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Adolescence and Suicide: Subjective Construction of the Suicidal Process in Young Gay and Lesbian Chileans

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ABSTRACT

The association between suicide risk and sexual minority status can be understood from the perspective of the social determinants of health, an approach that requires the development of culturally sensitive knowledge. The aim of this study was to characterize young gay and lesbian people's subjective construction of their experience of having lived and survived a suicidal process. Qualitative interviews were conducted and analyzed as products based on life events. In the participants' accounts, we identified hostile contexts associated with suicide, trajectories associated with gay/lesbian identification processes, and milestones related to victimization experiences as part of the intentionality and rationality of suicide.

KEYWORDS

Adolescence; suicide; gay and lesbian; qualitative research; internalized homophobia

A review of the research conducted over ten years in LGBT (lesbian, gay, bisexual, and transgender) populations concluded that, in general, self-identifying as a sexual minority (Tomicic et al., 2016a)—and being consequently exposed to stigmatization, discrimination, and gender victimization—is by itself a predictor of suicidal tendencies (e.g. Pereira & Rodrigues, 2015; Walls, Freedenthal, & Wisneski, 2008). Specifically, evidence shows that LGBT adolescents constitute a major risk group, given that they often encounter discrimination, violence, and humiliation due to their sexual orientation or gender identity (Cáceres & Salazar, 2013; Pineda, 2013; Puckett et al., 2016). Due to this situation, compared to their heterosexual peers, sexual minority young people continue to experience significant health disparities. These young people report differentially higher rates of anxiety, depression, suicidality, low self-esteem, and substance use (Institute of Medicine [IOM-US], 2011; Hatzenbuehler, Phelan, & Link, 2013; Tomicic et al., 2016a). Regarding

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suicidality, it has been consistently demonstrated that LGBT young people report higher levels of suicidal ideation, attempts, and completions than heterosexual young people, which represents the most concerning disparity for this population (Austin & Goodman, 2017).

Specifically, studies estimate a prevalence of suicide attempts in gay/lesbian/bisexual young people ranging from 20% to 53% (Tomicic et al., 2016a). In comparison, among sexual minorities, the odds of attempting suicide are approximately two to seven times higher than among heterosexuals (Haas et al., 2011; King et al., 2008).

Only a handful of studies on risk factors of suicide (e.g. psychological stress, bullying, victimization, discrimination) in LGBT adolescents have been conducted in Chile. An exploratory study carried out by León, Del Río, and Chaigneau (2012) with lesbian adolescents residing in the country's capital revealed a higher rate of psychological difficulties in them than in their heterosexual peers and in those questioning their sexual orientation. Some time later, TodoMejora [It Gets Better] Foundation conducted a nationwide survey in 2016 aimed at learning about the bullying and school abuse experiences of LGBT children and adolescents. This instrument revealed that over 50% of LGBT students had been victimized at school due to their sexual orientation or gender identity and that 76.2% of students who had experienced more regular victimization linked to their sexual orientation reported high levels of depression (Infante, Berger, Dantas, & Sandoval, 2016). A study performed by the Movement for Homosexual Integration and Liberation (Movilh, 2008) found that 40% of students, 55% of teachers, and 31% of parents or tutors had met at least one person who had been discriminated against at school due to their sexual orientation or gender identity. In addition, it has been reported that 39% of students attending public primary and secondary schools in Santiago have heard of at least one case of discrimination by school officials and/or teachers against a LGBT person (Movilh, 2012). Convergingly, studies conducted in Chile by the Pan American Health Organization and the United Nations Organization for Education have indicated that 42.1% of non-heterosexual young men report having been victims of frequent homophobic bullying and that 68% of LGBT boys and girls living in Chile report the presence of homophobic and transphobic bullying in schools (Cáceres et al., 2011).

The association between sexual minority populations and suicide risk has commonly been approached from the point of view of the social determinants of health (Logie, 2012). In this regard, it has been pointed out that LGBT populations have a high prevalence of mental health problems associated with stigmatization and discrimination. Specifically, the Minority Stress Model (Meyer, 2003; Meyer, Frost, & Nezhad, 2015; Meyer, Schwartz, & Frost, 2008) has provided a way of understanding how belonging to a minority that is discriminated against, such as lesbian and gay young people, is related

to worse outcomes in terms of mental health problems such as depression, substance abuse, social isolation, conflicts with peers, and victimization, all of which increases individual suicide risk factors. This model identifies four minority stress processes that can be categorized as either distal or proximal. External events, such as victimization and homophobic discrimination, are regarded as distal stress processes, heterosexist attitudes such as “assumed heterosexuality” and the problematization of sexual diversity are considered to be intermediate stressors, and the internalization of sexual stigmatization and the concealment of diverse gender identities and sexual orientations are examples of proximal stressors (Gillis & Cogan, 2009; Michaels, Parent, & Torrey, 2016). In this regard, it has been demonstrated that sexual orientation by itself does not lead to suicidality among LGB young people; rather, environmental reactions to non-heterosexual orientations increase suicide risk in this population (Michaels et al., 2016; Tomicic et al., 2016a). For example, the higher levels of psychiatric symptomatology and suicidality in LGBT young people are linked to the negative reaction of parents and the loss of friends due to the disclosure of their sexual orientation (Padilla, Crisp, & Lynn, 2010; Shpigel, Belsky, & Diamond, 2015). Similarly, a study conducted in the United Kingdom showed that discriminatory experiences in children and adolescents belonging to sexual minorities increase perceptions of shame and the use of individual coping strategies, which results in an increased risk of displaying self-destructive behaviors (McDermott, Roen, & Scourfield, 2008). Also, studies employing the Minority Stress Model (Meyer, 2003) have reported that LGBT young people who perceive rejection from their support groups may internalize this attitude and transform it into self-destructive actions, which makes this population especially vulnerable (Blais, Gervais, & Martine, 2014).

The present study

Three intertwined problems constitute the framework for this study: the high prevalence of suicide (12 per 100,000 inhabitants; MINSAL, 2013) and suicidal behavior in Chile (2.2% have thought of committing suicide and 0.7% have made an attempt in the last 12 months; MINSAL, 2018); the progressive growth of adolescent and young population as an at-risk group for suicidal conduct (MINSAL, 2013); and, within this group, male and female adolescents and young people belonging to a sexual minority as a high-risk group for suicidality—a risk that has been shown to be socially determined. These are problems that have yet to receive sufficient visibility in the production of scientific knowledge in Chile and South America.

With regard to the subjective experience of suicide, in line with the conclusions of studies conducted by the World Health Organization’s SUPRE-MISS and EURO agencies (Bertolote et al., 2005), researchers have stressed the need to conduct studies that approach this phenomenon upon the basis of the

meanings that suicidal behavior has for individuals. That is, studies that focus on the ways in which individuals with current or past experiences of suicidal ideation and/or behavior interpret themselves, their actions, and their environments (Hjelmeland & Loa Knizek, 2011). From this perspective, suicidal behavior is regarded as a continuum that ranges from the emergence of the feeling of hopelessness to the completion of suicide and includes ideation, planning, and suicide attempts (Ventura-Juncá et al., 2010). Also, the suicidal process is regarded as an intentional act which has meanings and which is always situated in a cultural context (Hjelmeland, 2011). Therefore, regarding sexual orientation and gender identity as a general determinant of health, and specifically as a risk factor for suicidal ideation and suicide attempts because of the stigmatization and social stressors that affect sexual minorities, makes it necessary to generate culturally-sensitive knowledge about this health issue. Doing this should improve our understanding of the issue, thus strengthening our assistance and prevention efforts aimed at specific social and cultural groups—in this case LG adolescents and young people. Consequently, the purpose of our study was to characterize the subjective experiences of young gay and lesbian Chileans who have survived a suicidal process.

Method

A multiple-case design was used to perform a qualitative analysis of narrative interviews conducted with lesbian and gay young people who have experienced and survived a suicidal process with the purpose of conducting an interrelated, systematic, and in-depth exploration of the subjective construction of their experiences (Stake, 2006). Also, this is a narrative study based on the assumption that the stories of suicide processes told by lesbian and gay young people convey meanings in themselves, because stories function as a basic human means of organizing and communicating life experiences (McLeod, 2010). This approach makes it possible to focus on the ways in which individuals who currently have or have had experiences of suicidal ideation and/or behavior interpret themselves, their actions, and their environments (Hjelmeland & Loa Knizek, 2011; Nicolopoulos, Shand, Christensen, & Boydell, 2017).

This article presents analyses of qualitative interviews with a sample of young people who self-identify as gay and lesbian taken from a larger research project, funded by the National Health Research Fund [Fondo Nacional para la Investigación en Salud (FONIS)] of the State of Chile. This larger project comprises 30 qualitative interviews with young people who self-identify as lesbian, gay, bisexual, or transgender.

Participants

Owing to the richness and density of their narratives, eight young people were selected for this study, four females who self-identify as lesbian and four males who self-identify as gay, all of them cisgender (see [Table 1](#)). Their ages ranged from 20 to 24 years at the time of the interview, from 11 to 21 years when “coming out,” and from 14 to 21 years at the beginning of their suicidal processes. Regarding the latter, the participants represented a variety of suicidal behaviors: initial suicidal ideation (1), serious suicidal ideation (1), a suicide attempt (4), and severe suicide attempts (2). Five of them were undergraduate students and three were working. Almost all of them had had a same-sex romantic relationship and only one was living alone.

The ethical protocol for this study was approved by the ethics committee of Universidad Diego Portales and informed consent forms were signed by all participants, who allowed their interviews to be used for research purposes and related publications.

Authors' reflexivity

The research team was led by the two first authors: a clinician and psychologist (PhD) with vast experience in treating people with suicide crises (CM) and a psychologist (PhD) with extensive experience in qualitative research methods and data analysis procedures (AT). Two of the authors (FA and JR) are experts in sexual diversity and gender related topics, with the former (FA) being the director of the Chilean foundation “CulturaSalud” (Culture and Health) and the latter (JR) being the coordinator of the mental health department of the “TodoMejora” (It Gets Better) foundation in Chile at the time of the study. FL, a child psychiatrist, and IL, a family therapist, were both postgraduate students—PhD and Master’s students respectively—working as research assistants. Finally,

Table 1. Participants' characterization.

ID	Title	SO ^a	Age ^b	Activity ^c	Suicide Behavior
1	THE SECRET	Gay	22	University student	Severe suicide ideation (14 years old)
2	P'S DOUBLE LIFE	Lesbian	23	University student	Suicide ideation and attempt (15 years old)
3	CONDEMNED TO SOLITUDE	Gay	23	University student	Suicide attempt (19 years old)
4	I'LL GO TO HELL	Gay	24	Public administration worker	Suicide ideation (16 years old)
5	IF I HAD BEEN HETEROSEXUAL	Gay	24	Works on subjects related to sexual diversity	Three attempts (14 years old), the last of which was serious
6	THESE THINGS HAPPEN	Lesbian	23	University student	Suicide attempt (14 years old)
7	FEAR OF REJECTION	Lesbian	20	University student	Suicide attempt (17 years old)
8	THE IMPERFECT DAUGHTER	Lesbian	23	Public administration worker	Severe suicide attempts, hospitalization

(a) All the participants identified themselves as cisgender. (b) Age at the moment of the interview. (c) Activity at the moment of the interview.

CR and CG are young clinical psychologists working as research assistants as well.

Procedures

Data collection

The participants were invited to enroll in the study through an advert on the websites of the associated institutions Todo Mejora and CulturaSalud, as well as on social media (Facebook, Twitter, and WhatsApp). This advert presented the title and purpose of the study, making explicit the inclusion criteria used: adolescents and young people who self-identify as LGBT, aged 18–24 years, and who had had suicidal thoughts, made suicide attempts, and/or or displayed suicidal behaviors between ages 12 and 23.

Semi-structured narrative interviews (Kvale & Brinkmann, 2009) were conducted by AT, CM, FA, FL, JR, and CG, all of them trained in interview techniques in qualitative research. An interview script was designed for this study and discussed in regular meetings of the research team in order to monitor the implementation of the interviews during the research process. The opening question for the interview was: “Why did you decide to participate in this study?” This question was aimed at understanding the interviewees’ position when telling their story. To initiate the narration of their experience we asked the participants: “I’d like you to describe in greater detail the process you experienced; tell me about your experience of having considered suicide or attempting to do so.” Together with each interviewee, we structured into a coherent story the multiple stages, milestones, causality attributions, and references to cultural and social imperatives surrounding their experiences of going through a suicidal process. During the interview, three topics were explored as they were mentioned in the participants’ narratives: (1) Attributions of causality regarding the suicide process experienced and its “drivers” (e.g. What situations do you think contributed to your decision to consider suicide?; (2) Requests for help (e.g. Did you ask for help at any point? What type of help? Whom did you contact? What expectations did you have regarding the help you would receive?; and (3) Reasons for living (e.g. What do you think made you “survive” or stop considering suicide? To name and refer to suicidal behavior, we prioritized the terminology used by the interviewee (e.g. taking one’s life, disappearing, dying).

All interviews were audio-recorded and transcribed verbatim. Interviewees were assigned a pseudonym to safeguard their anonymity; also, the information provided by them was edited to make it generic (e.g. street, city, university instead of the proper names used) and thus keep it from somehow revealing their identity.

Analysis procedures

The narrative interviews conducted were analyzed using Discovery-Oriented Biographical Analysis (DOBA), which involves two analytic operations (see Duarte, Fischersworing, Martínez, & Tomicic, 2017) aimed at examining the organization, interpretation, and meaning of the interviewees' experience. The analyses were led by the first author (AT), while all the members of the research team (CM, CR, FA, FL, JR, CG, and IL) participated performing the two analytic operations. To conduct the analyses and ensure their quality and trustworthiness, regular meetings were held in which the concepts and categories developed by each researcher were discussed upon the basis of interview excerpts.

One of the analytic operations performed, the open coding procedure, is taken from the Grounded Theory approach (Charmaz, 2006). This procedure consists in the development of concepts and categories inducted from the narrative of the participants. In order to do this, we approach the interpretation of the various fragments of the interview transcript with two analytic questions: What is the text talking about? and What does it say about it? The answer to the first question makes it possible to generate a concept or category, while the answer to the second question (what does it say about it?), applied to the same fragment of the transcript, allows us to develop the concept or category previously generated in terms of its properties or dimensions. Regular meetings were held with all members of the research team to triangulate the analyses and reach intersubjective agreement regarding the categories, concepts, and properties developed (Flick, 2007).

The other analytic operation is the narrative organization of the categories developed during the open coding procedure. This was done with the Model of Construction of the Self in Biographical Narration (Piña, 1999, 1998). This model regards narratives as the product of the *subjective I* which organizes, interprets, and gives meaning to life events. To reconstruct the subject's narrative in an interview, this model proposes the identification of contexts, stages, milestones, causality attributions, and references to moral imperatives in the narrative and their later organization into a narrative structure. Using this model to analyze the categories, concepts, and properties developed in the open coding of each interview, we reconstructed a unique narrative that conveys a shared experience regarding the participants' suicide process.

Results

By applying the DOBA to the narratives of the suicidal processes of the eight lesbian and gay participants, we were able to rebuild what seems to be a recurrent experience of members of sexual minorities when facing and surviving a suicidal process. We organized this recurrent experience by describing multiple aspects of it, which are temporally combined—

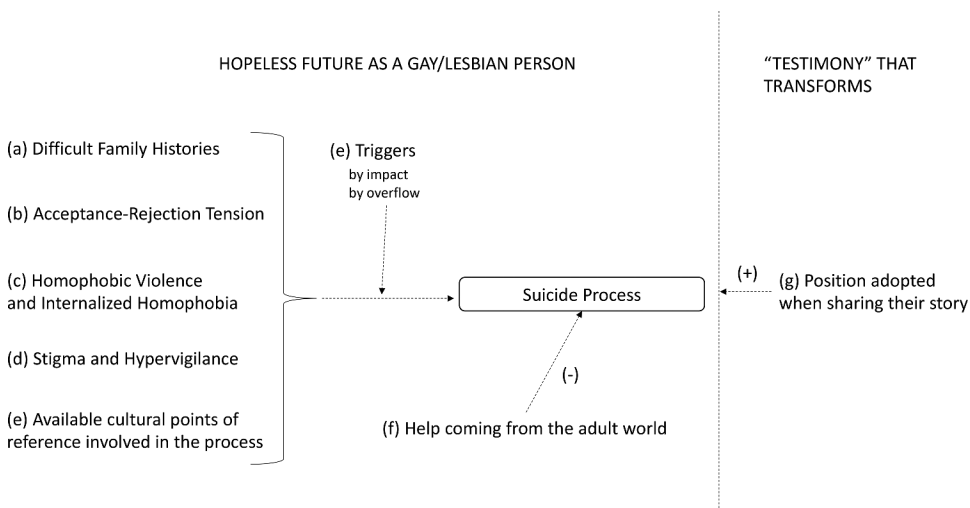


Figure 1. Subjective Construction of the Suicidal Process in Young Gay and Lesbian.

diachronically and synchronically—to give an account of the motives and intentions that are associated with and surround suicidal behavior, constructed as a “hopeless Future as a Gay/lesbian person” (see Figure 1). These eight aspects are (a) Difficult Family Histories, (b) Acceptance-Rejection Tension, (c) Homophobic Violence and Internalized Homophobia, (d) Stigma and Hypervigilance, (e) Available cultural points of reference involved in the process, (e) Triggers, (f) Help coming from the adult world, and finally (g) Position adopted when sharing their story.

In addition, cases were assigned a title summarizing their most salient aspect, taken from each participant’s experience of dealing with and surviving a suicidal process (see Table 1).

The following section presents each of the elements that configure the description of the recurrent experience of suicide as narrated by the interviewees. These elements are described in detail and illustrated with interview excerpts labeled with the title assigned to each case and noting the participants’ sexual orientation.

Difficult family histories

In all of the narrated experiences analyzed, we observed what we have labeled “Difficult Family Histories,” either due to conflicts at the family level and threatening parental figures—real or imagined—or due to a hostile family climate regarding sexual diversity.

Seven of our interviewees describe difficulties and conflicts at a family level that match risk factors generally associated with suicide. These difficulties and conflicts can be grouped into four categories: i) a complicated parental

breakup with the child acting as a go-between (1), ii) parental distancing, negligence, or abandonment (2, 5, 6), iii) alcoholism or drug consumption by a parent (1, 6), and iv) a restrictive, highly demanding family environment (2, 3, 7, 8).

Additionally, five of the eight cases analyzed (2, 3, 4, 5, 8) show the presence, at a family level, of homophobic tendencies that could express themselves in many ways, from discriminatory discourse to a direct rejection of the narrator's gay/lesbian sexual orientation. Some of the interviewees report aggressive or stigmatizing comments (1, 2, 3, 5, 6, 8); others describe discrimination, heteronormative vigilance of their gendered expressions, and a direct rejection of their sexual orientation by parents and siblings (2, 3, 5, 8) (for instance, in one of the cases a mother asks the narrator to avoid being noticeably gay/lesbian); and others even report tragic or disappointed reactions by parents to the disclosure of their children's gay/lesbian orientations, going as far as attempting, explicitly or implicitly, to convince them to attend a sort of "conversion therapy" (for instance, insisting that the narrator should consult a psychologist to get help with this "issue").

For instance, one interviewee notes how "off-the-cuff" comments from their loved ones, in this case his brother, contribute to the generation of a hostile and threatening family environment regarding their gay/lesbian orientation:

... My brother, before going off to Spain, used to say the nastiest things: 'If I had a gay son, I would kill him'. Things like that, harsh things.' (*The Secret, Gay*)

Some interviewees narrate scenes which, in an everyday and almost harmless way, reveal that their families become an environment where the fulfillment of heteronormative mandates is monitored, where diverse sexual orientations and gender expressions have no place or are discredited and stigmatized. This can be observed in the following excerpts taken from interviews with a gay young man and a lesbian young woman:

Even today, when they [my family] speak about homosexuality they kind of goof around, my cousins, my brothers, my uncles, they joke like ... You are not as much of a man, it is a very common joke, like, if a man lets a woman take charge, they joke like if you were less of a man. (*I Will Go to Hell, Gay*)

(...) and then when I was in high school—when I was in secondary school, my parents thought my romantic relationships weren't good because I had to be the same as all my friends and all my friends had 'hetero' relationships, they all went out with boys and everything (ha) and they had steady boyfriends and everything, and I, like, every time I tried it didn't work (*Fear of Rejection, Lesbian*)

These difficult relational histories constitute the background of the tension between acceptance and rejection of the narrator's diverse sexual orientation.

Acceptance-rejection tension

Acceptance-rejection tension is connected both with others, mainly parental figures, and with the self. In all the cases that were analyzed, fear of rejection appears to be the main effect of this tension.

On some occasions, this fear of rejection is based on behaviors and beliefs that participants identify in their parents and family contexts, a fear that is confirmed by their attempts to disclose their gay/lesbian orientation. For instance, the following fragment shows how the expected parental rejection of gay/lesbian sexual orientation is confirmed, either explicitly or implicitly, when they are discovered:

(...) I had accepted that I was going to finish college and I was never gonna see my parents again, you know? I was gonna have to live my life somewhere else, start from scratch, because that was the only way out (...) I had come to terms with the idea that they were gonna reject me and I didn't want to experience that either (...) My mother found out that I liked a girl and it was very chaotic, horrible ... It was difficult, because her reaction was to ask me how could I do this to them, after everything they had done for me, as good parents, giving me everything I needed, after supporting me, how could I repay them in this way ... I was very scared because, for me, the fact that I could feel something for another woman was stigmatized. (The Imperfect Daughter, Lesbian)

On other occasions, this fear of rejection is more a fantasy than a reality: narrations contain less evidence based on participants' concrete experiences in their relationship with their parents; also, when their gay/lesbian sexual orientation is revealed, they find that their fear was unfounded.

In various ways, this tension between acceptance and rejection results in the concealment of the narrators' sexual orientation, making it difficult for them to develop their own identity in a way that integrates their sexuality. Likewise, it is associated with making tremendous efforts—at a huge emotional cost—to hide that part of their identity, which, as a correlate, lead to progressive isolation, manifested through fantasies of escaping to other cities and breaking all family ties as strategies for avoiding the rejection that they fear so much. Furthermore, in seven of the eight cases analyzed (1, 2, 3, 4, 5, 7, 8), fear of rejection—real rejection of their sexual orientation or even the fantasy of being rejected over and over again in the future—was the main cause leading to suicide.

Homophobic violence and internalized homophobia

It is also possible to trace, in at least seven of the eight narrations, experiences of homophobic violence in the form of violent discourses, symbolic-institutional violence, transgressions of intimacy, and homophobic bullying. For example, the narrations implicitly shape the notion that gay/lesbian sexual

orientation is something that must be “treated,” “discussed,” corrected, or repaired—through therapy with a counselor or a psychologist. Also, some of the interviewees (1, 6, 7, 8) experienced the social pressure to expose their sexual orientation with the statement “you have to say it.” The following fragment makes this pressure explicit through the actions of psychologists who, by breaching their confidentiality agreement, institutionally inflict homophobic violence:

That’s when they told [my mom], I never said I actually was [a lesbian] and I never denied it to the psychologists, but they like had clearly seen that I actually um and they told her. My mom came crying into my room one day and she tells me ‘they said this and that to me, I want to know if it’s true’ and I told her ‘I have no idea what that is, I don’t know what a gay/lesbian is, but that’s right, I prefer to be with women, I like to caress them, I like to kiss them and I’m repulsed by men’ and then she started crying and everything and like that’s when the whole process started (Shit Happens, Lesbian).

Other interviewees (1, 4, 5, 6, 7) describe homophobic bullying experiences as well as violence and hate in public settings:

The situation in my class deteriorated greatly because they started making fun of me, everyone found out and the bullying became bad, really bad. I started feeling very isolated, nobody talked to me, I was very, very lonely (...) It started there, the moral judgment started there in front of the class, that it was not right, that it was like immoral, dirty, things like that (The Secret, Gay).

On the other side of the coin, some of the cases display signs of internalized homophobia. Such signs manifest themselves through (a) stereotyped and disqualified images of gay/lesbian sexual orientation which take part in the initial confusion and in the tension between acceptance and rejection of the narrators’ sexual orientation; (b) feelings of guilt and fantasized scenes in which love is not possible for a gay/lesbian person; and (c) a deep feeling of hopelessness.

... that’s what I felt, I hated myself at some point, because it was like ‘why do I act this way if I don’t have to be this way?, why do I do this?’. I hated myself, or I don’t know if I hated myself, but I didn’t like who I was (I Will Go to Hell, Gay).

Stigma and hypervigilance

In order to deal with homophobia and internalized sexual stigma, the young people interviewed become engaged in a process of “hypervigilance” in which the stigma associated with their own sexual orientation prevails. So, to a larger or smaller extent, they mention a permanent state of exploration and vigilance of their surroundings and of themselves in search of signs of hostility or security. This state of susceptibility appears in the participants’ narrations as

a chronic source of anxiety or anguish, progressively increasing their emotional burden.

It was like very tiring for me to have to think every day, I don't know ... I went to the mall and I found some clothes I liked and I said, "okay, are these normal 'straight' clothes? I mean, is this tracksuit fine? Or maybe if I choose this t-shirt it will be a bit like showing I'm gay," or, I don't know, in a conversation, "is my thinking gay or maybe it's 'straight'?" I preferred to keep those things to myself [so that] it wouldn't be noticeable (Condemned to Solitude, Gay)

In some cases (1, 2, 7, 8), hypervigilance regarding the stigma is transformed or resolved via the construction of a double life, simultaneously meeting the heteronormative expectations of their environment and those associated with living in accordance with their sexual orientation, but at a high emotional and psychological cost.

The thing is my friends are all 'good' girls I mean (...) they all had boyfriends, they all did things the right way, they were really feminine [cries], I'm like that too, but I had this thing that didn't fit in (ha) (...) and I would defend those girls they said things like 'oh, look, that girl is a 'lesbo' (...) and I would say 'it doesn't matter, let her be', but I'm telling you at the same time I didn't want to be singled out I didn't want any fingers pointed at me you know? (Fear of Rejection, Lesbian)

Available cultural references involved in the suicide process

Interestingly, in the narrations, cultural points of reference are not only present but also participate at different moments of the suicidal process. These points of reference, materialized by means of mass media images, amplify the participants' fear and hopelessness. Furthermore, some of the interviewees mention religious points of reference, of the Catholic religion specifically, in which gay/lesbian sexual orientation is condemned as a sin, causing guilt that could be expiated. In the following fragment, one of the participants narrates how he connects with the possibility of dying due to being gay/lesbian after watching a film at school.

They brought the movie Brokeback Mountain ... these two homosexual cowboys ... I was left devastated after the movie, because I was feeling very sensitive and the movie talked about love and many other things, at the end one of the actors is murdered, he's murdered due to his homosexuality. So, okay, I was feeling terrible and then I fell into a deep state of depression, sadness, crying, and, alone in the classroom I took all the pills I found in the first-aid kit (...) I think that when I saw that movie the theme of romanticism, of love, was already in the air, right? Love between two people, in ninth grade I didn't have that contact with anybody, and okay, at the end of the story one man is killed because he's homosexual. Right, I think that at that point, that was like "so this can happen to me, I can die because of this." It was, okay, like "I don't know what I'm doing here, I mean, if I'm going to die in any other way I'd rather die now" (If I Had Been Heterosexual, Gay)

Triggers of the suicidal process

In the eight stories analyzed, the way in which the suicidal process connects with the identity development process, homophobic violence, internalized homophobia, stigma, and hypervigilance can be determined by analyzing the suicidal trigger. This trigger can be either a specific event (trigger by impact) or a small event that functions as “the straw that broke the camel’s back” (trigger by overflow). In the first case, a specific event interrupts the process of discovery, acceptance, and integration of the participant’s diverse sexual orientation; this would apply, for example, if a school friend of the narrator told the whole class that he was gay, which would mean that his mother would eventually find out. In the second case, a minor or circumstantial event would confirm, for the narrator, the increasing impossibility and hopelessness that he or she associates with life as a gay or lesbian person:

For a start I wasn’t going to school anymore ‘cause I had lost my scholarship, I didn’t have any chances to return to school because the tuition was really expensive. I thought I had lost everything, my granny—who was a strong support for me—my career, my partner, my whole future and life. I really didn’t want to see or talk to anybody, and on that same day I arrive from a party, open Facebook and see a message from my ex (...), I didn’t want anything else, I closed everything, I didn’t care anymore, everybody was asleep, so I started popping pills, pills, pills, I had a few shots of alcohol so pills, shots, pills, shots until ... I really would have kept on taking pills if I hadn’t collapsed, passed out (Shit Happens, Lesbian).

In this mental, relational, and sociocultural context, suicide as an idea, intention, and/or action seems to materialize and express the fatigue and hopelessness that the young person feels in connection with developmental tasks which have been interrupted or hindered—or which he/she has given up trying to fulfill: mostly those of affirming one’s identity and establishing romantic relationships.

Well, what happens is that maybe due to my history, when I was feeling quite distressed by this issue [gay sexual orientation] my closest friends realized that I wasn’t feeling okay (...) um like many times I thought like the solution to this issue was suicide, and that time it’s like I said, okay, I have to put an end to this because I’m not doing what God wants, I’m going to make my family feel bad, sad, terrible, it would be for the best if I just wasn’t here. If I’m not here anymore I’ll stop sinning, maybe God will forgive me for having committed suicide because I had a good justification and maybe my family will be sad, but at least they will find peace because I’ll no longer be there with my [gay] way of life ... at least they won’t have to suffer the shame of accepting [me] (I Will Go to Hell, Gay).

In some of these cases, we can observe a hopelessness that is derived from depression caused by an accumulation of experiences of rejection, discrimination, and other issues. In other cases—which could be considered to be harder to tackle—this hopelessness is more permanent, being linked with the

impossibility to achieve an identity and a place in one's society and family or gain personal legitimacy as a gay or lesbian person.

... life in the case of gay people—or in my case, actually—won't be the same as for other people, I'll probably never have a stable relationship and I actually still think that way about gay people (...) it's very unlikely that I'll have a stable partner and when I grow up probably, I don't know, when I'm forty I'll be alone, I'll live alone (...) those thoughts bring me down sometimes (Condemned to Solitude, Gay).

Help coming from the adult world

In this process, the help coming from the adult world, from both the spheres of the school and mental health care, is described as rather clumsy and as something that at times deepens the problem. This is partly due to the fact that, in the experience of these young people, the problem is situated by the adult world as one that concerns their sexual orientation, thus contributing to the context of gender victimization. Particularly, in at least five of the eight cases, the psychologists' actions are described as discriminatory, ignorant, and characterized by interventions that do not help the patient and which even amplify their problems. We also observed that many of those interventions do not take into account specific themes and motives that preoccupy sexually diverse people. In this context, the possibility of receiving help from a mental health professional is affected by the activation of hypervigilance:

It's frustrating not being able to find a clear answer because I also think that this phenomenon, becoming aware that you are homosexual, and starting to get depressed is very likely to keep others from finding out and if someone finds out it's like the problem gets worse. Putting a psychologist in the middle of all this also makes you (I experienced that) deal with it as if it was another threat, I mean it's like the psychologist came to treat you as if you were sick (The Secret, Gay).

Other interviewees narrate actions and interventions that reveal a lack of specific competences that is frequent among those who work with gay/lesbian people:

Well, they forced me to go to a psychologist. I had a very bad experience with that psychologist. In fact she made me decide whether I was a lesbian or "straight," and I actually back then I didn't know what I was ... I was experimenting, I was living, I was discovering. And I was also very scared, because for me it was sort of stigmatized, the issue of having feelings for another woman (The Imperfect Daughter, Lesbian).

Testimonial positioning

Finally, in all the cases, we observed a subjective movement, a change in the narrators' positioning that reconciles them with their sexual orientation and

allows them to progressively integrate—and maybe reconstruct—their identity, and which is experienced as a constructive movement for themselves and for their environment. We call this movement “Testimonial Positioning,” that is, a psychological and identity-related place from which the participants can share their “testimony” of an experience of suffering that transforms them, helps them to grow as individuals, and completes them in their subjectivity, eventually becoming a comforting legacy for others:

It was a major change, very very important, (...) a change a change in my life—yes yes it was heavy it was quite a long and painful process but I think it was fruitful and that’s when I decided to be more political well and to join a foundation to work for young people, for people who went through this and who did not find support in their in their age group, so we can do some peer work with them, I don’t know—I joined Fundación Iguales, and at Fundación Iguales I was already studying political science precisely to change policies, I don’t know, it was a whole mentality already; that’s why I told you that it often defines me; sexuality defined many aspects of my life (If I Had Been Heterosexual, Gay).

Discussion

This study sought to explore the way in which a group of lesbian and gay young people biographically reconstruct how they experienced—and survived—a suicidal process. We have organized this discussion around four core aspects that summarize the results presented and allow us to discuss them.

The first element that stands out is the way in which certain “general” suicide risk factors acquire a “specific” form in the case of lesbian and gay young people. The narrations analyzed display hopelessness, a general risk factor for suicide (see Nicolopoulos et al., 2017) that adopts a very particular form in the interviewees. During their suicidal process, the possibility of an encouraging future, of personal fulfillment, is interrupted due to the mere fact of having a diverse sexual orientation. At a very basic level, this attitude toward the future is obstructed by a homophobic environment and its inclusion into the participants’ self, in the form of internalized homophobia. In this regard, we observe that normative development tasks, such as the construction of a positive personal identity and the establishment of romantic relationships, are interrupted or hindered by adverse events linked to prejudice against gays/lesbians or homophobic discrimination.

The above is in line with international research that indicates that LGB young people are at a higher risk for suicide if they reveal their sexual orientation at an earlier age (Remafedi, Farrow, & Deisher, 1991), possibly because they are exposed to discrimination due to their sexual orientation for a longer period and while their identity is less solid. Also, it has been reported that, for these young people, seemingly minor and trivial experiences of rejection and discrimination linked to stigmatization accumulate over time

(i.e. trigger by overflow), which results in serious consequences for their mental health (Meyer, Ouellette, Haile, & McFarlane, 2011). Microaggressions such as those described by the young people interviewed in this study convey and imply the erasure of their diverse identity and sexual orientation (Nadal, 2008; Sue et al., 2007). As pointed out by Meyer (2003), in its Minority Stress Model, continuous exposure to such stressful events—either open discrimination or microaggressions—makes the mental health status of sexual minority people worse than that of their heterosexual peers.

In connection with the above, and following Savin-Williams and Ream (2003), Bronfenbrenner's (1979) ecological model can be used as a framework to organize the components of suicide risk as well as the factors that protect and promote psychological well-being in lesbian and gay young people. These components, as the experiences of our interviewees have shown, can be located in various levels of the system: the immediate microsystem (e.g. family rejection, homophobia, bullying), the mesosystem (e.g. psychological care system, school system), and the macrosystem (e.g. heteronormative social imperatives and cultural points of reference leading to hopelessness). This view of risk factors involves considering how generic risk factors interact with specific ones associated with this social group, for instance, the way in which individual vulnerability to mental health problems is affected by specific stressors of sexual minorities.

A second element that must be highlighted is the link between identity construction, internalized homophobia, hypervigilance, and the suicidal process. Our analysis suggests that the connection between these conditions and the suicidal process lies in the events that trigger it. As the results presented reveal, either by impact or overflow, in all cases the content of the trigger is related to the interviewee's diverse sexual orientation. LGB research shows multiple ways in which issues linked to sexual diversity influence mental health processes that eventually lead to suicidal behavior. Thus, in the case of what we have called *trigger by overflow*, stress related to stigmatization can lead to isolation, internalized homophobia, and, in consequence, to a reduction in social support (Hatzenbuehler, 2009; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). Also, as noted by Pachankis, Golfried, and Ramrattan (2008) and as we observed in the interviewees' narrations, concerns regarding rejection and negative opinions can lead young people to avoid close relationships because they fear that their stigmatized identities will be discovered. In the mid and long term, this strategy provides them with relief and protection, but causes an increasing feeling of loneliness, isolation, and social anxiety.

Closely linked to the above, a third aspect that stands out in the results is that the participants' doubts regarding their right to exist in the world appear to "set in motion" the suicidal process. Thus far, we have observed that doubts, or in some cases certainty that being gay/lesbian is morally bad and/or entails

harm to loved ones—especially parents—, leads young people to put into question this fundamental right. Specifically, internalized homophobia and hypervigilance of stigma appear to be signs of these doubts, and therefore triggers of the suicidal process. In this regard, the chronicity of the stressors encountered emerges as the main source of hopelessness, a construction linked both to depression and suicide (Russell & Joyner, 2001). In addition, family is a context where doubts regarding one's right to exist as a gay/lesbian person can be strengthened. In several of our interviewees, the discovery of their gay/lesbian sexual orientation by family members in a context of imagined or real rejection was the event that precipitated, as a trigger by impact, the suicide process. In this regard, Ryan, Russell, Huebner, Diaz, and Sanchez (2010) showed that LGB young adults who had experienced high levels of family rejection were 8.4 times more likely to report having attempted suicide during adolescence and 5.9 times more likely to display depressive symptoms than peers from families with low or moderate levels of rejection. Thus, a supportive family environment is important when trying to reduce suicide risk in young people with a diverse sexual orientation, among other reasons because such support can attenuate the effects of sexual orientation-based victimization (Poteat, Aragon, Espelage, & Koenig, 2009; Rivers, 2001).

Finally, a fourth noteworthy element in our results relates to the question of how diverse sexual orientations can be integrated in interventions aimed at providing help in cases such as those examined in this study. When we talked about the effective help coming from the adult world, our interviewees emphasized the need for a reliable environment where victimization experiences are acknowledged, not minimized or ignored. Interviewees also refer to the usefulness of a discourse that challenges stigmatization and state that it is urgent and necessary to clearly manifest that these issues originate in discrimination and homophobic violence, and not sexual orientation. In this regard, Ryan et al. (2010) point out that mental health care and medical providers can help young people and their families identify supportive behaviors that can protect them from risk factors and promote a healthy psychological development. Such behaviors include talking to young people about their LGB identity, assist them when they are mistreated due to their diverse sexual orientation, and offer them an adult role model, as a lesbian or gay person, that reveals a possible future to them (Morrison & L'Heureux, 2001).

However, other studies have shown that the factors that hinder LGB young people's access to psychological and psychotherapeutic care include the fact that few professionals specialize in treating people with a diverse sexual orientation (Bidell, 2016; Rutherford, McIntyre, Daley, & Ross, 2012) and that some therapists harbor explicit or implicit prejudices and negative attitudes toward sexual minorities (Bidell, 2016; Bidell & Stepleman, 2017).

Although all interviewees provided relatively similar stories, eight cases may be insufficient when assessing how representative our results are

within the lesbian and gay population. Other sociocultural factors, such as social status, living in an urban or a rural area, or belonging to a gender activism or sexual diversity organization, may increase intersectionality, thus adding nuance and richness to the results highlighted here (e.g. Lardier, Bermea, Pinto, Garcia-Reid, & Reid, 2017). In addition, future analyses should take into account the gender variable, because the constructions of the suicide experiences of these young people may vary depending on sociocultural strictures linked to gender identities; for instance, those related to the binary and stereotyped division of roles and expressions of the female and male genders. Nevertheless, and despite the limitations noted, we consider that the cases analyzed and the results presented, as a shared experience, suggest a perspective that is both complex and situated. That is, it shows how general and specific risk factors for suicide, along with the stress processes that affect minorities, are linked with the biography and the singular experiences of LG young people who have survived a suicidal process (Morrison & L'Heureux, 2001; Savin-Williams & Ream, 2003). This perspective, though limited in terms of its generalizability to the whole population of gay/lesbian young people, is extremely generative when attempting to identify possibilities for suicide prevention and related interventions in these cases, both at the micro and the macro levels of the socioecological system.

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