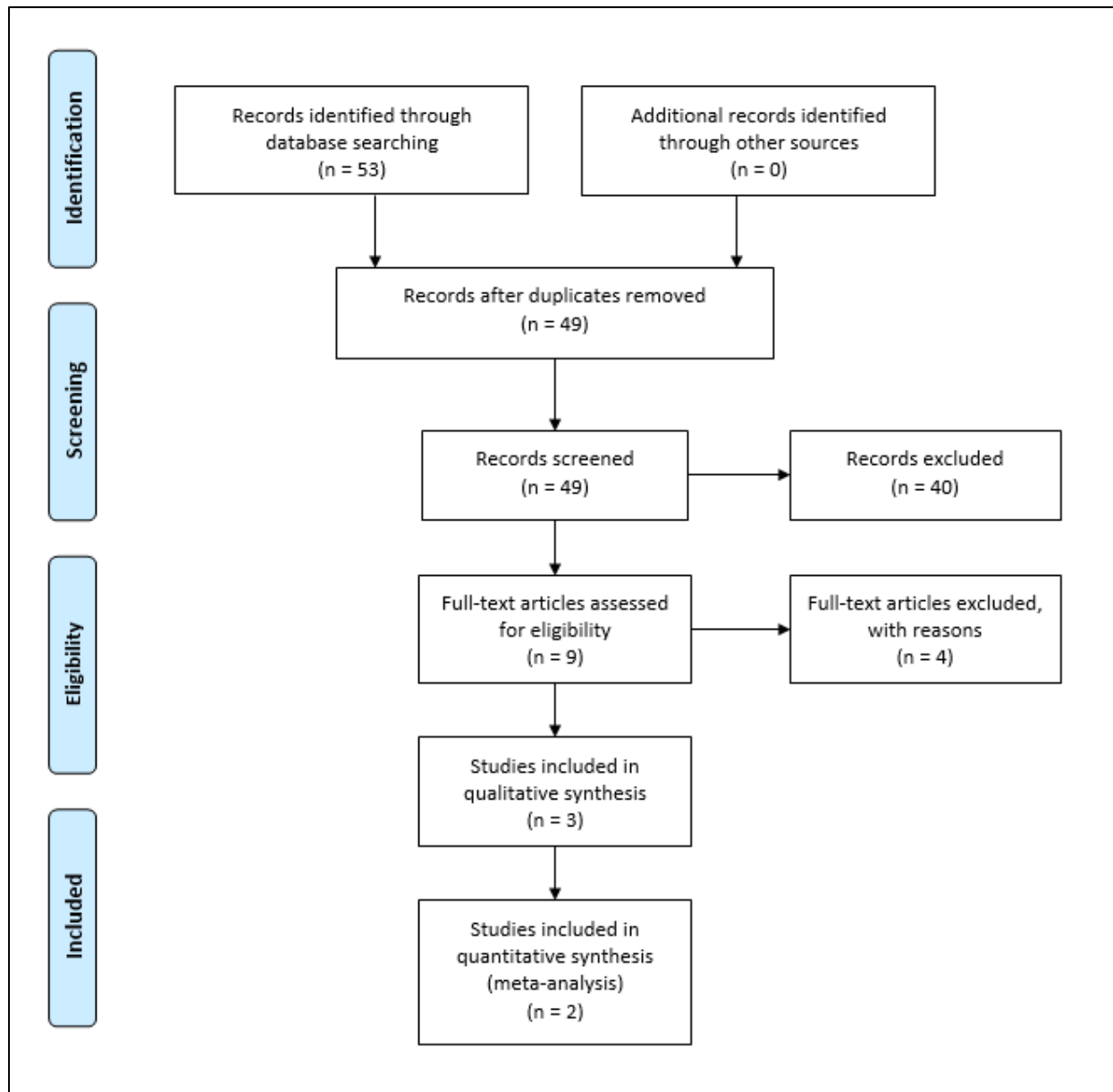
using key words only identified 1 article which met all criteria of limitations. Following this, 4 duplicate articles were removed to leave a remaining 49 publications.

**Table 2: Study Selection Parameters**

Database	Initial Results	Search	After Parameter Acceptability Limitation	Date	After Peer-Reviewed Journal Limitation	Necessity Of Article	After English Parameter Limitation	Specified Language
DISCOVER	76		74		17		17	
CINAHL	3		3		2		2	
MEDLINE	6		6		6		6	
Psychinfo	17		16		16		16	
Embase	10		10		10		10	
Cochrane Library	1		1		1		1	
BMJ	1		1		1		1	
<b>Total</b>							53	
<b>Total without Duplicates</b>							49	

After identifying these studies through the search strategy, the abstracts of all 49 studies were screened to ensure that the focus of the studies were on LGBT prevention and protective determinants for suicide, and that the study took place in a developed country. After this stage, 40 studies were excluded, largely because their foci were not on protective determinants, and in two cases, because of the country of the studies. A further four studies were removed upon consideration of the full article, as they did not provide specific focus on the research being reviewed for the systematic review despite briefly alluding to a consideration of protective determinants. The final number of studies selected for final inclusion in this subject specific review was five. A visual representation of this process can be seen overleaf in Figure 1: PRISMA 2009 Flow Diagram.

**Figure 1: PRISMA 2009 Flow Diagram**



## Synthesis of Results

Having described each of the five studies and their findings, the next stage for this systematic review is to synthesise the results. As noted in the methodology, this will be done using a narrative, thematic and interpretative analysis. Each study was coded for themes which were coded in relation to those relating to protective determinants – while other themes relating to risk factors were apparent across the studies, the focus of this review is on prevention and protective determinants, so these were the focus. The themes that occurred most frequently were: resilience; personality traits; mindfulness and self-esteem; social support and positive role models; and the need for culturally competent professionals. Each of these will now be addressed in turn.

## Results of Individual Studies

Before synthesising the results of the studies included for review, it is important that the results of each individual study are discussed to allow for future researchers to consider the effect of including or excluding any of the studies reviewed (Liberati et al, 2009: 17). The results of each of the individual studies are presented in Table 5 (Study Results) and discussed in more detail below. Table 5 provides a summary of the findings. The clinical implications of each study and future research recommendations are also set out in the Table 5 to support evaluation of the ways in which the studies can be used in practice and to develop further evidence for evidence-based suicide prevention models.

**Table 5: Study Results**

Study	Outcomes	Clinical Implications	Future Recommendations	Research
<b>Vostock and Stem</b>	<p>Mindful acceptance (MA) and self-esteem (SE) account for a significant portion of variance in psychological quality of life.</p> <p>MA and SE moderate the relationship between perceived stress and psychological quality of life.</p> <p>Positive correlation between psychological quality of life and both age and income. Correlation of MA and psychological quality of life in older LGBT people.</p>	<p>LGBT people who are distressed and detect threats to their quality of life may benefit from mindfulness skills and increased self-esteem. This information could benefit therapists who work with LGBT clients.</p> <p>Self-esteem may contribute to an empowered affirmed sense of self for LGBT adults who may feel disempowered or diminished</p>	<p>Applying same design to other geographic regions and different populations to explore how this model generalises.</p> <p>A longitudinal design would allow for a better understanding of how mindful acceptance and self-esteem affect the psychological well-being of sexual and gender minorities</p> <p>Explore relationship between various positive psychological constructs other than mindful acceptance and self-esteem in LGBT populations.</p>	
<b>Scourfield et al</b>	<p>Resilience, ambivalence and self-destruction themes raised.</p> <p>Resilience responses can be a protective determinant.</p> <p>Developing positive LGBT identity against heterosexual norms.</p> <p>Self-destructive sexual behaviour linked to LGBT identity.</p>	<p>Recognition of LGBT risk within suicide prevention strategies.</p> <p>Need for culturally competent practitioners</p> <p>Need to understand resilience as well as potential for self-harm.</p>	<p>Resilience to be researched in a systematic way.</p>	

	<p>LGBT people who self-harmed often experienced multiple problems.</p> <p>LGBT suicide caused by isolation, homophobic reactions and coming out.</p>		
<b>Rivers et al</b>	<p>Three themes highlighted in results. Being out can create stressors associated with LGBT suicides. Positive associations with people with shared identity challenged narratives.</p> <p>Concurrent mental health problems highlighted.</p> <p>Grieving over lost relationships</p>	<p>Interventions aimed at encouraging greater self-esteem and positive role models can have protective effect.</p>	<i>None made.</i>
<b>Moody et al</b>	<p>Protective determinants categorised into five themes: social support, gender identity-related factors, transition-related factors, individual difference factors, and reasons for living.</p>	<p>Mental Health providers to consider these protective determinants in suicide prevent models and care delivery.</p> <p>Help trans people with self-acceptance and support in learning about transgender. Suicide resilience, coping and problem solving can be focus when working with suicidal trans clients.</p> <p>Understanding the significance of transitioning to lives of trans people.</p>	<p>Further research on protective determinants with other groups of trans people to understand important differences between groups.</p>
<b>Livingston et al</b>	<p>Adaptive people scored low on neuroticism and highly on extroversion,</p>	<i>None given</i>	<p>Further research into personality and minority stressors as they relate to suicide.</p>

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agreeableness,  
conscientiousness.

People with adaptive  
personality profile less  
likely to report a previous  
suicide attempt.  
Adaptive people more  
likely to be slightly older.

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## **Discussion**

This systematic review has identified, synthesised and evaluated five research studies relating to protective determinants for LGBT suicide. By considering the study design, population, and findings of each paper individually at first, the validity and generalisability of each paper was able to be evaluated. Each paper recognised the limitations of its own population sample, and no attempt has been made by any of the authors or this reviewer to come to general conclusions about the LGBT population through this review. Moreover, the aims and populations of each paper varied, so a clear comparison between the papers was not possible, although considerations of the relationship between the papers were made. Despite these limitations, findings have been considered and can be the basis for improving practice and suicide prevention models for LGBT clients or patients, in the recognition that these findings are partial, varied, and ripe for further research.

A narrative analysis was conducted of the studies and their findings, examining individual findings, and synthesising these through inductive coding and thematic analysis (Joffe and Yardley, 2004). Inductive coding allowed the themes to be drawn out of the studies, opening the research up to a wider range of variables than a deductive coding approach would allow (Joffe and Yardley, 2004). Each theme that was coded appeared in at least two papers, and most appeared in three or more of the studies. The themes that were coded and discussed were: resilience; personality traits; mindfulness and self-esteem; social support and positive role models; and the need for culturally competent professionals.

### **Resilience**

Three of the five studies included in this review found that resilience was a protective determinant against suicide that manifested in a way that was specific to the LGBT population. The recurrence of this theme across papers reflects previous research on LGBT individuals that recognises resilience in the face of minority stress (Meyer, 2015). Resilience in these findings related to both resilience in response to homophobia or discrimination – ‘fighting back’ – but also resilience against suicidal ideation – recognising that just because one has suicidal thoughts, one need not act on them.

The repeated occurrence of resilience should be taken into consideration by mental health professionals when creating suicide prevention models and working with suicidal LGBT people. That is, the capacity for resilience could be a rich focus for discussion in assessment and treatment, to balance against understandings of increased minority stress. Mental health professionals should consider introducing tools or skills that focus on resilience against both external stressors and internal suicidal ideation.

### **Personality Traits**

Personality traits were identified by two of the five studies as a protective determinant. In particular, Livingston et al's (2018) study found a statistically significant negative correlation between people with adaptive personality profiles and a lower risk of attempted suicide or suicidal behaviour. Similarly, Moody et al (2015) found that personality traits such as help-seeking, optimism and problem-solving could act as a protective determinant against suicide for LGBT people. These reflect the findings of some older literature on suicidality in LGBT youth, which found that personality traits could be protective or 'resilience' factors against suicidality (Eisenhower and Resnick, 2006).

These findings are significant as, although the populations sampled are not generalisable, they highlight that underlying personalities can impact on individuals' responses to external minority stressors. As such, mental health professionals should take evidence of particular personality traits, such as adaptivity, into account when assessing the risk of suicide and creating treatment plans to prevent suicide.

### **Mindfulness and Self Esteem**

Three of the five studies included in this review made findings that higher levels of mindfulness and/or self-esteem can be a protective determinant for LGBT suicide. Mindfulness and self-esteem were found to moderate between stressors and quality of life (Vosnick and Stem, 2018). Drawing on this, mental health professionals could emphasise exercises aimed at mindfulness or self-esteem during assessment and treatment as a means to improve clients and patients' capacity to manage stressors and protect against suicidality.

### **Social support and Role Models**

Three of the five studies found that social support and positive role models could act as a protective determinant against suicide in LGBT people of all ages. Social support could be drawn from family, partners, friends, co-workers, or from more formal settings such as mental health professionals or support groups. The support functioned in different ways depending on its source, with social support from meaningful people reflecting acceptance of one's sexual or gender identity. Support groups were found to be a protective determinant as they allowed people to find people who identified similarly to them and made the participants feel less isolated. It has been noted, however, that many of those who participated in the studies were recruited through these groups, and therefore may have been more inclined to seek these groups out. It is possible that for others, being part of a social group might create added pressures relating to socialising and therefore be a risk factor.

With this in mind, mental health professionals could signpost LGBT individuals towards local groups as a protective determinant where appropriate, taking into account personality traits as discussed above.

Positive role models were also a protective determinant that was found; they had the effect of making people feel like part of a community and less isolated, as well as being a protective determinant when people saw themselves as a positive role model. Emphasis on other LGBT individuals and role models could be made during treatment to reinforce this protective determinant.

### **Culturally Competent Professionals**

It was found in three of the five studies that culturally competent professionals acted as a protective determinant against suicide. Although many professionals are already aware of the particular prejudices facing LGBT individuals, this is not universal, with some LGBT individuals reporting discrimination and prejudice from healthcare professionals (Stonewall, 2018). Sensitivity and culture training could be provided to mental health professionals to ensure that they are cognisant of the

particularities of LGBT suicide risk and protective determinants. More research must be undertaken before cultural competence can be based on a reliable evidence base.

## **Conclusion**

This systematic review of the literature revealed the need for further illumination of the issues that LGBT communities face, in their everyday lives, particularly those at specific risk of suicidal ideation. In the context of mental health nursing, this highlights areas for reflection by staff on their everyday interactions with all members of society in better understanding the need for individualised care and a dialogical approach to supporting and facilitating someone living with suicidal ideation. Although this review of the literature may be limited by the quantity and applicability of published research, and does not aim to come to general conclusions about the LGBT population, it continues to highlight protective factors in suicidal ideation within LGBT Communities. This has the potential to contribute to knowledge surrounding the improvement of practice and the integration of knowledge surrounding the suicide prevention models for LGBT patient caseloads. Protective determinants identified within the review were resilience, specific personality traits, mindfulness and self-esteem, social support and positive role modelling and the need for culturally competent healthcare provision, of which mental health nurses are an integral part.

In relation to these findings, recommendations from this review are fourfold:

Firstly, when developing and designing suicide prevention models in the context of specific care for LGBT patients, the development of resilience ought to be given key priority. This has the potential to counterbalance increased levels of stress and to equip those affected by both external stressors and potential feelings of suicidal ideation. Secondly, specific training for healthcare professionals regarding cultural competence and care and compassion ought to be integral to the management of all patients, and specifically tailored to the needs of LGBT patients. Signposting LGBT individuals towards local groups where appropriate, taking into account personality traits can be helpful in them gaining a sense of belonging and perspective in relation to the challenges they perceive. Finally, emphasis on mental health exercises aimed at building for capacity of mindfulness or increasing self-esteem during assessment and treatment as a means of improving coping mechanisms in everyday life.

Given the devastating impact on not only the LGBT community but also of the wider implications to society as a whole, the role that mental health nursing as a discipline can play in attempting to positively influence such devastating evidence, cannot be over emphasised.

## **CPD Questions:**

- A. Consider your own sexuality; how much does this impinge on the value judgements or perceptions you have towards others? Reflect on this and in the light of this article, consider how you might best adapt your practice or enhance approaches to working with members of the LGBT community in the context of mental health nursing.
- B. Identify the approaches you would take in supporting and caring for a patient who was from the LGBT community. How would you avoid homogenising and stereotyping them in practice so that you could ensure individualised and tailored care that did not marginalise them in any way.

- C. Reflect on this article and highlight any key aspects of it that have made you think differently about caring for all members of society. Why are these issues important to the context of our professional practice in the field of mental health?
- D. Consider how we might best develop practice based approaches to occurrences of suicidal ideation that limit the possibility of negative stereotyping.
- E. Contemplate which issue in this article will impact on your own professional practice and how this might become tangible in your everyday work.

## References

- Appleby, L., 2000. Suicide in women. *The Lancet*, 355(9211), pp.1203-1204.
- Beck, R.W., Morris, J.B. and Beck, A.T., 1974. Cross-validation of the suicidal intent scale. *Psychological Reports*, 34(2), pp.445-446.
- Beck, A.T., Kovacs, M. and Weissman, A., 1979. Assessment of suicidal intention: the Scale for Suicide Ideation. *Journal of consulting and clinical psychology*, 47(2), p.343.
- Byne, W., 2014. A New Era for LGBT Health. *LGBT Health* 1(1), p.1-2.
- Cabaj, R.P. (2000). Substance abuse, internalized homophobia, and gay men and lesbians. *Journal of Gay & Lesbian Psychotherapy*, 3, 5–24
- Diamant, A.L., Wold, C., Spritzer, K. and Gelberg, L., 2000. Health behaviors, health status, and access to and use of health care: a population-based study of lesbian, bisexual, and heterosexual women. *Archives of family medicine*, 9(10), p.1043.
- Emslie, C., Lennox, J. and Ireland, L., 2017. The role of alcohol in identity construction among LGBT people: a qualitative study. *Sociology of health & illness*, 39(8), pp.1465-1479.
- Goldbach, J.T. and Gibbs, J., 2015. Strategies employed by sexual minority adolescents to cope with minority stress. *Psychology of sexual orientation and gender diversity*, 2(3), p.297.
- Grant, J.M., Mottet, L., Tanis, J.E., Harrison, J., Herman, J. and Keisling, M., 2011. *Injustice at every turn: A report of the national transgender discrimination survey*. National Center for Transgender Equality.
- Grossman, A.H., 2006. Physical and mental health of older lesbian, gay, and bisexual adults. *Lesbian, gay, bisexual, and transgender aging: Research and clinical perspectives*, pp.53-69.
- Haas, A.P., Lane, A. and Working Group for Postmortem Identification of SO/GI, 2015. Collecting sexual orientation and gender identity data in suicide and other violent deaths: a step towards identifying and addressing LGBT mortality disparities. *LGBT health*, 2(1), pp.84-87.

Harden, A., and Thomas, J., 2010. Mixed Methods and Systematic Reviews: Examples and Emerging Issues. In Tashakkori, A., and Teddlie, C. *SAGE Handbook in Social and Behavioural Research*. London. Sage. Pp 749-775.

Harris, K.M., Syu, J.J., Lello, O.D., Chew, Y.E., Willcox, C.H. and Ho, R.H., 2015. The ABC's of suicide risk assessment: Applying a tripartite approach to individual evaluations. *PLoS One*, 10(6), p.e0127442.

Joffe, H. and Yardley, L., 2004. Content and thematic analysis. *Research methods for clinical and health psychology*, 56, p.68.

Joiner, T. E. (2005). *Why People Die By Suicide*. Cambridge, MA: Harvard University Press.

Karthick, S. and Barwa, S., 2017. A review on theoretical models of suicide. Available at: <https://core.ac.uk/download/pdf/141439870.pdf> Accessed: 29/09/18

King, M., Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popelyuk, D. and Nazareth, I., 2008. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC psychiatry*, 8(1), p.70.

Liberati, A., Altman, D.G., Tetzlaff, G., Mulrow, C., Gotzsche, P.C., Loannidis, J.P.A., Clarke, M., Devereaux, P.J., Kleijnen, J., Moher, D. (2009) Research Methods and Reporting. The PRISMA Statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions: exploration and elaboration. *BMJ* 2009; 339:b2700.

Linehan, M.M. and Nielsen, S.L., 1981. Suicidal behaviors questionnaire. *Unpublished inventory, University of Washington, Seattle, Washington*.

Linehan, M.M., Goodstein, J.L., Nielsen, S.L. and Chiles, J.A., 1983. Reasons for staying alive when you are thinking of killing yourself: the Reasons for Living Inventory. *Journal of consulting and clinical psychology*, 51(2), p.276.

Liu, R., & Mustanski, B. (2012). Suicidal Ideation and Self-Harm in Lesbian, Gay, Bisexual, and Transgender Youth. *American Journal of Preventative Medicine*, 42(3), 221–228

Livingston, N.A., Heck, N.C., Flentje, A., Gleason, H., Oost, K.M. and Cochran, B.N., 2015. Sexual minority stress and suicide risk: Identifying resilience through personality profile analysis. *Psychology of sexual orientation and gender diversity*, 2(3), p.321.

Mackley, A. (2018) House of Commons Briefing Paper: Suicide Prevention, Policy and Strategy. Available at: <https://www.parliament.uk/commons-library> Accessed: 16/09/18

Marshall, M.P., Friedman, M.S., Stall, R. and Thompson, A.L. 2009. Individual Trajectories of substance abuse in lesbian, gay and bisexual youth and heterosexual youth. *Journal of Adolescent Health* 49. 115-123.

McDaniel, J.S., Purcell, D. and D'Augelli, A.R., 2001. The relationship between sexual orientation and risk for suicide: Research findings and future directions for research and prevention. *Suicide and Life-Threatening Behavior*, 31 pp.84-105

McNair, R., Pennay, A., Hughes, T., Brown, R., Leonard, W. and Lubman, D.I., 2016. A model for lesbian, bisexual and queer-related influences on alcohol consumption and implications for policy and practice. *Culture, health & sexuality*, 18(4), pp.405-421.

Mereish, E.H., O'Cleirigh, C. and Bradford, J.B., 2014. Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. *Psychology, health & medicine*, 19(1), pp.1-13.

Meyer, I.H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38–564

Meyer, I.H., 2003. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, 129(5), p.674.

Meyer, I.H., 2007. Prejudice and discrimination as social stressors. In *The health of sexual minorities* (pp. 242-267). Springer, Boston, MA.

Meyer, I.H., 2015. Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), p.209.

Moher, D., Liberati, A., Tetzlaff, J. and Altman, D.G., 2009. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, 151(4), pp.264-269.

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., Shekelle, P., Stewart, L. A., and PRISMA-P Group. (2015). Preferred reporting for systematic review and meta-analyses protocols (PRISMA-P) 2015 statement. *Systematic Reviews* 4 (2015) 1-9.

Moody, C., Fuks, N., Peláez, S. and Smith, N.G., 2015. "Without this, I would for sure already be dead": A qualitative inquiry regarding suicide protective factors among trans adults. *Psychology of sexual orientation and gender diversity*, 2(3), p.266.

Mościcki, E.K., 1997. Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*, 20(3), pp.499-517.

Range, E. and Knott, L., 1997. Twenty suicide assessment instruments: Evaluation and recommendations. *Death Studies*, 21(1), pp.25-58.

NHS England (2016) Implementing the Five Year Forward View for Mental Health. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf> Accessed: 18/08/18

NHS ENGLAND (2017) Sexual Orientation Monitoring: Full Specification. Available at: <https://www.england.nhs.uk/wp-content/uploads/2017/10/sexual-orientation-monitoring-full-specification.pdf> Accessed: 09/08/18

NHS England (2018) Suicide Prevention and Reduction. Available at: <https://www.england.nhs.uk/2018/05/suicide-prevention-and-reduction/> Accessed 18/08/18

O'Donnell, I. and Farmer, R., 1995. The limitations of official suicide statistics. *The British Journal of Psychiatry*, 166(4), pp.458-461.

Office for National Statistics (2017) Suicides in the UK: 2017 Registrations. London. UK. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations> Accessed: 12/09/2018

Overholser, J.C., Braden, A. and Dieter, L., 2012. Understanding suicide risk: Identification of high-risk groups during high-risk times. *Journal of clinical psychology*, 68(3), pp.349-361.

Packman, W.L., Marlitt, R.E., Bongar, B. and O'Connor Pennuto, T., 2004. A comprehensive and concise assessment of suicide risk. *Behavioral sciences & the law*, 22(5), pp.667-680.

Petticrew, M., and Roberts, H. 2006. Systematic Reviews in the Social Sciences: A Practical Guide. Oxford. Blackwell.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K. and Duffy, S., 2006. Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version, 1*, p.b92.

Race, K., Lea, T., Murphy, D. and Pienaar, K., 2017. The future of drugs: recreational drug use and sexual health among gay and other men who have sex with men. *Sexual health*, 14(1), pp.42-50.

Rivers, I., Gonzalez, C., Nodin, N., Peel, E. and Tyler, A., 2018. LGBT people and suicidality in youth: A qualitative study of perceptions of risk and protective circumstances. *Social Science & Medicine*, 212, pp.1-8.

Rosenstreich, G., 2010. Excluded from the table: LGBT health and wellbeing. *Health Voices*, (6), p.12.

Rutter, P.A., 2008. Suicide protective and risk factors for sexual minority youth: Applying the cumulative factor model. *Journal of LGBT issues in counseling*, 2(1), pp.81-92.

Rutter, P.A., Freedenthal, S. and Osman, A., 2008. Assessing protection from suicidal risk: Psychometric properties of the suicide resilience inventory. *Death Studies*, 32(2), pp.142-153.

Samaritans (2018) Suicide Statistic Report. Available at: [https://www.samaritans.org/sites/default/files/kcfinder/files/Suicide\\_statistics\\_report\\_2017\\_Final.pdf](https://www.samaritans.org/sites/default/files/kcfinder/files/Suicide_statistics_report_2017_Final.pdf) Accessed 13/06/18

Scourfield, J., Roen, K. and McDermott, L., 2008. Lesbian, gay, bisexual and transgender young people's experiences of distress: resilience, ambivalence and self-destructive behaviour. *Health & social care in the community*, 16(3), pp.329-336.

Scourfield, J. and Evans, R., 2015. Why might men be more at risk of suicide after a relationship breakdown? Sociological insights. *American journal of men's health*, 9(5), pp.380-384.

Silenzio, V.M., Pena, J.B., Duberstein, P.R., Cerel, J. and Knox, K.L., 2007. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *American journal of public health*, 97(11), pp.2017-2019.

Stein, G.L., Beckerman, N.L. and Sherman, P.A., 2010. Lesbian and gay elders and long-term care: Identifying the unique psychosocial perspectives and challenges. *Journal of Gerontological Social Work*, 53(5), pp.421-435.

Stonewall (2018) Glossary of terms. Available at: <https://www.stonewall.org.uk/help-advice/glossary-terms#> Accessed: 01/10/18

Southworth, P.M., 2016. Hegemonic masculinity and suicide: A review of the literature. *European Health Psychologist*, 18(1), pp.7-12.

Sutton AJ, Abrams KR, Jones DR, Sheldon TA, Song F (1998) Systematic reviews of trials and other studies. *Health Technology Assessment* 2: 1–276

Wang, M.C., Richard Lightsey, O., Pietruszka, T., Uruk, A.C. and Wells, A.G., 2007. Purpose in life and reasons for living as mediators of the relationship between stress, coping, and suicidal behavior. *The Journal of Positive Psychology*, 2(3), pp.195-204.

Warriner, K., Nagoshi, C.T. and Nagoshi, J.L., 2013. Correlates of homophobia, transphobia, and internalized homophobia in gay or lesbian and heterosexual samples. *Journal of homosexuality*, 60(9), pp.1297-1314.

White, J., 1998. Comprehensive youth suicide prevention: A model for understanding. *Suicide in Canada*, pp.275-290.

Weerasekera, P., 1997. Postgraduate psychotherapy training. *Academic Psychiatry*, 21(3), pp.122-132.

World Health Organization, (2014). *Preventing suicide: a global imperative*. World Health Organization. Available at: [www.who.int/mental\\_health/suicide-prevention/world\\_report\\_2014/en/](http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/) Accessed 28/09/18

World Health Organisation (2018) *Suicide Fact Sheet*. Geneva. WHO. Available at: <http://www.who.int/mediacentre/factsheets/fs398/en/> Accessed: 12/02/2018