“CELEBRATE, UPLIFT, RESIST!”

A MIXED METHODS EXPLORATION OF SUICIDALITY AMONG QUEER AND TAKATĀPUI PEOPLE IN AOTEAROA NEW ZEALAND

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Abstract

In Aotearoa, a growing body of research has demonstrated a greater 'risk' for suicidal ideation, self-harm, and attempted suicide among people with diverse sexualities and genders, compared with cisgender-heterosexual counterparts. Few studies have investigated the applicability of explanatory theories of suicide with queer and takatāpui samples. Of those which have, the Interpersonal Theory of Suicide and the Minority Stress Model are commonly utilised, arguably attributing suicidal risk and resilience to one's internalised processes in application. Alternatively, the Three-Step Theory of suicide and the Theory of Decompensation provide frameworks for understanding how social processes elicit and attenuate suicidality among queer and takatāpui people. The current mixed-methods research consisted of a survey examining the applicability of the Three-Step Theory, and a qualitative study, informed by the Theory of Decompensation, exploring queer and takatāpui people's perspectives on suicide. In study one, the three steps were tested using survey data from 250 queer and takatāpui people. Step-one, discrimination and hopelessness were positively associated with suicidal ideation, but the interaction of these variables did not predict suicidal ideation. Step-two, among participants with high discrimination and hopelessness, social support was negatively associated with suicidal ideation when social support exceeded discrimination. Step-three, participants who previously attempted suicide (SI/SA subgroup) had greater self-harm behaviours than participants who experienced suicidal ideation but never attempted suicide (SI/- subgroup). Self-harm more precisely categorised SI/SA subgroup membership than SI/- subgroup membership. In study two, twenty queer and takatāpui people were interviewed to explore understandings of suicidality, discrimination, and resilience. Five themes were developed using a theory-driven approach to reflexive thematic analysis, underpinned by social constructionism and the Theory of Decompensation. These themes were "*Not just this Amorphous Subject*", "*You're Removing the Responsibility from Society*", "*Social Norms Require a Deviant Group*", "*the Straw that Broke the Camel's Back*", and *Ethnicity and Resilience to Suicidality*. The applicability of step-two and step-three processes were supported, and the influences of ideologies, intersectionality, and privilege on suicidality were discussed by participants. These findings are situated within literature on suicide and the two respective theories used. Implications for clinical practice are discussed in relation to *processes* of suicidality and *co-appraisal* of suicide risk assessment.

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Takatāpui should define the line between what we accept and what we tolerate. We should not accept being tolerated. We should only tolerate being accepted for who and what we are.

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Language: On the Same Page

The importance of language cannot be overstated in terms of its use, power, and meaningfulness (Tuffin, 2005). As the basis for almost all our social interactions, language acts as the medium in which we communicate ideas, develop connections with people, and construct understandings of intangible and abstract concepts. It is often not until we are confronted with the misuse of language, particularly when directed towards ourselves, that we reflect on the impact that it can have (e.g., misgendering). Hence, I wish to start this thesis by orientating the reader towards the language that characterises the current research project. I think of this as a process of forming a shared understanding and providing insight into the communities that contributed to this research as both consultants and participants.

Table 1 presents this language in three parts. The first part presents terms used by the participants, academic literature, and me to describe the diverse sexualities and genders within our world. Most of these terms have been defined using the *Trans 101 Glossary* (Gender Minorities Aotearoa, 2020) and the *InsideOUT Terminology* (InsideOUT, 2022). I have provided cautionary disclaimers for some of these terms. Specifically, if the use of the term has been deemed **unacceptable** by queer and takatāpui communities, or if the term is **only** acceptable to use within **certain contexts** or when someone **identifies** with the term. The second part pertains to kupu (words) of te reo Māori (Māori language) that I use throughout this thesis and have primarily been defined using *Te Aka Māori Dictionary* (Moorfield, 2023). For the third part, I have outlined the terms which are commonly used within mental health settings and the field of suicidology when referring to thoughts, behaviours, and actions related to suicide, which I use interchangeably throughout this thesis.

Given that language is ever evolving, and the appropriateness of words fall in and out of fashion, it is important that this glossary is read with a grain of salt. While I have endeavoured to present terms in a respectful manner, and highlighted terms that are no longer appropriate within contemporary society, I cannot safeguard against the forces of change, nor should anyone endeavour to do so. As such, this glossary is best thought of as a guide rather than a comprehensive dictionary.

Table 1

Glossary of terms and words relevant to the current research project

Sexuality and Gender Terms	Definition
Agender	A term to refer to feeling neutral in one's gender or to denote the rejection of gender influences upon one's self-identification. **
Aromantic	A spectrum of romantic orientations, generally indicating one who experiences little to no romantic attraction towards other people.
Asexual	A spectrum of sexual orientations, generally indicating one who is not motivated by sexual desire/attraction towards other people.
AFAB	An abbreviation meaning *assigned female at birth*, used as an appropriate means of referring to trans people's sex assigned at birth. **
AMAB	An abbreviation meaning *assigned male at birth*, used as an appropriate way of referring to trans people's sex assigned at birth. **
Bisexual (bi)	Previously referring to people attracted to both men and women within the gender binary, the term has since been redefined to denote those who are attracted to both their own gender and other genders. Of note, bisexual is still commonly used according to the outdated definition (i.e., sexual attraction to both binary men and women). **
Cisgender (cis)	A prefix or adjective that denotes people who identify with the gender they were assigned at birth. **
Cisgenderism	"Refers to the cultural and systemic ideology that denies, denigrates, or pathologizes self-identified gender identities that do not align with assigned gender at birth as well as resulting behaviour, expression, and community. This ideology endorses and perpetuates the belief that cisgender identities and expression are to be valued more than transgender identities and expression and creates an inherent system of associated power and privilege" (Lennon & Mistler, 2014, p. 63).
Cisnormativity, cisnormative	The social norm that those who self-identify with the gender that they were assigned at birth (i.e., cisgender) are normal/superior/natural compared with those who self-identify with a gender that differs from the one they were assigned at birth (e.g., trans, nonbinary). **
Coming out, come out	Shortened versions of the metaphor, *coming out of the closet*, which refers to the process in which one comes to

	accept and/or identify with their own sense of gender and/or sexuality, and in turn discloses their gender identity and/or sexuality to others.
Cross-dresser	A term describing people who typically identify with the gender they were assigned at birth but partake in expressing themselves using attire associated with other genders. Unless stated by an individual who identifies as a cross-dresser, this behaviour is not inherently indicative of one's sexual orientation or sexual preferences. This term is only appropriate to use if the person self-identifies with this word. **
Deadname	The name assigned to a person at birth, or used prior to transitioning, which is no longer used by the individual.
Discrimination	For the purposes of the current research, discrimination is defined as the prejudicial treatment and/or negative attitudes towards people on the grounds of their attributes and/or demographic characteristics (e.g., age, sex, ethnicity). As a pan-descriptive term, discrimination will encompass synonyms, including victimisation, bullying, harassment, marginalisation, stigmatisation etc. (Herek & McLemore, 2013).
Diverse…	I use the word diverse as an adjective to denote that the subsequent or proceeding subject(s) and/or noun(s) differ from counterparts that are typically considered to be 'normative' or 'dominant' within society. For example, *diverse sexualities* would denote sexual orientations other than heterosexual/straight.
Endosex	"A person who possesses sex characteristics that would have them classified as male or female at birth" (InsideOUT, 2022, p. 1), and does not experience diverse sex characteristics.
Gay	A term to describe people who experience sexual and/or romantic attraction to others of the same sex or gender. Gay is typically used as an identity term to denote the sexuality of men who are primarily or exclusively attracted to men.
Gender, gender identity	"One's actual, internal sense of being male or female, neither of these, both, etc. In some circles, gender identity is falling out of favour, as one does not simply identify as a gender, but is that gender" (Gender Minorities Aotearoa, 2020, p. 4).
Gender-affirming healthcare	"Healthcare that is respectful and affirming of a person's unique sense of gender and provides support to identify and facilitate gender healthcare goals. These goals may include

	supporting exploration of gender expression, support around social transition, hormone and/or surgical interventions" (Oliphant et al., 2018, p. 4).
The gender binary, the sex binary	Archaic categorical systems that (incorrectly) assume that both gender and sex consist of only two possible categories, male and female. As such, these systems insight discrimination against people who do not align with either of the two categories for gender and sex, including intersex and trans people. **
Gender dysphoria	A clinical term referring to the psychological distress experienced by individuals, precipitated by incongruence between one's birth-assigned sex and/or bodily characteristics, and one's sense of gender (American Psychiatric Association, 2022).
Gender expression/presentation	The physical appearance of one's gender as expressed through external presentation (e.g., clothing, make-up, hairstyle) and mannerisms (e.g., voice, gesturing, behaviour). **
Gender modality	A term to describe the connectivity, or disjunction, between one's gender identity and the gender/sex that they were assigned at birth. As an open-ended category, gender modality invites the disclosure of any term that denotes one's experience of this relationship, including trans, cis, nonbinary, and intersex (Ashley, 2021).
Gender norms	A set of socially- and/or culturally- defined principles that govern the societies' expectations on what attributes, behaviours, and roles are appropriate or normative for males and females. Gender norms encompass gender stereotypes regarding masculinity and femininity, as well as the gendering of spaces, objects, activities, appearances, and bodies.
Genderfluid	An identity term relating to a type of nonbinary identity, whereby one's gender and/or gender expression changes. These shifts may be in accordance with the different components to one's sense of gender. **
Genderqueer	An identity term that denotes the rejection of binary genders. Genderqueer may include, neither identifying as male or female, having a sense of gender that is in between the gender binary, and/or rejecting the gender norms that are socially expected of men and women. **
Heteronormativity, heteronormative	The social norm that sexual and romantic relationships between cisgender men and cisgender women are

	normal/superior/natural, whereby all other relationship dynamics are deemed as abnormal/inferior. **
Heterosexual (het, hetero), heterosexuality, straight	The terms, heterosexual and heterosexuality, were coined by Karl-Maria Kertbeny in 1868 to denote men and women who experience sexual desire towards members of the opposite sex (Féray et al., 1990). Kertbeny also referred to such individuals as 'normally-sexed' people.
Homophobia, transphobia, queerphobia	The use of the '-phobia' suffix emphasises fear, discomfort, and distrust as premises for negative attitudes, victimisation, and stigmatisation towards queer and trans people, depicting such prejudicial treatment as *irrational* to the perceiver (Herek & McLemore, 2013).
Homosexual, homosexuality	These terms were coined by Karl-Maria Kertbeny in 1868 to denote men and women who experience sexual desire towards members of the same sex (Féray et al., 1990). Kertbeny differentiated homosexualism between men and women ('tribaden' or lesbian) into typologies. For men, homosexuals were characterised as either 'mutual', 'pygists', or 'Platonists'. For women, homosexuals were characterised as either 'passive' or 'active'. Since the conception of homosexual and homosexuality, these terms have been used by physicians, psychiatrists, and psychologists to pathologize queer and takatāpui people throughout history (see LGBT Issues Committee, 2012). As such, I have endeavoured to avoid using these terms throughout this thesis, with exception to the Introduction Chapter.
Intersex	A term that refers to individuals who experience variations in their sex characteristics (e.g., chromosomal patterns, hormonal patterns, sexual anatomy and/or reproductive organs) which have been present, or developed, since birth. **
Lesbian	A woman or gender diverse individual who experiences sexual and/or romantic attraction to women, and usually self-identifies as such (InsideOUT, 2022).
LGBT, LGBTQIA+	An abbreviation for lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/agender/aromantic, plus others who are not straight and/or cisgender.
Microaggression	A form of discrimination that is indirect or subtle in nature, which is typically unintentionally expressed but still reinforces harmful social norms or prejudicial attitudes regarding marginalised communities.

MVPFAFF+	An abbreviation for Pasifika terms that describe diverse genders and/or expressions of sexuality, which are best defined and understood within their cultural contexts (InsideOUT, 2022). This includes, Mahu (Tahiti/Hawaii), Vaka se lewa lewa (Fiji), Palopa (Papua New Guinea), Fa'afafine (Samoa), Akava'ine (Cook Islands), Fakaleiti/Leiti (Tonga), Fakafifine (Niue), Pinaoinaaine/Binabinaaine (Tuvalu & Kiribati), Rae rae (Tahiti), Haka huahine (Tokelau), Fa'atama/Fa'afatama (Samoa), Māhūkāne (Hawaii), and Binabinamane (Kiribati).
Nonbinary	An umbrella term that encompasses any gender identity which does not align with the gender binary. **
Pansexual (pan)	A term that denoting attraction to all genders, or attraction to people regardless of their gender, gender expression, or sex (InsideOUT, 2022).
Passing	The concept of being recognised/identified by other people as the gender that one wishes to be recognised/identified as. **
Queer	Once recognised as a pejorative term for gay, this umbrella term has been reclaimed to denote individuals who are not heterosexual and/or cisgender. This includes LGBTQIA+ identities, as well as any other diverse genders and sexualities (Schimanski & Treharne, 2019).
Sex	The classification system that assigns people as either male or female, primarily based on external genitalia, but can include other primary sex characteristics such as, chromosomes, reproductive organs, hormones, and fertility. **
Sexual orientation	One's enduring physical, romantic, emotional, sexual, and/or spiritual attraction to other people. **
Sexuality	A term which includes one's sexual orientation (e.g., attraction), sexual identity (e.g., gay, lesbian, straight), sexual fantasies, as well as their attitude towards sexual intercourse.
Social norms	Standards and rules that are implicitly (and sometimes explicitly) communicated, and are understood, among members of a community to restrict or permit social behaviours, leading to a perceived social pressure to adhere and comply with these (Dempsey et al., 2018).
Transgender (trans)	An umbrella term denoting people whose gender identity and/or gender expression differs from the gender norms of the gender or sex they were assigned at birth. **

Kupu Māori (Māori Word)	Tautuhi (Definition)
Aotearoa	Initially referring only to the North Island, Aotearoa has since become the Māori name for New Zealand, and is commonly understood to mean, *long white cloud*. *
Hui	Gathering, meeting, assembly, seminar, or conference. *
Irawhiti	Transgender (trans). *
Kaupapa	"A set of values, principles and plans which people have agreed on as a foundation for their actions" (Te Ahukaramū Charles Royal, 2022).
Koha	Gift, offering, donation, or contribution. *
Mahi	Work, job, practice, occupation, activity, or function. *
Mātauranga Māori	Māori knowledge originating from tūpuna/tīpuna (ancestors), encompassing Te Ao Māori and tikanga Māori. *
Pākehā	New Zealander of European descent. *
Tāhine	A portmanteau of tāne and wāhine, this term approximately means nonbinary, mixed gender, or genderfluid (InsideOUT, 2022).
Takatāpui	"A traditional term meaning 'intimate companion of the same sex.' It has been reclaimed to embrace all Māori who identify with diverse genders and sexualities such as whakawāhine, tangata ira tāne, lesbian, gay, bisexual, trans, intersex and queer" (Kerekere, 2021, p. 2).
Tāne, tānetangata	Male, man, manhood, masculinity. *
Tangata ira tāne	Trans man, or in the manner, spirit, or gender of a man. **
Tangata ire wāhine	Trans woman, or in the manner, spirit, or gender of a woman. **
Tauiwi	Foreigner, European, non-Māori, or colonist. *
Wāhine	Female, woman, or feminine. *
Whakapapa	To lay one upon another, genealogy, genealogical table, lineage, or descent. *
Whakatāne	Trans man, or to become a man. **
Whakawāhine	Trans woman, or to become a woman. **
Whakawhanaungatanga, whanaungatanga	The Māori cultural value of building relationships and connections with others, providing a sense of belonging. *
Whānau	Extended family, family group, or referring to friends who have any kinship ties to other members. *

Suicide Terminology	Definition
Attempted suicide, suicide attempt	Any nonfatal and self-inflicted behaviour (potentially causing harm or injury to self) undertaken by a person with

	the intention of ending their own life as a result of the behaviour (Silverman, 2006). *Synonyms*: nonfatal suicidal behaviours, nonfatal attempt at suicide, and attempt to end their life (Beaton et al., 2013).
Nonsuicidal self-injury (NSSI)	Any deliberately self-inflicted injury(s) and/or pain upon oneself undertaken without any intent to die from said injury(s).
Protective factors	Any attribute, environmental exposure, circumstance, resource, or relationship that decreases the likelihood of experiencing suicidality and increases wellbeing.
Risk factors	Any attribute, environmental exposure, circumstance, or relationship that increases the likelihood of experiencing suicidality.
Self-harm	The intentional act of self-inflicting injury(s) and/or pain upon oneself, which may be motivated by the intent to end one's own life or function as a means of coping with distress. *Synonyms*: self-injury, and deliberate self-injury/harm.
Suicidal ideation	Thoughts of ending one's own life and/or thinking about suicide, which vary in terms of intensity (e.g., passive, active) and duration (e.g., fleeting, ruminative). **Passive suicidal ideation** refers to wishing that one were dead, contemplating one's own death, and/or thinking that one would be better off dead than alive. **Active suicidal ideation** refers to thoughts of ending one's own life, which are accompanied with suicidal intent and/or suicidal planning. *Synonyms*: contemplating suicide, suicidal thoughts, suicidal preoccupations, suicidal ruminations (Silverman, 2006), suicidal ideas, and suicidal desire.
Suicidality	An umbrella term that refers to the risk of suicide, which encompasses indicators, including suicidal ideation, suicidal intent, suicidal plans, self-harm, and attempted suicide (American Psychiatric Association, 2022). *Synonym*: Suicidal behaviour(s), suicidal distress.
Suicide	The act of ending one's own life, whereby the suicidal behaviour was undertaken with the intention of dying. *Synonyms*: died by suicide, suicided, ended their life, took their own life (Beaton et al., 2013).

Notes. * Definitions adapted from *Te Aka Māori Dictionary* (Moorfield, 2022), ** definitions adapted from the *Trans 101: Glossary of trans words and how to use them* (Gender Minorities Aotearoa, 2020).

Introduction: Setting the Scene in Aotearoa

People with diverse sexualities, genders and sex characteristics have suffered at the hands of mental health services, medical providers, academic institutes, and sovereignties. To date, many strides have been made to progress the rights, wellbeing, and acceptance of queer and takatāpui people in Aotearoa. As we move further into the 21st century it remains important that we look to our past while moving forward into the future to ensure that we do not repeat the atrocities of bygone eras. Below, I have provided an overview of historical, social, and political movements which have influenced the current social climate for queer and takatāpui people. Next, I introduce the central subject of this thesis by highlighting suicide as a pertinent issue within Aotearoa. I then end this introduction by describing key studies that explored the risk of suicidality among queer and takatāpui living in Aotearoa.

As with most inequities in Aotearoa, the persecution of queer and takatāpui people began with the process of colonisation. The signing of Te Tiriti o Waitangi (the Treaty of Waitangi) in 1840 introduced the British legal system, and with it, legislation which criminalised sexual intercourse between men (Rishworth, 2007). While never made illegal in Aotearoa, women who engaged in same-sex relations and intimacy were privy to being committed under psychiatric institutions. It was not until 1962 that the first gay organisation, the Dorian Society, was founded in Aotearoa; later becoming the New Zealand Homosexual Law Reform Society in 1967 (Kerekere, 2016).

The 1969 Stonewall Uprising laid the foundations for the Gay Liberation Day March of 1970 in New York City, setting a precedent for queer activism and acting as a catalyst for global changes. During the 1970s Gay Liberation groups, including the National Gay Rights Coalition, were formed throughout Aotearoa; partly fronted by Dr Ngahuia Te Awekotuku after she was denied entrance into the USA in 1972 on the grounds of her sexual orientation (Te Awekotuku, 1991). In 1973, homosexuality was declassified as a psychiatric disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the Australian and New Zealand College of Psychiatry followed suit by denouncing their recognition of homosexuality as a mental illness (Grey, 2022).

The Homosexual Law Reform Act was passed by Parliament in 1986, legalising consensual sexual relations between men over the age of 16 in Aotearoa. Discrimination on the basis of sex and sexual orientation was outlawed under the Human Rights Act of 1993, but this Act does not explicitly make reference to discrimination on the basis of gender identity and gender expression. However, the Human Rights Commission (2010) has since proclaimed that the Act extends to criminalise discrimination on the basis of gender identity. In 1995, Georgina Beyer was elected as the world's first transgender mayor, and in 1999, became the world's first transgender Member of Parliament (Kerekere, 2016).

The Civil Union Act was passed in 2004, providing legality for civil partnerships between same-sex couples, and approximately the same legal rights were afforded to all couples (de facto, marital, and civil union partnerships) under the Relationships (Statutory References) Act (2005). Though, couples in civil union partnerships were unable to jointly adopt; a right which was reserved for married couples (Rishworth, 2007). Aotearoa became the 13th country to gain marriage equality in 2013 following the redefinition of marriage to recognise the union of two people irrespective of gender identity, sex, or sexual orientation: under the Marriage (Definition of Marriage) Amendment Act (2013).

In 2021, the Births, Deaths, Marriages, and Relationships Registration (BDMRR) Act (1995) was reformed, introducing a self-identification process for those seeking to amend the sex recorded on their birth certificates. Under the BDMRR Act (2021), the legal recognition of one's gender identity no longer requires involvement with the Family Court nor to have sought gender-affirming medical interventions prior. Instead, a statutory declaration can be submitted directly to the Registrar-General for those aged 18 and over. As of 2022, the Conversion Practices Prohibition Legislation Act (2022) has criminalised conversion practices, defined as any "treatment that is done with the intention of changing or suppressing the individual's sexual orientation, gender identity, or gender expression" (p. 3).

Despite the progress to date, queer and takatāpui people remain subject to the ongoing effects of interpersonal, social, and institutional discrimination (Treharne & Adams, 2017). For example, the retention of gender dysphoria within the DSM-5-TR, maintains the history of pathologising and stigmatising trans and gender diverse people (Lev, 2013; Davy & Toze, 2018). Members of the intersex community strongly advocate against the currently legal practice of genital 'normalising' surgery on intersex infants, arguing that these procedures

represent traumatic experiences that disregard consent, uphold the use of medically unnecessary (and harmful) practices, and reinforce power imbalances within the decision-making process (McGeorge, 2018). Further, contemporary research demonstrates that queer and takatāpui people in Aotearoa suffer from prejudicial treatment, negative socioeconomic outcomes, barriers to accessing healthcare, and mental health disparities (e.g., B. Fraser et al., 2022; G. Fraser et al., 2022; Veale et al., 2021; Treharne et al., 2020; Schimanski & Treharne, 2019; Adams et al., 2013). In addition, greater likelihoods for suicidal behaviours have been found among queer and takatāpui people when compared with cisgender and/or heterosexual controls (Fergusson et al., 2005; Clark et al., 2014; Tan et al., 2021). However, our understanding of the true interrelationship between suicide and these communities is impaired by the lack of, and inconsistent, measurements of sexual orientation and gender modality (Pega et al., 2013). Thus, systemic and operationalised approaches to data collection are require in order to capture the true nature of this association.

Suicide has been recognised among the leading causes of death in the world with an estimated ~703,000 people dying by suicide each year (World Health Organization, 2021). Based on national statistics from 2009 to 2013, Aotearoa had the highest rate of suicide among adolescents aged 15-19 (15.6 per 100,000 population) when compared with 36 OECD and EU countries (UNICEF Office of Research, 2017). In Aotearoa, mortality information pertaining to suicide is disseminated from two sources. Firstly, the Office of the Chief Coroner issues provisional data on the number of suspected self-inflicted deaths. Secondly, Manatū Hauora (Ministry of Health) publishes confirmed deaths attributed to suicide. The most recent figures released by the Office of the Chief Coroner (2022) showed that 538 people (a rate of 10.2) were suspected to have died from suicide between 1st April 2021 and 30th June 2022. Table 2 summarises of the number of suspected and confirmed deaths by suicide from 2010 to 2021, including the rates of death per 100,000 people based on annual population estimates. As evident by the frequency trends, the national rate (M = 11.5) of confirmed suicides fluctuates annually but remains consistently higher for Māori (M = 16.2) compared with tauiwi (M = 10.3), and higher for males (M = 17.2) compared with females (M = 6.1). Consequently, the combination of these statistics set a precedent for researching and addressing factors that precipitate suicide among groups, particularly those pertaining to Māori and males. However, the national standards for recording demographic information in Aotearoa prevents the utility of such datasets (Table 2) for determining the prevalence of suicide among other communities.

Table 2

The number and rates of confirmed and suspected suicides from 2010 to 2021

Year [a]	Suspected *N* (rate)	Confirmed *N* (rate)	Māori [b] *N* (rate)	Tauiwi [b] *N* (rate)	Male [b] *N* (rate)	Female [b] *N* (rate)
2010	544 (12.1)	534 (11.9)	102 (14.8)	432 (11.0)	387 (17.7)	147 (6.5)
2011	509 (11.5)	495 (11.2)	113 (16.1)	382 (9.8)	377 (17.4)	118 (5.2)
2012	545 (12.2)	550 (12.4)	119 (16.3)	431 (11.0)	405 (18.6)	145 (6.4)
2013	533 (11.5)	513 (11.0)	104 (14.4)	409 (9.8)	365 (15.9)	148 (6.5)
2014	515 (11.0)	510 (10.8)	93 (13.1)	417 (10.0)	379 (16.4)	131 (5.5)
2015	547 (11.4)	529 (11.1)	118 (16.1)	411 (9.7)	384 (16.2)	145 (6.1)
2016	580 (11.8)	563 (11.4)	135 (18.2)	428 (9.8)	416 (17.0)	147 (6.0)
2017	634 (12.7)	603 (12.0)	142 (18.6)	461 (10.5)	453 (18.1)	150 (6.1)
2018	636 (12.3)	626 (12.1)	139 (18.1)	487 (10.7)	451 (17.5)	175 (6.8)
2019	671 (13.0)	-	-	-	-	-
2020	598 (11.4)	-	-	-	-	-
2021	599 (11.3)	-	-	-	-	-

Notes. Source: Ministry of Health (2022), [a] calendar year, [b] figures pertain to confirmed deaths by suicide. The missing data from 2019 to 2021 indicates that cases of suicide are yet to be confirmed.

The Mortality Collection serves as the primary database for all registered deaths in Aotearoa, classifying the cause of death and demographic information of deceased persons (Ministry of Health, 2021a). This includes the person's age, names, sex assigned at birth, ethnicity, occupation, and date of birth/death as recorded by the Births, Deaths and Marriage Office; however, does not currently include their sexuality nor gender identity (Ministry of Health, 2021b). This stands as a barrier to capturing the national prevalence of suicide among queer and takatāpui communities in Aotearoa. Instead, research conducted with longitudinal cohorts and cross-sectional samples provide estimates on the risk of suicidality among these communities. A summary of the studies conducted in Aotearoa to date are presented in Appendix A, describing the participants, study designs, measures, and findings in a concise manner. Rather than taking these studies at face value, I have provided a critical commentary in the subsequent paragraphs to highlight: 1) how the measurements and categorisation of diverse sexual orientations and gender identities have evolved with time, and 2) what conclusions can be drawn from findings.

Suicidality Among Queer and Takatāpui People in Aotearoa

The Christchurch Health and Development (CHD) Study was the first longitudinal research in Aotearoa to examine suicide risk among queer and takatāpui people. Results from this cohort,

aged 21-years, found that participants classified as 'gay, lesbian, or bisexual (GLB)' were 5.4 and 6.2 times more likely to have experienced suicidal ideation and attempted suicide during their lifetime, compared with 'heterosexual' participants (Fergusson et al., 1999). A two-variable method was used to categorise participants according to sexual orientation, measuring past *same-sex relationships* and current *sexual preference* (albeit, only three responses available). However, despite having self-identified as 'heterosexual', eight participants were allocated to the GLB group on account of their past same-sex partners; thus, undermining their self-selected preferences to prioritise their prior sexual behaviours. Additionally, Fergusson et al. (1999) proposed two problematic explanations regarding these findings: 1) susceptibility to psychiatric difficulties may cause susceptibility to same-sex attraction, and 2) the lifestyle choices of GLB people elevates their risk to adversity and, by extension, suicidality.

Skegg et al. (2003) also examined associations between suicidality and sexual orientation on a longitudinal cohort (Dunedin Multidisciplinary Health and Development Study) aged 26, employing a two-variable method to categorise sexual orientation. Unlike Fergusson et al. (1999), sexual orientation was measured using past and present *sexual attraction*, resulting in participants allocated to one of three groups (Skegg et al., 2003). After initial groupings, participants classified with 'minor' or 'major' same-sex attraction were combined to increase the group size for comparative analyses, forming a group who had experienced any degree of same-sex attraction irrespective of whether past or present (Skegg et al., 2003). This seemed to be a reductive approach given that the study had measured *sexual attraction* on a 5-point Likert scale and aimed to examine how past and present attraction patterns related to lifetime suicidality. Results indicated that men who had experienced same-sex attraction had significantly higher odds for deliberate self-harm ($OR = 5.5$) and attempting suicide ($OR = 3.2$) during their lifetime, as well as suicidal ideation within the last year ($OR = 3.1$), compared with opposite-sex attracted men. For women who had experienced same-sex attraction at any time, deliberate self-harm and suicidal ideation were 2.9 and 1.9 times more likely, compared with opposite-sex attracted women (Skegg et al., 2003). However, this study was not without shortcomings including the exclusion of four women on the basis that they reported no sexual attraction to either sex, a marked disregard for those within the asexuality spectrum.

In contrast to the two prior studies, Fergusson et al. (2005) and Spittlehouse et al. (2020) employed latent class modelling to categorise sexual orientation. Fergusson et al. (2005) measured multiple variables of sexual orientation on the CHD longitudinal cohort at ages 21

and 25, including *sexual preference/identification*, *sexual attraction*, and *sexual behaviours*, resulting in a three-class model: 'exclusively heterosexual', 'predominantly heterosexual', and 'predominantly homosexual'. The rates of suicidal ideation and attempted suicide were significantly higher for 'predominantly homosexual' men (71.4%, 28.6%, respectively) and women (30%, 10%, respectively) when compared with sex-matched peers categorised as 'predominantly heterosexual' or 'exclusively heterosexual'. Spittlehouse et al. (2020) replicated these methods on the same longitudinal cohort at ages 21, 25, 30, and 35, with an additional measure of *sexual fantasy* included in the latent class model, which categorised participants into four-classes: 'heterosexual', 'mostly heterosexual', 'bisexual', and 'gay/lesbian'. The odds ratios showed that suicidal ideation was significantly more likely among participants categorised as 'bisexual' (*OR* = 5.5), 'gay/lesbian' (*OR* = 4.6), or 'mostly heterosexual' (*OR* = 1.8), compared with 'heterosexual' participants. Despite both employing latent class models, these two studies produced differing sexual orientation groups in terms of the quantity and terminology used to characterise, which may in part be attributable to the inclusion of *sexual fantasy* and a larger number of longitudinal datapoints in Spittlehouse et al. (2020).

The Youth2000 surveys are a series of population-based cross-sectional studies on nationally representative samples of secondary school students in Aotearoa. To date, these surveys have been undertaken in 2001 (Youth'01), 2007 (Youth'07), 2012 (Youth'12), and 2019 (Youth'19). Like Skegg et al. (2003), self-selected *sexual attraction* was measured across the Youth2000 surveys to categorise participants according to sexual orientation, though presented as a single item on their current preference rather than past and present preferences (Lucassen et al., 2011; Clark et al., 2014; Lucassen et al., 2015; Fenaughty et al., 2021). In Lucassen et al. (2011), the use of *sexual attraction* as a proxy measure for sexual orientation is rationalised by research showing that adolescents are less likely to respond to questions asking to disclose their sexual identity (Saewyc et al., 2004). Results from the Youth'07 survey indicated that participants who experienced same-sex attraction, attraction to both-sexes, or were unsure, were significantly more likely to have deliberately self-harmed (*OR* = 2.8, 5.8, 1.8, respectively) and attempted suicide (*OR* = 4.8, 7.0, 2.4, respectively), compared with opposite-sex attracted participants (Lucassen et al., 2011). When differentiated by sex, males with same-sex attraction (*OR* = 4.5) or attraction to both-sexes (*OR* = 5.8), were more likely to have experienced suicidal ideation. For females, those attracted to both-sexes (*OR* = 4.4), or unsure (*OR* = 1.6), were more likely to have experienced suicidal ideation. Further, males and females

categorised as ‘sexual minority youth’ had consistently higher likelihoods for attempted suicide across the Youth’01 (*OR* = 2.9, 1.9, respectively), Youth’07 (*OR* = 7.7, 4.0, respectively), and Youth’12 (*OR* = 5.6, 3.7, respectively) surveys, when compared with sex-mated peers categorised as ‘exclusively opposite-sex attracted’ (Lucassen et al., 2015).

In the Youth’01, Youth’07, and Youth’12 surveys, *sex* was measured using self-selection as either ‘male’ or ‘female’, with no additional questions about gender identity, or sex assigned at birth (Lucassen et al., 2015). By employing the sex binary as an indicator of participants’ genders, these surveys did not capture intersex people and individuals who may not have identified with a binary gender (e.g., nonbinary, genderqueer). The Youth’12 introduced a question on gender modality, asking participants if they identified as *transgender* and providing examples of the identities encompassed in this umbrella term (Clark et al., 2014). Despite these diverse examples, there were four possible responses to the question, yes, no, unsure, and do not understand the question; lacking the specificity to capture the exact nature of one’s gender identity and individuals who do not specifically refer to themselves as transgender. Results from the Youth’12 survey showed that transgender participants and those unsure were more likely to have self-harmed (*OR* = 2.7, 2.2, respectively) and attempted suicide (*OR* = 5.0, 1.8, respectively), compared with cisgender participants (Clark et al., 2014).

In contrast to the longitudinal studies and earlier Youth2000 surveys, contemporary research has employed *sexual identity* and *gender identity* to categorise participants for comparative analyses. Using 2016 and 2018 data from the New Zealand Mental Health Monitor (NZMHM) surveys, Tan et al. (2021) examined mental health disparities among people with diverse sexualities and genders. *Gender identity* and *sexual identity* were captured on two items, which were limited to the selection of one of four options per item. For gender, possible responses were male, female, gender diverse, and unsure; while sexuality consisted of gay or bisexual/takatāpui, bisexual/takatāpui, straight/heterosexual, and other. Participants were categorised as either ‘diverse gender and sexuality’ or ‘cisgender/heterosexual’, and findings showed indicated that the former were at 3.1 higher risk of having experienced thoughts of suicidality within the past two weeks compared with the latter (Tan et al., 2021). Given the limited number of response options, and inability to select multiple responses, on the measures for gender and sexuality, these findings are likely to underrepresent people whose identities were not included (e.g., trans, asexual).

The Counting Ourselves study is a national community-based survey examining the health and wellbeing of gender diverse people in Aotearoa (Veale et al., 2019). Indirectly remedying measurement limitations identified in the NZMHM surveys (Tan et al., 2021), the 2018 Counting Ourselves survey utilised a two-variable approach to categorise participants according to gender modality. *Gender identity(s)* was self-selected using an item consisting of 27 gender terms, whereby participants could select multiple terms, including an option to add additional responses. The study also assessed participants' *intersex status*, *sex assigned at birth*, and *pronouns*. Participants were then categorised as 'trans men', 'trans women', or 'nonbinary', according to their selected *gender identity(s)* and *sex assigned at birth*. Findings demonstrated that 42% of respondents had deliberately self-harmed, 56% had experienced suicidal ideation, and 12% had attempted suicide, within the past 12 months (Veale et al., 2019). For lifetime prevalence, 79% of respondents had experienced suicidal ideation and 37% had attempted suicide. Consistently across all these measures of suicidality, youth (i.e., 14-24 years) and disabled respondents were significantly more likely to have self-harmed, experienced suicidal ideation, and attempted suicide, compared with matched demographic groupings (Veale et al., 2019). As a community-based study, the inclusion criteria pertained to gender diverse people through convenience sampling, meaning that cisgender people were intentionally excluded; as such, were unable to be utilised as a comparative sample.

In direct response to the lack of research comparing the rates of suicidality between transgender and cisgender people, Treharne et al. (2020) conducted an international cross-sectional survey with samples living in either Aotearoa or Australia. Like Veale et al. (2019), multiple variables were measured to categorise participants according to gender modality, including *gender identity*, *intersex status*, and *transgender identifying*. Accordingly, participants were categorised as 'transgender' if they responded with a diverse gender identity, were intersex, and/or identified as transgender; while all other participants were categorised as 'cisgender' (Treharne et al., 2020). Results indicated no significant differences between the Aotearoa and Australia samples on measures of suicidality and self-harm. Transgender participants displayed significantly higher rates of both lifetime and recent (past 12 months) suicidal ideation (93.6%, 40.1%, respectively), self-harm (88%, 36.9%, respectively), and suicide attempt(s) (53.4%, 16.8%, respectively), compared with cisgender participants (Treharne et al., 2020).

Exploration into the research examining the risk of suicidality among queer and takatāpui people reveals several methodological limitations. Evident among the longitudinal cohort

studies were inconsistencies regarding the aspects of sexual orientation measured (i.e., preference/identity, behaviour, attraction and/or fantasy), as well as differing methods used to categorise participants accordingly (e.g., latent class modelling vs two-variable approaches). Resultantly, the validity of these results fall-short when examining the nuances of group allocation across studies. For example, the three earlier studies found that the rates of suicidal ideation were significantly higher among participants with the greatest degree of same-sex orientation, suggestive of a dose-response relationship (Fergusson et al., 1999; Skegg et al., 2003; Fergusson et al., 2005). However, Spittlehouse et al. (2020) found that the rate of suicidal ideation was significantly higher among participants categorised as 'bisexual' compared with all other groups, including 'gay/lesbian'. As such, the generalisability of these longitudinal cohort studies may be inhibited by the inconsistency regarding sexual orientation categories, or suggestive that temporal differences (e.g., 1999 vs 2020) impede contemporary applicability of the older studies.

Common threads can be drawn between the longitudinal cohort studies and the Youth2000 series. As an initial connection, Skegg et al. (2003) and all surveys from the Youth2000 series (Lucassen et al., 2011; Clark et al., 2014; Lucassen et al., 2015; Fenaughty et al., 2021) measured sexual attraction as an indicator of sexual orientation and subsequently utilised this variable to categorise participants accordingly. Additionally, however, similarities are apparent by the exclusion of participants who experienced no attraction to either males or females (Skegg et al., 2003; Lucassen et al., 2015) and the narrowed measurement of sex as either male or female (Fergusson et al., 1999; Skegg et al., 2003; Fergusson et al., 2005; Lucassen et al., 2011; Clark et al., 2014; Lucassen et al., 2015; Spittlehouse et al., 2020), thus, disregarding participants who may identify within the asexuality and/or nonbinary spectrums. The use of the sex binary posed a particular shortcoming within the Youth'12 survey, whereby the self-selection of sex provided no indication as to whether to respond with one's sex assigned at birth or gender self-identity (Clark et al., 2014).

Shifting away from past measures of sexual orientation and sex, contemporary research has instead embraced sexuality and gender self-identification as a way of categorising participants. The NZMHM surveys presented two single items, with four possible responses per item, to capture participants' sexual and gender self-identities. However, as noted by Tan et al. (2021), the limited number of sexuality and gender terms, and inability to select multiple responses, likely resulted in the undercounting of people who did not self-identify with the terms included

(e.g., trans, nonbinary, asexual). Amending these shortcomings, the 2018 Counting Ourselves survey measured gender identity and sex assigned at birth to categorise gender modality; though, intentionally excluded cisgender people from participating, meaning that comparative analyses were among those with diverse genders (Veale et al., 2019). Treharne et al. (2020) employed a similar method, measuring gender identity, intersex status, and transgender identifying to categorise participants as either transgender or cisgender, enabling comparative analyses to be undertaken.

Overall, it is evident that each subsequent study builds upon the work of the previous, ameliorating prior shortcoming with innovative approaches to measuring gender and sexuality. Each study (see Appendix A) has consistently demonstrated that people with diverse sexualities and genders in Aotearoa experience significantly greater risk for suicidal ideation, self-harm, and attempting suicide when compared with cisgender-heterosexual counterparts. As such, these findings have identified issues that currently plague these communities, suggesting that these people are in some way socially positioned within Aotearoa to be at higher risk of suicidality. The missing piece of the puzzle is an understanding of *why* these associations exist. The current mixed methods research, comprised of two theory-driven studies, aims to utilise Klonsky and May's (2015) Three-Step Theory of suicide and Riggs and Treharne's (2017) Theory of Decompensation as approaches to explaining and understanding suicidality among queer and takatāpui people. In the following section, I present summaries on the chapters in this thesis.

Thesis Structure: Lay of the Land

In *Chapter 1*, I review the literature on explanatory theories of suicidality and minority stress that have been applied to queer and takatāpui samples. I start by highlighting the limitations of Meyer's (2003) Minority Stress Model and then present Riggs and Treharne's (2017) Theory of Decompensation (ToD) as a novel socially embedded framework for exploring queer and takatāpui peoples' understandings of suicidality. Next, I describe the ideation-to-action framework, which was first introduced within Joiner's (2005) Interpersonal Theory of Suicide. The shortcomings of Joiner's theory provide a rationale for my use of Klonsky and May's (2015) Three-Step Theory (3ST) of suicide, which offers a set of processes that can be flexibly applied to explain pathways from suicidal ideation to attempting suicide.

Chapter 2 explores factors that have been suggested to contribute to, or ameliorate, suicidality among people with diverse sexualities and genders. I first outline past ideas that pathologised queer and takatāpui people and positioned them as passive subjects to suicide risk, and then present counter arguments that acknowledge suicide risk as multicausal, complex, and located within social processes. Next, I synthesis bodies of research on prominent mechanisms of suicidality as a means of providing evidence for the applicability of the 3ST of suicide and the ToD. These mechanisms are namely, social discrimination, hopelessness, social support, non-suicidal self-injury (NSSI), ideologies, intersectionality, and privilege. I conclude by explaining the gaps in knowledge regarding the use of the 3ST of suicide and the ToD as frameworks for understanding suicidality among queer and takatāpui people.

In *Chapter 3*, I briefly outline the two studies that I conducted. I discuss study one as a quantitative project examining the applicability of the 3ST of suicide on survey data collected from queer and takatāpui people. I present an adapted version of the 3ST of suicide using the mechanisms outlined in Chapter 2, followed by the current hypotheses. I then discuss study two as a qualitative project that explored queer and takatāpui peoples' understandings of suicidality, discrimination, and resilience. I describe that a theory-driven approach to reflexive thematic analysis was used to analyse the data, briefly highlight the theoretical orientations that underpinned this analysis, and list the overarching research questions.

Chapter 4 encompasses my quantitative methodology, including characteristics of the survey design; the data collection protocol; the measures and questionnaires; the data cleaning processes; and the analytic approach used to examine the 3ST of suicide. The results from study one are presented in *Chapter 5*, which yielded mixed findings. *Chapter 6* illustrates my qualitative methodology, including the underpinning theoretical framework; Braun and Clarke's reflexive thematic analysis; ethical processes; the recruitment process; participant characteristics; the semi-structured interviews; and the data analysis as informed by the ToD. The five themes I developed are presented in *Chapter 7*, which pertains *"Not just this Amorphous Subject"*, *"You're Removing the Responsibility of the Society"*, *"Social Norms Require a Deviant Group"*, *"the Straw that Broke the Camel's Back"*, and *Ethnicity and Resilience to Suicidality*.

In the *General Discussion* chapter, I situate the findings from the two studies within broader literature on suicide and integrate these into the 3ST of suicide and the ToD. I discuss the

implications for clinical practice, focusing on how my research informs suicide risk assessments to integrate *processes* of suicidality and *co-appraisal* of suicide risk. Next, I outline the strengths and limitations of my research and suggest future directions for research. I end by reflecting on my research journey and provide my concluding thoughts.

Chapter 1: How is Suicidality Modelled and Theorised?

In this chapter, I position Riggs and Treharne's (2017) *Theory of Decompensation* and Klonsky and May's (2015) *Three-Step Theory* of suicide as the two frameworks that I will utilise within the current research project. I begin this chapter by describing Meyer's (2003) *Minority Stress Model* as a popular framework for explaining psychological distress among people with diverse sexualities and genders. A critical review of the Minority Stress Model (Riggs & Treharne, 2017) is then covered, highlighting shortcomings regarding the model's theoretical assumptions. Riggs and Treharne (2017) offer amendments to these shortcomings by proposing their Theory of Decompensation as a socially situated framework for understanding how institutionalised social norms produce psychological distress for marginalised peoples, acknowledging that ideology, intersectionality, and privilege function as the primary mechanisms. Next, I focus on theories that have been developed to specifically explain suicide. The *ideation-to-action framework* is described as an emerging way of conceptualising the processes of suicidality. Joiner's (2005) *Interpersonal Theory of Suicide* was among the first to propose that suicidal ideation and suicide attempts are driven by distinctive mechanisms of cause. However, critiques from Hjelmeland and Knizek (2020) suggest that the Interpersonal Theory of Suicide is impeded by methodological limitations and limited evidence to support its components. As such, Klonsky and May's (2015) Three-Step Theory of suicide is presented as an alternative, providing flexible, but structured, hypotheses for examining the emergence of suicidal thinking and subsequent trajectory to attempting suicide. I end by briefly summarising key points and highlighting the current gaps in knowledge that were identified.

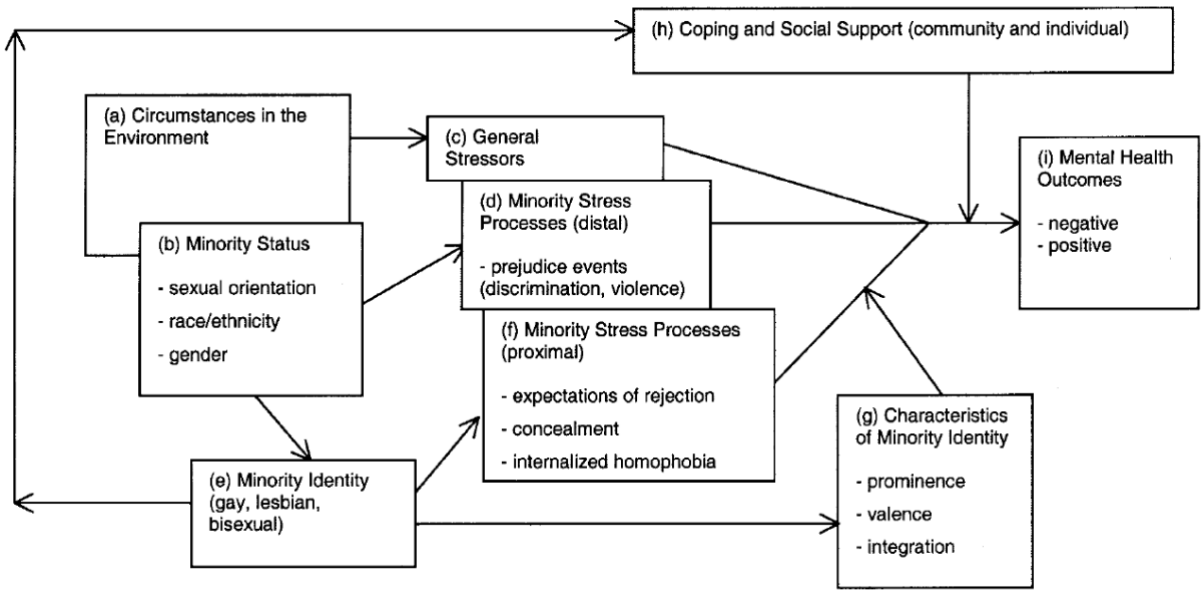
The Minority Stress Model

Meyer's (1995; 2003) definition of *minority stress* recognises this form of stress as distinct from the general stress experienced in daily life. Framed within the Minority Stress Model (MSM), negative mental health outcomes among lesbian, gay, and bisexual (LGB) people are thought to develop from external and internal factors that are unique to these individuals who are socially marginalised (Meyer, 2003). As such, Meyer's account of minority stress assumes that the stress processes acting upon these marginalised individuals are constituted by distinctive *minority stressors* that are additive to *general stressors*.

In Meyer's MSM (Figure 1), the marginalised LGB person is situated within *environmental circumstances*, representing general stressors (e.g., unemployment, poverty, loss) that are experienced by all people. The framework overlaps these circumstances with one's *minority status* – the positioning of the person as a *minority* based upon their sexuality (Meyer, 2003). Meyer considers this minority status as separate from, but interconnected with, the person's *minority identity*, whereby the latter emerges from personal identification with the former (e.g., gay, lesbian, bisexual). At this point, processes of minority stress are distinguished into two forms: *distal* and *proximal*. *Distal stressors* are conceptualised as objective reality that function independent of peoples' psychological appraisals, such as discrimination, prejudicial violence, and negative societal attitudes (Meyer, 2003). These stressors are considered external to the marginalised person and are enacted upon them when socially positioned within a minority status. At the other end of the continuum, *proximal stressors* are conceived as subjective by nature, emerging within the individual when their psychological perception of external stressors renders these as important or meaningful to their sense of self (Meyer, 2003). As such, these stressors are positioned as internal to the marginalised person and are dependent upon their (minority) self-identity, which can manifest as concealing their identity, expecting rejection, and internalised homophobia (Meyer, 2003).

Figure 1

Meyer's Minority Stress Model



Note. From "Prejudice, social support, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence" by I. H. Meyer, 2003, *Psychological Bulletin*, *129*(5), p. 679.

The final two components of Meyer's MSM are understood as modifying factors within the stress process (Figure 1). Firstly, the impact of minority stressors weakens when the marginalised person: 1) does not have their minority identity more prominently positioned, or regards it as more salient, in their identity hierarchy; 2) has positive valence towards their minority identity (e.g., self-acceptance); and 3) has identity synthesis, whereby their minority identity is integrated, with other identities, as just one component to their sense of self (Meyer, 2003). These factors of *prominence*, *valence*, and *integration* are understood as internal characteristics of identity. Secondly, minority identity is thought to bolster the marginalised person's capacity to cope with stressors when it enables access to group-level support structures, such as social supports and community groups (Meyer, 2003). This *minority coping* component represents external coping mechanisms (e.g., validation from others, self-enhancing values) that are then incorporated into one's personal coping capacity.

Meyer's MSM is one of the most readily used frameworks for examining suicidal thoughts and behaviours among people with diverse sexualities (e.g., Mereish et al., 2019; Michaels et al., 2016; Pitoňák, 2017; Rogers et al., 2021). Additionally, the MSM has been expanded to be applied to transgender and gender diverse peoples as an explanatory model of suicidality (e.g., Staples et al., 2018; Tebbe & Moradi, 2016), and an adapted version, the Gender Minority Stress Framework (GMSF), was developed to account for the unique factors that contribute to psychological distress among these communities (Hendricks & Testa, 2012; Tan et al., 2020a; Testa et al., 2015). However, critical appraisals of the MSM have demonstrated shortcomings with the model's theoretical underpinnings, particularly regarding Meyer's conceptualisation of stress (Peel et al., 2022; Riggs & Treharne, 2017).

In the early development of the MSM, Meyer (1995; 2003) draws from social, critical, experimental, and constructionist literatures to outline the minority stress concept. Starting with an *engineering analogy*, stress is initially conceptualised as a load exerted on a support surface (Meyer, 2003). Meyer (2003) then introduces *social stress*, framing this form of stress as distinguishable from, or additional to, the prior engineering analogy; seemingly attempting to build an argument that individual stressors (e.g., personal events) are separate to these social stressors (e.g., social structures within environments). As highlighted by Riggs and Treharne (2017), the distinction between stress as a 'load' or as 'social' is not required since both represent an external force imposed upon a person. In Riggs and Treharne's (2017) reorientation of the engineering analogy, the 'load' is socially produced stress that is exerted

on the 'support surface' (i.e., a marginalised person), constituting the expression of stress as weight baring down on people.

While defining minority stress, Meyer outlines a series of descriptions regarding where stress arises and details the causes of stress. In doing so, minority stress becomes located within the social positions of marginalised peoples: "excess stress to which individuals from stigmatised social categories are exposed [to] as a result of their social, often a minority, position" (Meyer, 2003, p. 675). This account attributes the cause of minority stress to the person's *minority position*, which arguably removes the idea of stress as entirely social by nature (Riggs & Treharne, 2017). Meyer (2003) continues to individualise the causes of minority stress by highlighting the role of people's *negative regards* towards marginalised peoples. This act to frame interpersonal conflicts as a cause of stress rather than acknowledging broader social contexts which render marginalised people as "legitimate targets of negative regard" (Riggs & Treharne, 2017, p. 595).

Meyer (2003) further localises minority stress to the marginalised person while iterating the idea of *disharmony* between the person and their social context. Not only is the minority position again attributed as the cause of stress (Riggs & Treharne, 2017), but also, it is the marginalised person's deviance from their environment which creates the discontinuity. This is reinforced by Meyer's (2003) account of *distal* and *proximal* process of minority stress among lesbian, gay, and bisexual people. Distal stressors (external and objective) are brought into the proximity of the marginalised person when they appraise or perceive these as mattering to their sense of self (i.e., minority identity). In this regard, proximal stressors (internal and subjective) represent the person's "decisions about how they respond to the world around them" (Riggs & Treharne, 2017b, p. 595).

The final caveats of the MSM are evident in Meyer's (2003) conceptualisation of an objective to subjective spectrum of minority stressors. In defining distal stressors as objective stress, Meyer (2003) frames these stressors (e.g., prejudicial violence) as inherently stressful irrespective of the marginalised person's appraisal processes, rendering them as "passive victims of prejudice" (p. 691). Attempting to diminish this perspective of marginalised people, Meyer (2003) incorporates subjective stress into the MSM as a means of highlighting that these individuals are *resilient actors* to stressors and possess *coping abilities*. However, as stated by Meyer (2003), "failure to cope, failure of resilience, can therefore be judged as a personal,

rather than societal, failing" (p. 691). Thus, the marginalised person is framed as responsible for resisting against, or coping with, minority stressors, which minimises the influence of one's social environment as a producer of stress.

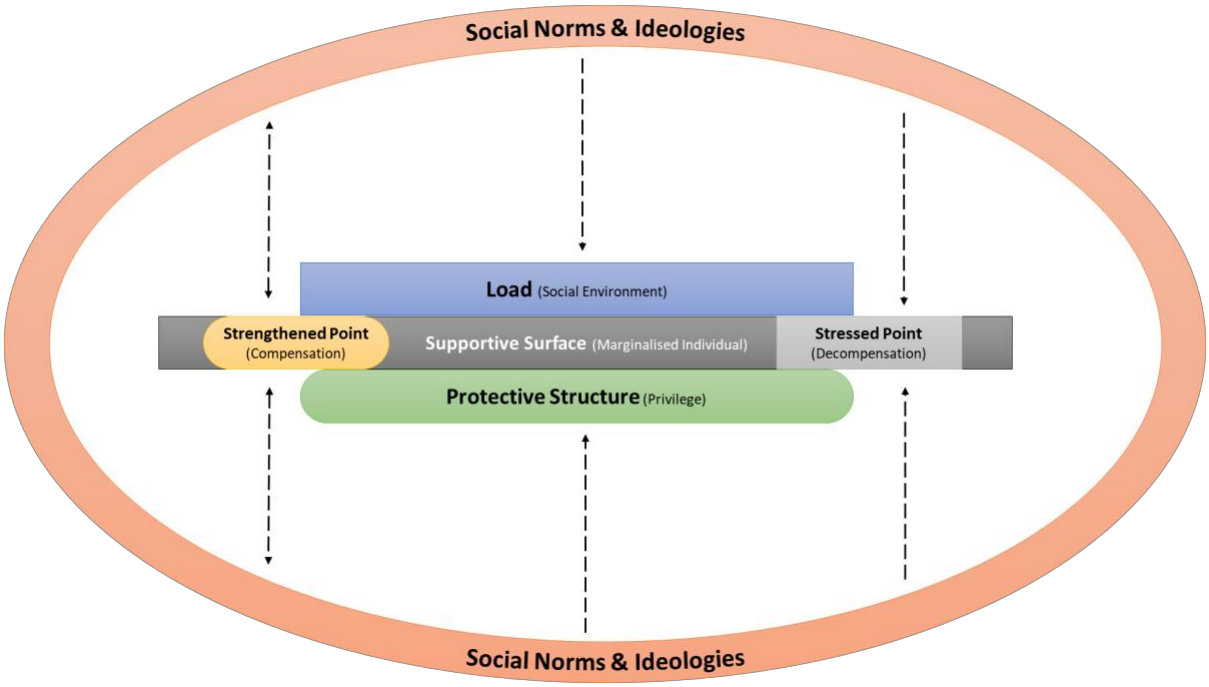
Overall, Meyer's description of minority stress raises questions regarding the ownership of stress, particularly the locality of cause. Rather than maintaining continuity with the idea of social stress, the MSM positions contributors of stress within individuals. By extension, coping and resilience become individualised constructs regarding how the marginalised person is responsible for ameliorating their own experiences of stress. As such, the MSM as applied to suicidality places the onus of risk on queer and takatāpui people, disregarding the roles of social norms and ideologies as agents of cause (Riggs & Treharne, 2017). In the subsequent sections, I propose that the Theory of Decompensation offers more social, rather than individual, mechanisms for examining suicidality among queer and takatāpui people.

The Theory of Decompensation

Riggs and Treharne's (2017) Theory of Decompensation (ToD) is a direct response to the limitations with Meyer's MSM, and represents a reconceptualisation of the engineering analogy that was dismissed by Meyer (2003). Figure 2 depicts the ToD as a social model for understanding the stressors which are imposed upon marginalised communities, rather than locating the causes of stress within these individuals (e.g., behaviours and appraisals). This is achieved by reframing minority stress as a product of social factors, namely, *ideology*, *intersectionality*, and *privilege* (Riggs & Treharne, 2017). I have referred to the model depicted in Figure 2 as the Decompensation Model (DM), and the underpinning theoretical orientations to this model as the ToD.

Figure 2

A Model Representation of the Theory of Decompensation



Note. Adapted from "Gender minority stress: A critical review" by K. Tan, G. Treharne, S. Ellis, J. Schmidt, and J. Veale, 2020, *Journal of Homosexuality*, *67*(10), p. 1473. The dashed arrows represent the directions of influence between the components.

Acknowledging that people are not the sole determinants of their social environments, the DM is encompassed by the component of *institutionalised social norms* and ideologies (Figure 2). When applied to identity categories (e.g., ethnicity, sexuality, gender) ideologies function to define which identities are considered normative (social norms), thus rendering identities that do not approximate to these established social norms as targets of marginalisation (Riggs & Treharne, 2017; Tan et al., 2020a). The ToD conceptualises social norms and ideologies as an omnipresence within society, continuously influencing the social ideals that people should strive to align with. Within the DM, social norms and ideologies functions as the producer of stressors that are expressed within one's *social environment*, as represented by the weighted *load* (Riggs & Treharne, 2017; Tan et al., 2020a). This load is positioned a top the *supportive surface* (i.e., a *marginalised individual*), signifying the collated forms of stressors that are exerted upon the marginalised person.

The ToD deconstructs the notions of proximal and distal stressors proposed in the MSM, positioning stressors as entirely social by nature. Minority stressors are still defined as phenomena that are uniquely experienced by people who are marginalised but are understood to arise from social norms and ideologies embedded within societies, rather than given legitimacy through an individual's psychological appraisals (Riggs & Treharne, 2017). Refuting Meyer's conceptualisation of people occupying minority positions, the DM acknowledges that the weight of the load is not uniform across all support surfaces (Figure 2), just as the experience of stress is not uniform across all people. People are given socially defined minority positions based upon their identity categories, and the degree of stress exerted on the marginalised person is affected by how normative their social context considers their intersecting identity categories to be (Riggs & Treharne, 2017). Intersectionality modifies and moderates the relationship between the person and the stressors within their social environment. Thus, minority stress is determined by intersecting identities and different social environments.

In Meyer's MSM, a person's tolerance to minority stress is contingent upon their capacity to function as a resilient actor and the coping abilities they possess (Meyer, 2003). By extension, the marginalised individual becomes responsible for ameliorating their own experience of stress, even when interacting with social supports, as the individual is required to adopt and internalise the coping mechanisms of others. Contrastingly, the ToD acknowledges that just as stressors are socially located, so too are protective factors (Riggs & Treharne, 2017). In the DM, the *protective structure* represents the *privilege* afforded to people whose identities align with social ideals and is situated underneath the support surface (Figure 2). This can be thought of as a cushioned-like structure that bares some of the weight exerted on the support surface by the load. Just as ideologies and social norms afford some identities a minority position, these also function to produce privileges for other identities by granting membership to the dominant societal group based on conformity to social ideals (Riggs & Treharne, 2017). As such, the privileges that are socially granted to some people mitigate the stress that they are subjected to, depending on the identity collectives that they intersect with.

The final two components of the DM have intentionally been placed within the support surface (Figure 2). This is **not** to represent these as deterministic factors, nor to locate the causes of minority stress within the individual, but to acknowledge *compensation* and *decompensation* as experiential and as outcomes of institutional social norms. Drawing upon the engineering

analogy, the *stressed point* represents the process in which the force exerted on the support surface exceeds the threshold to maintain structural integrity under the weight of the load. Riggs and Treharne (2017) frame this stress process within the language of decompensation, however, emphasis that to decompensate is not a reflection of one's inability to cope, but rather, "a product of the force of social norms, and hence the failing […] is the failing of multiple ideologies to offer protection and inclusion" (p. 600). Complimentary to this, the *strengthened point* represents the actions and behaviours of compensation that are required from the marginalised person to counteract minority stress. As such, when compounding experiences of stress exceed one's privilege and protective mechanisms, the individual is forced to decompensate as they can no longer compensate for social norms and ideologies (Riggs & Treharne, 2017).

Overall, the ToD amends several of the shortcomings within the MSM. Using the framework of the engineering analogy, the DM (Figure 2) posits that ideologies, intersectionality, and privilege are essential mechanisms for understanding the stressors imposed upon queer and takatāpui people and how the experience of stress varies across individuals. The ToD explicitly positions the processes of minority stress as external to marginalised peoples by framing social norms and ideologies as the causes of stressors within a social environment. The established social norms within any given social context will then vary depending on the ideologies that define which identities are normative and who is granted personhood, and therefore given attention in discourse about social injustices (Riggs & Treharne, 2017). Drawing upon intersectionality, these social norms marginalise some identity collectives while also privileging others based upon how closely these align with established social ideals. As such, people do not occupy marginalised positions, instead, these are afforded, whereby an individual can be both marginalised and privileged because of their intersecting identities. Since stressors are socially produced, a marginalised person is forced to compensate against their experience of stress, which can result in decompensation when the force of stressors exceeds their privilege and protective mechanisms. In some cases, this decompensation can result in suicidality and specific models of suicide can help understand the related mechanisms.

The Ideation-to-Action Framework

The study of suicidology endeavours to answer the fundamental questions of suicide among the entire population: *What causes suicidal behaviours and thoughts, and how can we prevent*

these? While several risk factors have been identified as predictors of suicidality, it is a fallacy within research that these factors provide us with any greater clarity on the differences between suicidal ideation and suicide attempts. This is a particularly important distinction to make since most people who experience suicidal thoughts will not subsequently attempt suicide (Klonsky & May, 2014). Hopelessness, impulsivity, and psychiatric disorders correlate with suicidal thoughts and behaviours, yet findings remain inconclusive on the utility of these variables as differentiators between people who only experience suicidal ideation and those who will go on to engage in suicidal behaviours (Klonsky et al., 2016; Klonsky & May, 2014; May & Klonsky, 2016). As such, research has suggested that these variables likely function as robust predictors of suicidal thoughts rather than suicidal behaviours (Klonsky & May, 2014; May & Klonsky, 2016). Klonsky and May (2014) propose that our limited capacity to accurately predict and prevent suicide is in part attributed to explanatory theories having "conflated the question of why people *feel* suicidal with the question of why people *act* on suicidal thoughts" (p. 3).

In response to the limited utility of past theories of suicide, the ideation-to-action framework has emerged as a novel approach for identifying and examining potential mechanisms of suicidality. Utilising dual processes rather than of a singular explanatory concept for suicide (e.g., escapism, psychache, hopelessness), this framework is underpinned by two key assumptions (Klonsky et al., 2016; Klonsky et al., 2018). Firstly, the emergence of suicidal ideation and the progression from suicidal ideation to attempting suicide are assumed to represent two discrete processes (Klonsky et al., 2016). Secondly, these two processes are assumed to be underpinned by distinct mechanisms and predictor variables (Klosky et al., 2016). By conceptualising suicidal ideation and suicide attempts as separate processes, this framework encourages research to make direct comparisons between idolators and attempters, establishing this as an imperative principle in suicide study designs (Klonsky et al., 2016).

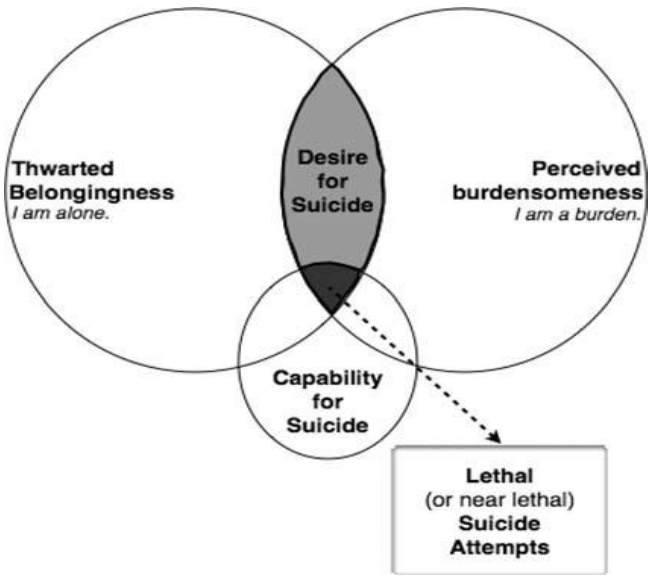
The Interpersonal Theory of Suicide

The Interpersonal Theory of Suicide (IPTS) is considered among the first ideation-to-action theories (Figure 3). Proposed by Joiner in 2005, the IPTS posits that passive suicidal ideation is caused by the simultaneous experience of thwarted belongingness (TP) and perceived burdensomeness (PB), which develops into the desire for suicide when the prospect of changing these circumstances is perceived as hopeless (Joiner, 2005; Van Orden et al., 2010). It is not until one has acquired capability (AC) for suicide that intent to act on suicidal desire

(i.e., suicide attempts) emerges, including decreased fear of death and elevated pain threshold (Van Orden et al., 2010). While the IPTS has been extensively researched, and applied to different populations, results from meta-analyses show this theory offers mixed benefits in explaining suicidality (Hjelmeland & Knizek, 2020). Of the 66 studies included in the meta-analysis conducted by Ma et al. (2016), 29 studies showed support, 33 showed partial support, and four showed no support, for the components of the IPTS that were examined within respective studies (i.e., TP, PB and/or AC). As predictors of suicidal ideation: 57 of the 69 (82.6%) tests examining PB were significant, 22 of the 55 tests (40%) examining TB were significant, and 8 of the 12 tests (66.6%) examining a PBxTB interaction were significant (Ma et al., 2016). Further, 5 of the 9 tests (55.5%) examining AC as a predictor of suicide attempt(s) were significant, and 3 of the 7 tests (42.8%) examining an interaction of all the IPTS's components (PBxTBxAC) were significant (Ma et al., 2016). Additionally, a meta-analysis of 114 articles conducted by Chu et al. (2017) found that the effect sizes of TB and PB as predictors of suicidal ideation, and AC as a predictor of suicide attempt(s), were weak to modest. As such, these two meta-analyses offered mixed support for the IPTS.

Figure 3

Joiner's Interpersonal Theory of Suicide



Note. From "The interpersonal theory of suicide" by K. Van Orden, T. Witte, K. Cukrowicz, S. Braithwaite, E. Selby, and T. Joiner, 2010, *Psychological Review*, *117*(5), p. 576.

Hjelmeland and Knizek's (2020) critical analysis of the IPTS indicates that the theory's potential limitations are in part due to the underpinning assumptions. The first two components of the IPTS seemingly function in contradiction of one another. Specifically, to experience perceived burdensomeness (PB) an individual would need to be connected with others to an extent, which contrasts with thwarted belongingness (TB), whereby an individual believes that people do not care for them (Hjelmeland & Knizek, 2020). Joiner's (2005) conceptualisation of PB and TB emphasises suicidality as internal phenomena, locating the cause of suicidal ideation/desire within an individual's *perceptions* of their current circumstances, which 1) represents the IPTS as an *intra-personal* theory not an inter-personal one, and 2) neglects the role of one's environmental factors (Hjelmeland & Knizek, 2020). Joiner further reinforces his idea of suicidality as internalised processes by implying that people function within some parameters of eusociality, which is claimed to account for the social withdrawal, elevated arousal, and PB presented by some suicidal individuals (Joiner et al., 2016). As such, Joiner equates suicide to an individual's impaired mental state (i.e., psychopathology), whereby an individual misperceives self-sacrifice as a beneficial act for the greater good of society (Joiner et al., 2016; Hjelmeland & Knizek, 2020). Again, by reducing suicide to (mis)*perceptions*, the IPTS implies that contributors to suicidality are subjective by nature, rather than acknowledging that burdensomeness and thwarted belongingness are objective realities for people (Hjelmeland & Knizek, 2020).

Overall, Joiner's IPTS is best understood as a reductionist and intrapersonal approach to explaining suicidality. Similar to the issues raised earlier regarding Meyer's MSM (Riggs & Treharne, 2017), the IPTS decontextualises people from their environmental circumstances and locates the causes of suicidality within the suicidal individual. This is particularly evident by Joiner's (2005) conceptualisation of burdensomeness and lack of belongingness as "perceptions, not realities that should be blamed on survivors" (p. 224). With these limitations in mind, I now outline the Three-Step Theory of suicide in the following section, which stands as a novel iteration of the ideation-to-action framework.

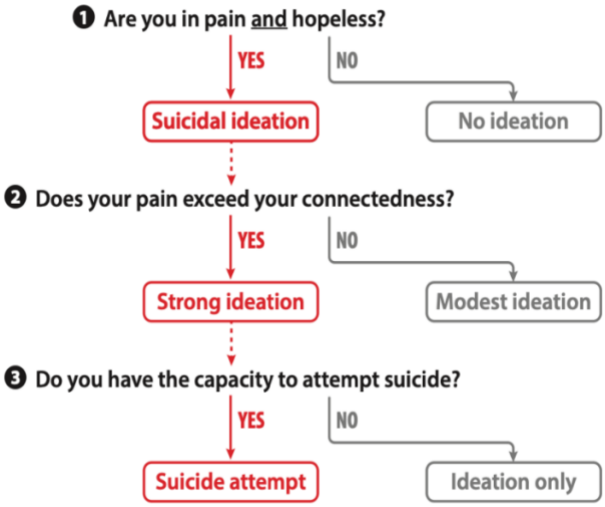
The Three-Step Theory of Suicide

Inspired by Joiner's (2005) IPTS and O'Connor's (2011) Integrated Motivation-Violation Model, Klonsky and May (2015) developed a Three-Step Theory (3ST) of suicide (Figure 4). Underpinned by the ideation-to-action framework (Klonsky et al., 2018), the 3ST consists of

four components (pain, hopelessness, connectedness, and suicide capacity) that explain suicidality through three distinct processes (i.e., 'steps'). Initially proposed as three hypotheses, the first process posits that suicidal ideation emerges from the combination of experienced pain and hopelessness (Klonsky & May, 2015). The component of pain is intentionally unspecified, recognising that different forms of pain will be experienced as aversive to different people, which may comprise of physical, psychological, and/or emotional pain. However, pain will not eventuate as suicidal ideation if an individual is hopeful that their day-to-day experience of pain will eventually subside; therefore, one must simultaneously feel hopeless about their future prospects for suicidal ideation to develop (Klonsky & May, 2015).

Figure 4

Klonsky and May's Three-Step Theory of Suicide



Note. From "Suicide, suicide attempts, and suicidal ideation" by E. Klonsky, A. May, and B. Saffer, 2016, *Annual Review of Clinical Psychology, 12*, p. 320.

The second process introduces connectedness as a factor that modifies the severity of suicidal ideation. An individual's attachment to people, an occupation, and/or hobbies, which create meaningfulness and purpose, maintains the individual's investment in living (Klonsky & May, 2015). One's suicidal ideation remains moderate in the face of pain and hopelessness if they are connected with someone or something. It is when one's experienced pain exceeds their connectedness, or when connectedness is entirely absent, that suicidal ideation will intensify into the desire to end one's own life (Klonsky & May, 2015). Klonsky and May (2015) highlight that connectedness functions as a protective factor against suicidal desire, influencing

the experience of pain and hopelessness, but is not necessary for the initial development of suicidal ideation.

The third process of the 3ST explains the progression from suicidal desire to attempting suicide, namely one's suicide capacity. Similar to Joiner's (2005) conceptualisation, acquired capacity represents the process of habituating to pain and the fear of dying through exposure to painful and traumatic experiences, including the loss of a loved one, physical abuse, sexual abuse, and self-harm (Klonsky & May, 2015). The 3ST proposes two additional types of capacities that contribute to suicide. Dispositional capacity refers to biological and genetic predispositions that are inherent to the individual, such as a lowered sensitivity to pain or blood. Practical capacity entails the pragmatics of making a suicide attempt, including having knowledge of suicide methods and access to lethal means (Klonsky & May, 2015). Acquired, dispositional, and/or practical capacities for suicide is assumed to drive a suicide attempt in the presence of strong suicidal ideation.

The 3ST offers remedies to some of the caveats apparent in the MSM and the IPTS. Firstly, the causes of suicidality are not conceptualised as internal liabilities, such as one's perceived burdensomeness and lack of belongingness or one's approximation to external stressors (e.g., internalised homophobia). Instead, the component of pain is recognised as something which is particular to, but experienced by, the individual and is intentionally unspecified because "what is painful or punishing for one person may be rewarding or reinforcing for another" (Klonsky et al., 2021, pp. 5-6). It is important to draw attention to the component of hopelessness, which is dependent upon one's psychological appraisal of current circumstances, specifically one's negative expectations that suffering will not subside in the future. In this regard, the 3ST does localise some of the suicidality processes within the individual, rather than extraneous factors. However, pain and hopelessness have been found to be the most frequently reported motives for suicide attempts compared with other risk factors, including TB, PB, escapism, and fearlessness of death (May & Klonsky, 2013).

Another strength of the 3ST is it's description as an explanatory theory of suicide, not a model for predicting suicide, *per se* (Klonsky et al., 2021). In their meta-analysis of studies that had attempted to examine the IPTS, Chu et al. (2017) suggest that research has neglected to test the components of the IPTS on instances of suicide and near-lethal suicide attempts, proposing psychological autopsies and longitudinal cohorts as methods for adequately testing the IPTS.

However, an individual could not provide a retrospective account of the deceased person's thoughts (e.g., TB, PB) or feelings prior to them taking their own life, as would be required for psychological autopsy (Hjelmeland & Knizek, 2020). Further, as a way of predicting future suicidality, longitudinal studies pose several limitations when examining the IPTS, including the necessity of large samples for statistical power, leading to heterogenous sample characteristics (Hjelmeland & Knizek, 2020). In contrast, longitudinal designs are inappropriate for testing the 3ST, recognising that the key components of this theory are subject to change over time and that predictive utility is distinct from theory validity (Klonsky et al., 2021). As such, the 3ST emphasises the use of study designs, including cross-sectional, which make direct comparisons between people who have only experienced suicidal ideation (ideators) and people who have also attempted suicide (attempers) (Klonsky et al., 2021).

An advantage of the 3ST over Meyer's MSM is the incorporation of social processes, recognising that people are dynamic and do not operate in a vacuum, which is highly relevant in application to queer and takatāpui people. For example, the second step frames socialisation as a modifying factor, whereby a lack of connectivity to salient aspects within one's environment exacerbates the severity of suicidal thoughts from ideation to desire (Klonsky & May, 2015). Contrastingly, the MSM posits that internal characteristics of one's identity (i.e., prominence, valence, and integration) modifies the severity of stress, and even the benefits of communities and social supports are dependent on the individual internalising others' coping resources into their own coping abilities (Meyer, 2003). Resilience to stress is conceptualised as the individual's coping capabilities, while the 3ST proposes that suicidal ideation can be ameliorated through external connections that evoke meaning and purpose within one's life.

Overall, the 3ST of suicide functions as a flexible and actionable theory for explaining suicidality. With exception to hopelessness, the components of the 3ST do not position the causes or severity of suicidality within the suicidal person. Instead, the mechanisms of pain, connectedness, and capacity for suicide remain unconstrained by specific variables, recognising that these are defined by sociocultural, environmental, physical, and psychological factors (Klonsky, 2020). Additionally, the 3ST acknowledges that psychological autopsy and longitudinal cohorts pose a myriad of practical (e.g., sample size) and ethical (e.g., retrospective recall from a third party) limitations. Instead, Klonsky et al. (2021) advocates for the use of cross-sectional data collection when examining the components of the theory.

Summary

Several theories have been proposed to explain the processes that precipitate, and intensify, suicidality. Of these theories, none have focused on the unique factors that influence the ways in which queer and takatāpui people experience suicidality. Meyer's MSM was initially developed to explain mental health disparities among gay men (1995) but has since been expanded to account for other diverse sexualities (2003) and adapted for trans and gender diverse peoples (Hendricks & Testa, 2012; Testa et al., 2015). Despite its popularity, Meyer's MSM locates the causes of minority stress within those with diverse sexualities and gender identities, and implicitly positions these individuals as responsible for coping with this stress. Contrastingly, Riggs and Treharne's (2017) ToD explicitly locates the causes of minority stress within the social environment, acknowledging that social norms marginalise people who do not align with social ideals and privilege those who do, determined by one's intersectionality. The ideation-to-action framework posits that suicidal ideation and suicide attempts represent distinct processes. Joiner (2005) was arguably the first to explicitly differentiate between these dual processes using a formalised IPTS, underpinned by TB, PB, and AC. The IPTS remained relatively unchallenged until Hjelmeland and Knizek (2020) critiqued the theory's limited empirical evidence and problematic theoretical assumptions. Klonsky and May's (2015) 3ST of suicide proposes that the experience of pain and hopelessness elicits suicidal ideation, which is moderated by belongingness, and develops into attempting suicide when one has acquired, dispositional, or practical capacity. As such, I propose that the 3ST and the ToD represent suitable theories for understanding suicidality among queer and takatāpui peoples, and form the foundation for the current research project. In Chapter 2, I highlight factors and variables that have been associated with suicidal ideation and suicide attempts, particularly those prominent within research conducted with gender and sexuality diverse communities.

Chapter 2: What Contributes to, and Protects Against, Suicidality?

In this chapter, I review literature pertaining to precipitants and protective factors of suicidality as a means of building my rationale for the current research project. I start by addressing the notion of 'at-risk', which reduces queer and takatāpui people to subjects of 'pathology' and inherently 'vulnerable' to suicidality. I then highlight counter arguments that recognise suicidality as socially produced through multiple contributing factors. An application of the Three-Step Theory (3ST) of suicide is reviewed, and then I sequentially outline evidence for social discrimination, hopelessness, social support, and non-suicidal self-injury as explanatory factors for suicidality among queer and takatāpui people. Next, I discuss one study that has directly applied the Theory of Decompensation (ToD) to explore how queer and takatāpui people understand suicide, discrimination, and pride events. I draw on research which dissects the ways in which ideologies, intersectionality, and privilege might contribute to suicidality within marginalised communities. I conclude by summarising evidence for the 3ST and the ToD as frameworks for investigating suicidality among queer and takatāpui people and highlight gaps in the literature that require bridging.

Themes and Discourses of Suicide 'Risk'

People with diverse sexualities, genders, and ethnicities continue to be pathologised. Within the fields of psychology and psychiatry, an 'at-risk' discourse serves to label people as psychologically disordered by virtue of deviating from social norms (McDermott & Roen, 2016), thus reinforcing dominant ideologies which define who or what is given a 'normative' status (Riggs & Treharne, 2017). For queer and takatāpui people, non-conformity to heteronormative and cisnormative practices and ideologies renders these individuals as 'at-risk' subjects of suicidality. Specifically, research on these communities discursively constructs them as 'vulnerable' and 'at-risk' of suicidality, whereby identification to a 'non-normative' sexuality or gender is to be defined as 'pathological' (Bryan & Mayock, 2012). McDermott and Roen (2016) argue that this positions suicide risk as individualised, rather than socially precipitated. The 'risk' is localised to the marginalised person, thereby reducing suicidality as an outcome of individual pathology. To date, research conducted in Aotearoa has largely reinforced an 'at-risk' discourse by focusing on showing higher rates of suicidal

ideation, self-harm, and suicide attempts among queer and takatāpui people (e.g., Fergusson et al., 1999; Skegg et al., 2003; Fergusson et al., 2005; Lucassen et al., 2011; Clark et al., 2014; Fenaughty et al., 2021), providing limited insights into the processes that elicit their suicidal distress.

Some have challenged psychomedical constructions of LGBTQIA+ people as 'pathological' and 'vulnerable' subjects to suicidality. Analyses conducted on queer people's talk have presented arguments against the discourse of a causal link between being queer and suicidality, rationalising that while suicidal thoughts and behaviours occur among these individuals, suicidal distress is attributable to external precipitants (Bryan & Mayock, 2012; McDermott et al., 2015; Bryan & Mayock, 2017). This counter discourse rejects the construction of suicidality as an inherent attribute of people with non-normative sexualities and gender identities, instead, arguing that suicidality is socially produced and negotiated. The most consistently and strongly evidenced of these social processes is discrimination (Fenaughty & Harré, 2003; McDermott et al., 2008; Scourfield et al., 2008; Bryan & Mayock, 2012; McDermott et al., 2015; Bryan & Mayock, 2017; Schimanski & Treharne, 2019).

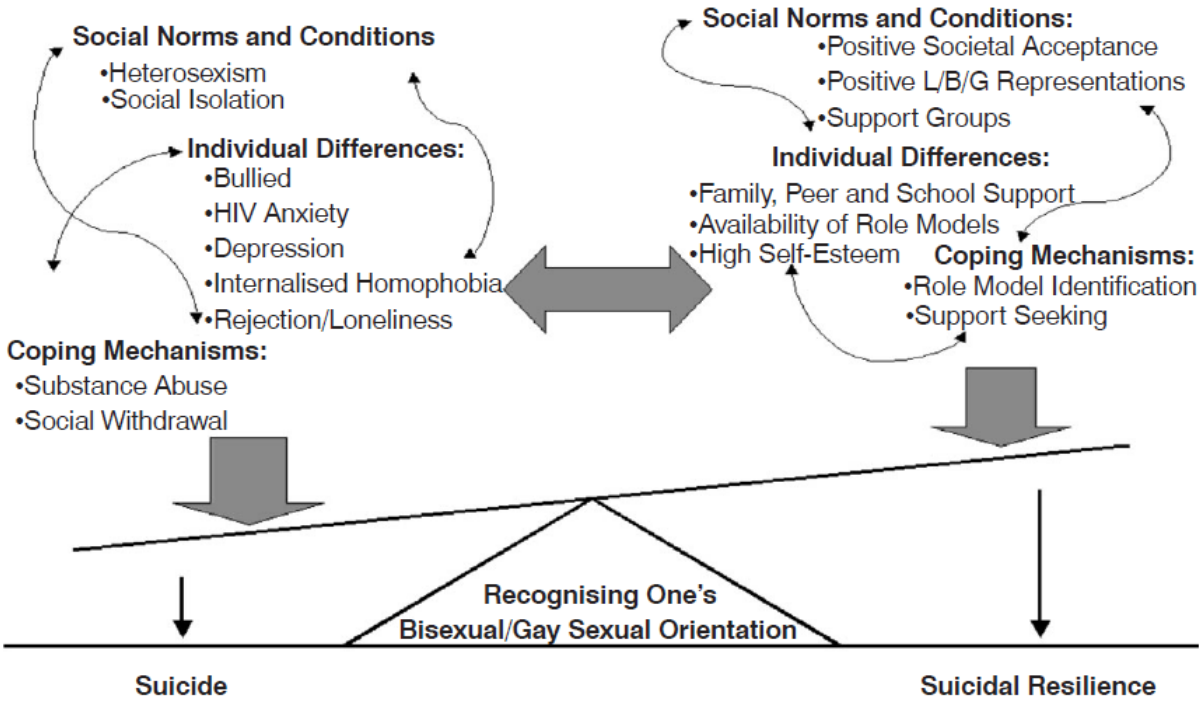
Scourfield et al. (2008) explored the understandings of suicide and self-harm among 69 LGBT people living in the UK, aged 16-25, using focus group interviews. Participants framed self-harm as a reaction to discriminatory social climates, which 1) prompted self-harm as a form of self-punishment due to hating one's queer identity, and 2) elicited distress such that one felt compelled to self-harm. Similarly, suicide was discussed as a 'genuine' and 'understandable' response to social isolation from supports due to rejection, experiences of homophobia, and the adversities of remaining closeted or coming out to family members (Scourfield et al., 2008). These perspectives mirror the findings presented by McDermott et al. (2008), who conducted a Foucauldian discourse analysis on UK based LGBT people's talk regarding self-destructive behaviours. Participants constructed homophobia "as punishment for the transgression of heterosexual norms" (p. 821), serving to shame the individual as an abnormality because of their non-heterosexual orientation, which could eventuate as suicide (McDermott et al., 2008). Further, participants discussed their processes of negotiating homophobia to avoid becoming shamed, such as framing homophobia as 'mundane' and 'routine' to minimise the severity of its impact and developing an 'adult identity' by positioning oneself as independently responsible for coping with the distress of homophobia. These two studies showed that

discrimination was understood to significantly precipitate suicidality, which digresses from the 'at-risk' discourse and instead localises suicide risk within one's social environment.

Endeavours to deconstruct the 'at-risk' discourse have also encouraged researchers to move beyond research paradigms and designs that rely upon examining singular risk factors for suicidality (McDermott & Roen, 2016). Instead, studies have attended to multicausal explanations of suicidal distress by prioritising the lived experiences and perspectives of queer and takatāpui people. In a prime example, Fenaughty and Harré's (2003) Seesaw Model of Bisexual and Gay Male Suicide is likely one of the only frameworks of suicide constructed from the narratives of queer men living in Aotearoa (Figure 5). Developed using a grounded theory approach, the Seesaw Model positions multiple risk and resiliency factors of suicide at opposite ends of a seesaw (i.e., representing the gay/bisexual man), with one's sexual orientation situated in the centre, acting as a pivoting structure (Fenaughty & Harré, 2003). The seesaw is understood to continuously fluctuate between suicide resiliency and suicide risk depending on the types of experiences weighing down the respective ends. These experiences are differentiated into three levels of occurrence: 1) 'social norms and conditions' (e.g., heteronormativity vs. social acceptance); 2) 'individual differences' (e.g., depression vs. bolstered self-esteem); and 3) 'coping mechanisms' (e.g., substance use vs. help seeking) (Fenaughty & Harré, 2003). Within this framework, suicidal distress is conceptualised as a complex and nuanced phenomenon, whereby risk and resiliency factors interact and influence how suicidality is, or is not, experienced by queer and takatāpui people. Though the Seesaw Model rebuts the construction of queer people as passive subjects to the 'at-risk' discourse, it is not without limitations. Specifically, the homogenous characteristics of the interviewees (gay and bisexual men aged 19 to 23) narrows the model's applicability by omitting the perspectives of people with other marginalised identity categories (e.g., trans and gender diverse).

Figure 5

Fenaughty and Harré's Seesaw Model of Suicide



Note. From "Life on the seesaw: A qualitative study of resiliency factors for young gay men" by J. Fenaughty, and N. Harré, 2003, *Journal of Homosexuality*, *45*, p. 17.

Bryan and Mayock (2012; 2017) actively challenged dominant constructions of LGBT identities as intrinsically associated with suicide 'risk' by analysing the life narratives of 40 LGBT people aged 16 to 62, living in Ireland. Participants iterated that their experiences of suicidality could not be attributed to monocausal explanations but were rather multifactorial by nature. These narratives presented a duality between suicidal factors related to 'being' queer within society and those related to general existence. Regarding the former, the social pressure to conform to heteronormative expectations was described as a leading reason for having attempted suicide (Bryan & Mayock, 2012). Experiences of rejection from family and friends, and feelings of isolation, were understood by participants to arise from daily assumptions of heterosexuality, which inhibited the expression of one's queer identity. As such, the relationship between suicide risk and LGBT people was constructed through heteronormativity, which created social environments characterised by a lack of acceptance due to non-conformity to normative social expectations of heterosexuality. In addition, participants recognised the contribution of general life stressors (e.g., schooling, home environment, friendships) in precipitating suicidality (Bryan & Mayock, 2012; 2017). These stressors were framed as accumulated negative life experiences that were unrelated to one's

LGBT identification but rather generic and universal to existence (e.g., exam pressure, familial conflict). In contrast to the narratives of suicide risk, social supports were understood to foster resilience against suicidality, such as positive connections with family, friends, queer-based services, and supportive occupational environments (Bryan & Mayock, 2012). Overall, these narratives highlight the necessity to account for the influence of both queer-specific and universal factors related to suicidality risk and resiliency, particularly as a means of deconstructing the portrayal of queer and takatāpui people as 'at-risk' subjects.

In the following sections, evidence for the Three-Step Theory of suicide and the Theory of Decompensation is outlined. This research is specifically tailored to factors and variables that influence the experience of suicidal distress among people with diverse sexualities and gender identities. Attention is given to mechanisms that are theorised to precipitate or mitigate suicidality within queer and takatāpui communities, consisting of both queer-specific (e.g., heteronormativity, cisnormativity) and universal (e.g., hopelessness, self-harm) factors. The aim was to acknowledge that unique factors influence how suicidality is experienced by queer and takatāpui people, while recognising that suicidality is not inherent to individuals with marginalised sexualities and gender identities.

Applicability of the Three-Step Theory of Suicide

Only a small number of studies have developed theoretical frameworks to explain suicidality among queer and takatāpui people (e.g., Fergusson & Harré, 2003; Burgess et al., 2021). Instead, research conducted with these communities has examined the utility of existing theories of suicide that have been conceptualised to explain suicidality within the general populous. This research has primarily applied the Interpersonal Theory of Suicide (IPTS) to samples with diverse sexualities and genders (e.g., Hill & Pettit, 2012; Grossman et al., 2016), and tested theoretical frameworks that integrate factors from both the IPTS and the Minority Stress Model (e.g., Baams et al., 2015; Fulginiti et al., 2020; Chang et al., 2022). However, limited attention has been given to the ideation-to-action processes outlined in Klonsky and May's (2015) 3ST of suicide.

Wolford-Clevenger et al. (2021) measured the psychological pain, hopelessness, social connectedness, and suicidal ideation of 38 transgender and gender diverse people (aged 18-64 and living in the US) using daily surveys over a 30-day period. These surveys were

administered to participants using an online survey platform, which yielded data from 836 (73.3%) completed surveys. For step-one of the 3ST, results showed that psychological pain ($B = .25$, $p < .001$), hopelessness ($B = .26$, $p < .001$), and the interaction term of these variables ($B = .36$, $p < .001$) significantly predicted suicidal ideation (Wolford-Clevenger et al., 2021). For step-two, social connectedness scores were subtracted from psychological pain scores to create a 'difference score'. On days when participants' psychological pain and hopelessness scores were both high, this difference score was moderately associated with suicidal ideation ($B = 0.44$, $p < .001$), and was weakly associated with suicidal ideation ($B = 0.11$, $p < .001$) on days when psychological pain and/or hopelessness scores were low (Wolford-Clevenger et al., 2021). Though step-three of the 3ST was not tested, these findings support the utility of steps one and two for explaining suicidal ideation among transgender and gender diverse people. To date, this study is the only published literature to directly apply the 3ST of suicide to explain suicidality among queer people.

Social Discrimination

Step-one of the 3ST of suicide stipulates that the simultaneous experience of pain and hopelessness will elicit suicidal ideation (Klonsky & May, 2015). The component of *pain* is intentionally left unspecified, recognising that diverse negative experiences (e.g., psychological distress, physical pain, financial hardship) will elicit pain for different people (Klonsky et al., 2021). One factor that may be applicable to queer and takatāpui people is the construct of *social discrimination*: representing a psychologically, emotionally, and/or physically painful experience.

Bhugra (2016) defines social discrimination "as sustained inequity between individuals on the basis of illness, disability, religion, sexual orientation, gender, or any other measures of diversity" (p. 336). Adopting this definition as an underlying premise of discrimination, I use social discrimination as a comprehensive term, encompassing the prejudicial treatment (e.g., verbal/physical abuse), oppression, rejection, stigmatisation, victimisation, and marginalisation of queer and takatāpui people (Herek & McLemore, 2013). The breadth of these terms are included within the current definition of social discrimination to acknowledge that discrimination is experienced at the intrapersonal, interpersonal, and institutional levels of existence. Further, the terms 'homophobia', 'transphobia', 'queerphobia', and 'biphobia' have intentionally been omitted from this definition since '-phobia' positions irrational fear towards queer and takatāpui people as the basis of discrimination (Herek & McLemore, 2013).

Discrimination has been well established as a contributing factor to negative mental health outcomes among queer and takatāpui people, including symptoms of psychopathology (e.g., depression, anxiety), psychological distress, and suicidality (Mays & Cochran, 2001; Russell & Joyner, 2001; Adams et al., 2013; Woodford et al., 2014; Bostwick et al., 2014; Woodford et al., 2018; Lyons et al., 2021). A meta-analysis on LGBT samples conducted by Liu et al. (2019) found that the pooled effects of interpersonal and intrapersonal discrimination on non-suicidal self-injury varied from small (d = .32, N = 3,457) to medium (d = .35, N = 3,322), respectively. Synthesised data from 12 publications showed that the odds of social discrimination was 3.74 times greater among queer youth aged 12-25 with histories of suicidality, when compared with cisgender-heterosexual counterparts (Williams et al., 2021). Additionally, greater suicidal ideation and suicide attempts have been linked with both interpersonal (e.g., rejection, physical violence) and institutional (e.g., inequitable policies and laws) forms of social discrimination among people with diverse sexualities and genders (Haas et al., 2010; McNeil et al., 2017; Gosling et al., 2022). Given the magnitude of evidence, studies have explored mechanisms that may facilitate the trajectory from social discrimination to suicidality.

Wolford-Clevenger et al. (2018) conducted a systematic review using the ideation-to-action framework to identify factors associated with suicidality among transgender people. In particular, the authors' aimed to partition-out correlates according to their independent associations with suicidal ideation, attempted suicide, and suicide. Among the dynamic factors identified, higher external discrimination (e.g., victimisation, stigma, rejection) was consistently, and strongly, related to higher suicidal ideation among transgender people (Wolford-Clevenger et al., 2018). Wolford-Clevenger et al. (2018) proposed that social discrimination may function as an elicitor of psychological pain that in turn drives suicidal ideation. This discrimination-ideation pathway was paralleled with Hatzenbuehler's (2009) mediation framework, which posits that associations between external queer-related stressors (e.g., discrimination) and psychopathology are mediated through psychological (e.g., emotional regulation, cognitions) and social (e.g., social norms) processes.

A number of studies have proposed explanatory mechanisms for various discrimination-ideation pathways. Drescher et al. (2023) assessed the mediating effects of emotional regulation on correlates of suicidal ideation using survey data from 115 transgender and gender

diverse people (M_{age} = 27.6), living in the US. Results showed that emotional regulation significantly mediated the indirect effects of gender-based victimisation on suicidal ideation (B = .08), suicidal intent (B = .03), and total risk of suicidality (B = .42) but did not mediate the effects of gender-related victimisation on deliberate self-harm. Foster et al. (2022) conducted moderated serial-mediation analyses using measures of internalised homophobia, sexual orientation self-concept ambiguity (SSA), loneliness, and outness from 198 US-based non-heterosexual adults (aged 18-68). The overall model demonstrated that, among non-heterosexual adults who concealed their sexual orientations (moderator), the positive association between internalised homophobia and suicidal ideation was explained by ambivalence regarding their sexual orientation (SSA; first-order mediator) and subsequent feelings of loneliness (second-order mediator).

Peterson et al. (2021) researched the relationship between suicidal ideation and discrimination, with psychological pain proposed as a meditating variable. Self-identified LGBTQ people (N = 200, M_{age} = 35) living in the US completed an online survey measuring direct discrimination (e.g., harassment, victimisation), ambient discrimination (e.g., vicarious trauma), psychological pain, and suicidal ideation, within the past year. Both direct discrimination (B = 5.24, $p < .001$) and ambient discrimination (B = 3.33, $p < .001$) independently predicted psychological pain. More experiences of direct discrimination were significantly associated with higher suicidal ideation (B = 15.12, $p < .001$), but the inclusion of psychological pain (R^2 = .05, B = 8.16, $p < .01$) showed a full mediation effect, such that the direct effect of direct discrimination on suicidal ideation became nonsignificant (B = 6.96, p = .13). Similarly, more experiences of ambient discrimination were significantly associated with higher suicidal ideation (B = 8.58, $p < .01$), which was fully mediated by the inclusion of psychological pain (R^2 = .04, B = 6.21, $p < .01$), resulting in the direct effect of ambient discrimination on suicidal ideation becoming nonsignificant (B = 2.36, p = .48) (Peterson et al., 2021).

Hopelessness

Klonsky and May (2015) proposed that ongoing pain is insufficient to elicit suicidal ideation in isolation, also requiring the individual to perceive their current situation as hopeless. The concept of hopelessness can be defined as a negative anticipation about oneself and future life circumstances, which includes notions of pessimism (Beck et al., 1974). In relation to suicidality, hopelessness has been found to differentiate people who experienced suicidal ideation (ideators) from nonsuicidal individuals, with ideators exhibiting moderately higher

hopelessness ($d = .55$, $p < .05$) by comparison (May & Klonsky, 2016). However, hopelessness scores did not significantly differ between ideators and people with prior suicide attempts (attempters), suggesting that hopelessness may specifically contribute to the precipitation of suicidal ideation rather than suicide attempts (May & Klonsky, 2016). The following paragraphs outline studies that have examined hopelessness as a potential mediating variable.

Langhinrichsen-Rohling et al. (2011) examined the mediating effects of depressive symptoms and hopelessness on the association between sexual preference and suicide susceptibility (Life Attitudes Schedule-Short Form) with a sample of 200 LGB adolescents aged 13-18, living in the US. Results from the first mediation model showed that the direct effects of sexual preference on hopelessness, and hopelessness on suicide susceptibility, were both significant. In the same model, hopelessness fully mediated the relationship between sexual preference and suicide susceptibility, with the direct effect of sexual preference on suicide susceptibility yielding a nonsignificant result (Langhinrichsen-Rohling et al., 2011). These same results were evident in the second mediation model where depressive symptoms were used as the mediating variable instead of hopelessness.

Hirsch et al. (2017) investigated mediating pathways between LGBTQ identification and suicidal behaviour (i.e., suicidal ideation, attempts, and intent) using data from 349 LGBTQ university students, based in the US. Hypothesised was that LGBTQ identification would be associated with less dispositional hope and greater hopelessness and, sequentially, to elevated depressive symptoms, with suicidal behaviour as the outcome variable. Serial mediation models were significant, demonstrating that LGBTQ identification indirectly predicted higher suicidal behaviours via less hope and greater hopelessness (first-order mediators) and subsequent elevated depressive symptoms (second-order mediator) (Hirsch et al., 2017). Further, hopelessness and depressive symptoms exhibited significant direct mediation effects on the association between LGBTQ identification and suicidal behaviours, but results were nonsignificant when hope was used as a mediating variable.

Mustanski and Liu (2013) conducted a longitudinal study in the US with 237 LGBT youth aged 16-20 to assess the properties of proximal and distal factors as predictors of suicide attempts over a one-year period. Measures were administered at baseline and one-year follow-up, which included the number of lifetime and recent (12-months) suicide attempts, psychiatric symptoms of conduct disorder and depression, hopelessness, impulsivity, social support, gender non-

conformity, age of same-sex attraction, and queer-related victimisation (Mustanski & Liu, 2013). Multivariate cross-sectional analyses indicated that only depressive symptoms ($B = .16$) and hopelessness ($B = .99$) significantly increased participants' likelihoods of attempting suicide, yielding odds ratios of 1.17 and 2.69, respectively. Of particular interest, both hopelessness and depressive symptoms were found to partially mediate the effect of victimisation on lifetime suicide attempts. For longitudinal analyses, baseline measures of depressive symptoms, hopelessness, and lifetime suicide attempts were used to predict participants' suicide attempts during the 12-month follow-up period, which showed that only lifetime suicide attempts ($B = 2.35$, $OR = 10.52$) significantly predicted subsequent suicide attempts (Mustanski & Liu, 2013).

Evidence from these three studies supports hopelessness as an explanatory mechanism in trajectory pathways to suicidality among queer and takatāpui people. Specifically, associations between suicidality and people with marginalised sexualities or genders are likely linked by a hopelessness-depressive pathway (Langhinrichsen-Rohling et al., 2011; Mustanski & Liu, 2013; Hirsch et al., 2017) A potential conceptualisation of this pathway is that social discrimination (e.g., queer-related victimisation) contributes to feelings of hopelessness which sequentially leads to depressive symptoms (Mustanski & Liu, 2013; Hirsch et al., 2017), and the co-occurring experience of hopelessness and depression may elicit suicidal distress (Langhinrichsen-Rohling et al., 2011). Though this framework aligns with step-one of the 3ST of suicide, it is important to note that none of these studies examined an interaction term of hopelessness and pain (e.g., depression, discrimination) directly tested as a predictor variable.

Social Support and Connectedness

Step-two of the 3ST of suicide proposes that for people experiencing simultaneous pain and hopelessness, connectedness protects against the intensification of suicidal ideation severity (Klonsky & May, 2015). Similar to pain, the source of connectedness is intentionally unspecified but can pertain to any form of attachment (e.g., people, occupations, projects) as long as it provides the individual with a purpose or meaning for remaining alive (Klonsky & May, 2015). Adding clarity to what variables constitute as measures of connectedness, Klonsky et al. (2021) illustrate that belongingness, valued occupations, burdensomeness, and social support are all appropriate proximations of connectedness.

Social support is a multidimensional concept with aspects of socialising (e.g., networking, exchange, help-seeking) used when conceiving definitions for it (Procidano & Heller, 1983; Zimet et al., 1988). For the scope of the current literature review, social support is defined as providing emotional comfort, practical assistance, material resources, information, and/or esteem support to people for the purpose of helping them overcome psychological, social, and biological stressors (American Psychological Association, 2023). Sources of social support can include people within one's social network (e.g., whānau, friends, partners, colleagues, social groups) and external organisations (e.g., caregivers, support workers, public services). Studies have shown mixed findings with regards to the effects of social support and connectedness on suicidality among queer and takatāpui people.

Rogers et al. (2021) investigated the mediating effects of internalised homophobia on the link between social discrimination and suicidal ideation and proposed queer community connectedness as a potential moderator. Data was collected from 329 adults, based in the US, aged 18-74 with diverse sexualities and genders using online surveys. Findings indicated that internalised homophobia fully mediated the relationship between social discrimination and suicidal ideation (β = .04, p = .459), whereby greater social discrimination was related to elevated suicidal ideation (β = .22, p < .001) through higher experienced internalised homophobia (Rogers et al., 2021). Counter to the authors' hypotheses, higher queer community connectedness (β = .61, p < .001), rather than lower (β = .38, p < .001), strengthened the positive relationship between social discrimination and internalised homophobia. Similarly, higher queer community connectedness strengthened the positive relationship between internalised homophobia and suicidal ideation (β = .54, p < .001), rather than lower connectedness (β = .34, p < .001). These results contradict the proposed buffering effect of connectedness on suicidal ideation outlined in step-two of the 3ST (Klonsky & May, 2015), instead, shown to strengthen mediation pathways between social discrimination and suicidal ideation. However, studies examining the effects of social support on suicidal ideation, rather than connectedness, have yielded evidence that aligns with step-two of the 3ST.

Trujillo et al. (2017) assessed the ameliorating role of social support on suicidality among 78 transgender and gender diverse adults (M_{age} = 29.6), living in the US. Participants completed an online survey that measured social discrimination, social supports, suicidal ideation, and symptoms of anxiety and depression. The mediation model showed that higher depressive symptoms fully mediated the positive association between social discrimination and suicidal

ideation. Three sources of social support (family, friends, and significant other) were then independently applied to this mediation model as potential moderating variables. Among the three moderated mediation models analysed, neither social support from friends or social support from family yielded significant interaction effects with either depressive symptoms or social discrimination, when suicidal ideation was the outcome variable (Trujillo et al., 2017). In contrast, among participants who received lower social support from their significant other, the positive association between social discrimination and suicidal ideation was significantly stronger, compared with moderate or higher social support (B = -.18, p <.05). Overall, these findings indicate that depression can explain a pathway from social discrimination to suicidal ideation, with social support from partners ameliorating the negative impact of social discrimination on suicidal ideation.

Treharne et al. (2020) investigated correlates of suicidality and self-harm among 392 transgender and 308 cisgender people aged 18-74, living in either Aotearoa or Australia. Among transgender participants, higher social support was significantly associated with lower likelihoods of suicidal ideation in the past month (OR = .71, p = .007) and lifetime suicide attempts (OR = .73, p = .003) but was not associated with self-harm behaviours (Treharne et al., 2020). Liu and Mustanski (2012) found similar results from their longitudinal study assessing risk and protective factors associated with suicidal ideation and self-harm in 246 LGBT youth aged 16-20 in the US. Hierarchical linear regressions were used to produce contemporaneous models (i.e., prediction at each time point) predicting suicidal ideation and self-harm, and a time-lagged model (i.e., prior scores as predictors of current) predicting suicidal ideation (Liu & Mustanski, 2012). Lower social support and higher victimisation were independently associated with elevated suicidal ideation, in both the contemporaneous (B = -.05, p = .02; B = .09, p = .03, respectively) and time-lagged models (B = -.05, p = .03; B = .10, p = .02, respectively). Contrastingly, self-harm was not significantly predicted by social support (B = -.02, p = .83). These two studies contribute to the ideation-to-action framework, highlighting suicidal ideation and self-harm as distinctive aspects of suicidality, whereby social support seemingly contributes to the former but not the latter.

Research conducted with queer people has suggested that various sources of social support may have different buffering effects on suicidality. Among queer women aged 18-66 living in the US, higher social support from family members (β = -.19, p < .05) and significant others (β = -.27, p < .001) was associated with lower suicidal ideation, but social support from friends

was nonsignificant (Tabaac et al., 2016). For lifetime suicide attempts, only social support from family members had a significant buffering effect (β = -.19, p < .05). In Lytle and colleague's (2017) study based in the US, queer youth aged 18-24 (N = 203) who experienced suicidal ideation and/or attempted suicide (suicidal behaviours) were more likely to seek social support from friends rather than school personnel, professionals, and family members. However, queer youth who received more social support from family members were significantly less likely to experience suicidal behaviours (OR = .92, p < .05) and attempt suicide without medical intervention (OR = .77, p < .05) compared with those who received less. These same benefits were not evident for social support received from friends (Lytle et al., 2017). As such, familial social support may function as a stronger protective factor against suicidality than social support received from friends.

Non-Suicidal Self-Injury

Step-three of the 3ST of suicide posits that suicidal ideation progresses to attempting suicide when one has dispositional, acquired, and/or practical capacities for suicide (Klonsky & May, 2015). Acquired capacity is constituted from painful and traumatic life events that cause habituation to pain and the fear of dying, including self-harm behaviour, abuse, and the loss of a close relationship due to suicide. This conceptualisation of suicide capacity was selected for the current research project since it is shared with the Interpersonal Theory of Suicide (Van Orden et al., 2010), which has been applied to samples of queer people (e.g., Grossman et al., 2016). The subsequent literature will focus on the idea of non-suicidal self-injury (NSSI) as a potential form of acquired capacity for suicide and constructing a rationale for examining this among queer and takatāpui people.

Self-harm is a broad term referring to the action of deliberately injuring oneself, which can be accompanied with the intention of ending one's life or undertaken as a way of coping with psychological distress. NSSI encompasses the latter of these intentions and has been identified as a phenomenon that contributes to the trajectory from suicidal ideation (e.g., suicide plan) to subsequent suicide attempt (Kiekens et al., 2018; May & Victor, 2018). A review of 17 longitudinal studies assessing the relationship between NSSI and suicide attempts found that number of NSSI episodes (i.e., NSSI frequency) consistently predicted future suicide attempts, such that the risk of attempting suicide elevated with increasing instances of NSSI (Griep & MacKinnon, 2022). In a specific example, a sample of 997 US-based university students (aged 18-41), participants' NSSI frequencies (B = 0.64, p < .01), and the number of different self-

harm methods used (NSSI methods; $B = .81$, $p < .001$), were positively associated with their lifetime suicide attempts (Ammerman et a., 2016). Also, participants' levels of pain during NSSI were a significant moderator, whereby lower pain significantly strengthened the effect of NSSI frequency on attempted suicide ($B = .47$, $p = .006$), but not with higher pain ($B = .09$, $p = .46$). While Ammerman et al. (2016) did not directly assess habituation to pain through NSSI, these findings suggest that a lowered sense of pain during NSSI intensifies the pathway from frequent NSSI to attempting suicide (NSSI-attempt pathway).

Another US-based study of NSSI found that persistence through higher levels of physical pain and cognitive distress strengthened the positive association between NSSI frequency and lifetime suicide attempts (Law et al., 2017). Specifically, one's persistence through both increasingly painful and distressing circumstances moderated the effect of NSSI on suicide attempts (Law et al., 2017); thus, contributing to evidence for the role of pain tolerance in the NSSI-attempt pathway (Ammerman et al., 2016). However, queer and takatāpui people have largely been absent from research examining NSSI as a precipitant of subsequent suicide attempts.

Evidence shows that the prevalence (24.68% to 46.65%) and odds ($OR = 1.91$ to 4.37) of NSSI are significantly greater for people with marginalised sexualities and genders, compared with cisgender-heterosexual people (Batejan et al., 2015; Liu et al., 2019; Marchi et al., 2022). Mechanisms that may connect these communities and NSSI include emotional dysregulation (Fraser et al., 2017), sadness and hopelessness (Nickels et al., 2012), reduction of distress caused by gender dysphoria (Morris & Galupo, 2019), and coping with social discrimination (Alexander & Clare, 2004). These findings share similarities with studies that have examined the functions of NSSI among non-queer samples, in that people engage in NSSI to reduce negative emotions and physiological distress (Klonsky, 2007).

Reisner et al. (2014) examined risk and protective factors for NSSI and suicide attempts with 3,131 students from 59 Massachusetts, US high schools. The sample consisted of 2,906 heterosexual and 225 non-heterosexual students, and 'sexual orientation identity' was included in the multivariable blocked models predicting NSSI and suicide attempts within the past year. In the model adjusting for demographics, non-heterosexual students had significantly higher odds ($OR = 5.43$, $p < .0001$) for having attempted suicide in the past year compared with heterosexual students (Reisner et al., 2014). However, the disparity between non-heterosexual

and heterosexual students was attenuated when NSSI frequency was included in the model (*OR* = .1.81, *p* = .081), whereby NSSI significantly predicted past suicide attempts (*OR* = 11.02, *p* < .0001), adjusting for demographics, risk factors, protective factors, and social supports. As such, repeated NSSI may serve as a predictor of subsequent suicide attempts, irrespective of one's sexuality and gender identity.

Applicability of the Theory of Decompensation

Riggs and Treharne's (2017) ToD stands as a compelling framework for bolstering the inclusivity and applicability of minority stress theories. For example, Tan et al. (2020a) conducted a critical review of *gender minority stress* as conceptualised within the Minority Stress Model (Meyer, 2003) and the Gender Minority Stress Theory (GMST; Testa et al., 2015). Cisnormativity (i.e., institutional social norms) was identified as a prominent contributor to discriminatory social climates endured by transgender and gender diverse (TGD) people, and the authors' argued for incorporating intersectionality (e.g., racism and cisgenderism) into the GMST as a means of understanding systemic inequities among TGD people according to diverse identity categories (Tan et al., 2020a).

There is a dearth of research investigating the effects of ideologies, intersectionality, and privilege on suicidality among queer and takatāpui people. Schimanski and Treharne's (2019) study is the only one to have explicitly applied the ToD as a framework for understanding suicidality in Aotearoa. This qualitative study consisted of 28 queer and takatāpui people (aged 18-25) interviewed within seven focus groups to explore their perspectives on suicidality, discrimination, and pride events. Suicidal behaviours were framed as stigmatised occurrences within society, whereby hegemonic masculinity, and censored media coverage of suicides, inhibited open discussions on suicide (Schimanski & Treharne, 2019). Participants discussed nondeterministic pathways from social discrimination to suicidality that varied according to intersecting identity categories (e.g., sexuality, gender, ethnicity). As such, social isolation from queer communities and the invalidation of certain identities were understood to precipitate suicidality and arose from social norms that privileged cisgender gay men and women while marginalising bisexual and transgender people (Schimanski & Treharne, 2019). Pride events were described by participants as a display of social support towards queer and takatāpui communities that challenged prejudicial ideologies through passive (e.g., raising awareness of inequities) and active (e.g., protests against authorities who victimise transgender

people) forms of activism. In contrast, superficial support at pride events (e.g., corporate sponsors) was equated with disingenuous displays of condolence towards queer people who had ended their own lives (Schimanski & Treharne, 2019). This research provides a preliminary structure for furthering our knowledge on how broad social processes contribute to the suicidality experienced by people with marginalised sexualities, genders, and ethnicities.

Ideologies and Social Norms

The constructs of ideologies, intersectionality, and privilege as applied to queer and takatāpui communities are all important. Ideologies represent networks of beliefs and ideals that are institutionally embedded to provide structure and organisation to a society (e.g., politics, economics). Moving closer to the interpersonal level, ideologies manifest as institutional social norms, whereby implicit and explicit rules about human behaviour establishes who or what is rendered 'normative', thus accepted within the broader society structure (Riggs & Treharne, 2017). The effects of ideologies and social norms are typically examined within smaller socio-ecological contexts, such as familial dynamics, schooling climates, and groups with shared identities. For example, Lin et al. (2022) studied the relationships between familial sexual stigma (i.e., prejudicial beliefs regarding diverse sexualities), internalised homonegativity, and self-identity disturbance among 1,000 young LGB adults (M_{age} = 24.6) in Taiwan. The structural equation model showed that familial sexual stigma was positively related to internalised homonegativity ($\beta = .24$, $p < .001$), and the indirect effect of familial sexual stigma on internalised homonegativity was mediated through self-identity disturbance. This study highlights that negative familial beliefs regarding diverse sexual orientations can influence LGB youth to develop a negative sense of their own sexualities by disrupting the formation of their identities (Lin et al., 2022). As such, the effects of institutional social norms (e.g., heteronormativity) within queer people's social environments evidently contribute to negative outcomes among these communities.

The detrimental impacts of social norms on LGB youth have also been studied within the context of secondary schooling environments. D'Augelli et al. (2002) measured the effects of sexual orientation victimisation, atypical childhood gendered behaviours, LGB identifiability (i.e., openness about one's sexuality during high school), and internalised homonegativity, on the mental health of LGB youth (M_{age} = 19.2, N = 350) living in America, Canada, or Aotearoa. Greater gender atypicality ($t = 2.23$, $p < .05$) and more openness about one's sexual orientation ($t = 2.90$, $p < .01$) both predicted higher verbal victimisation during high school. Additionally,

higher internalised homonegativity ($t = 6.14$, $p < .001$) and verbal victimisation ($t = 4.05$, $p < .001$), as well as lesbian and bisexual females ($t = 3.86$, $p < .001$), were associated with elevated trauma symptoms (D'Augelli et al., 2002). Overall, the heteronormativity and gendered social norms embedded within schooling environments seemingly elevates LGB youths' susceptibility to verbal discrimination from peers when such norms are not adhered to. Speculating upon underlying processes, repeated exposure to such prejudicial climates may incite LGB youth to judge their own sexualities negatively, which in turn may contribute to subsequent trauma responses.

Two studies provide proximal evidence of the connectivity between institutional social norms and suicidality among queer and gender diverse people. D'Augelli et al. (2005) surveyed 528 LGB youth (aged 15-19) in New York City, measuring atypical childhood gendered behaviours, past suicide attempts, and mistreatment from parents (e.g., psychological abuse). Results demonstrated that 1) parental discouragement of atypical gendered behaviours during childhood, and 2) being derogatorily called LGB by a parent, significantly differentiated participants with suicide attempt histories from participants without (D'Augelli et al., 2005). Grossman and D'Augelli (2007) measured past suicide attempts, gender nonconformity, and verbal and physical parental abuse among 55 transgender youth (aged 15-21) from New York City. Adverse parental reactions to participants nonconforming gender expressions; namely verbal ($F = 4.86$, $p < .05$) and physical ($F = 8.90$, $p < .05$) abuse, significantly differentiated participants with suicide attempt histories from participants without (Grossman & D'Augelli, 2007). As primary role models of social norms during early development, negative parental reactions towards queer identities perpetuate ideologies of heteronormativity and cisnormativity. In turn, suicidality is cultivated among their children with diverse sexualities and gender identities through framing them as deviants of societal ideals and establishing expectations (i.e., institutional social norms) that they are unable to adhere to.

Qualitative approaches to understanding suicidality have further ascertained cisnormativity and heteronormativity as prominent contributors. Social determinants of suicidality identified by LGBT youth (aged 13-25, $N = 29$) living in England included social norms pertaining to sexuality and gender ideals which imposed a social message that there was something wrong with participants because of their diverse identities (McDermott et al., 2017). During narrative interviews with queer people from Scotland (aged 16-24, $N = 24$), who had lived experiences of suicidality, participants described how 'cis-heteronormativity' was continuously reinforced

through gestures of prejudice (e.g., microaggressions) towards their queer identities, which established an expectation of being rejected across environments (Marzetti et al., 2022). Based on these perspectives, institutional social norms marginalise queer and gender diverse people through establishing climates that permit these communities to be discriminated against on the basis of deviating from social ideals of heterosexuality and cisgenderism.

Intersectionality

Developed within the works of Kimberlé Crenshaw (1989; 1991), intersectionality acknowledges that people are socially located according to their intersecting identity categories and emphasises that the organisation of society affords inequitable distribution of power, social status, and privilege. As such, social, educational, legal, and political structures victimise some people according to their intersecting identities through ideologies of racism, sexism, ableism, classism, cisgenderism, and heterosexism (Grzanka et al., 2020). Within critical psychology, intersectionality is not conceptualised as a matter of 'additional' or 'multiple' identity categories but is rather concerned with the quality of experiences (e.g., social discrimination, privileges) according to one's social locality (Grzanka, 2020). Riggs and Treharne's (2017) ToD provides a structure for applying intersectionality to understand how institutional social norms differently affect people with diverse sexualities, genders, and ethnicities to produce differing experiences of suicidality.

The ongoing effects of colonisation in Aotearoa have cultivated a system of health, social service, education, criminal justice, and economic disparities among Māori (Human Rights Commission, 2022). Oral histories and archival materials demonstrate that people with diverse sexualities and genders were traditionally embraced within Māori societal structures prior to the colonisation of Aotearoa, which introduced British constitutions, Papal Bulls (decrees of the Catholic Church), and puritanical social norms (Aspin & Hutchings, 2007; McBreen, 2012). The resurgence of *takatāpui* within literature, language practices, and political movements represents Māori activism and resistance against the colonial processes that bleed into the modern day, including social discrimination (Murray, 2003; Kerekere, 2021). As with most social movements, changes within contemporary Aotearoa are slowed by systems intent upon maintaining the colonial/inequitable status quo (Human Rights Commission, 2022). However, promising findings have emerged from intersectional research conducted with queer and takatāpui people in Aotearoa.

Chiang et al. (2017) collated national data from the Youth'07 and Youth'12 surveys in Aotearoa to examine mental health outcomes among secondary school students according to their intersecting sexuality, gender, and ethnic identities. The sample of 17,607 students completed measures of depressive symptoms, attempted suicide in the past year, and general psychological wellbeing. Cisgender-heterosexual (cis-het) participants (n = 16,301) were compared with queer and takatāpui participants (n = 1,306), with regression analyses differentiated by ethnicity categories and dichotomous gender. Compared with cis-het Māori males and females, takatāpui males (OR = 2.02) and takatāpui females (OR = 1.98) showed significantly greater odds of having attempted suicide within the prior year (Chiang et al., 2017). Similarly, both queer Pākehā males (OR = 8.25) and queer Pākehā females (OR = 4.58) displayed significantly greater odds of past suicide attempts compared with cis-het Pākehā males and females. However, comparisons between takatāpui and queer Pākehā students demonstrated that both takatāpui males (OR = .58) and takatāpui females (OR = .97) were at reduced odds of having attempted suicide. These findings run counterintuitive to a 'double jeopardy' paradigm, whereby the intersection of Māori and diverse sexualities/genders would be anticipated to yield poorer outcomes due to the multiple aspects of discrimination.

Similar associations to those identified by Chiang and colleagues (2017) have also been found within the Youth'19 survey. Participants consisted of 7,721 secondary school students of which, 123 were transgender and gender diverse; 875 were cisgender and queer; and 154 were takatāpui (Roy et al., 2021). Results indicated that takatāpui students experienced significantly higher rates of suicidal ideation in the prior year (45.7%, CI = 36.4-55) when compared with cis-het Pākehā (15.4%, CI = 13.8-17.1) and cis-het Māori (23.3%, CI = 20.5-26.1) students. However, there was no significant difference between takatāpui students and queer Pākehā students (44.9%, CI = 37-52.9) regarding the rate of suicidal ideation (Roy et al., 2021).

Overall, the findings from Chiang et al. (2017) and Roy et al. (2021) suggest that Māori identification imposes a buffering effect against suicidality for those with diverse sexualities and genders. Two protective mechanisms have been proposed to bolster Māori with diverse sexualities and gender identities, 1) supportive whānau, friendships, and social networks as sources of *relational hope* when confronted with social discrimination (Lawson-Te Aho, 2016), and 2) practices of *whanaungatanga* which construct connectedness in the absence of whānau and self-determination to challenge heterosexism, racism, and cisgenderism (Hamley et al., 2021). Beyond these studies, there exists a dearth of research that has explored the

ameliorating processes of intersectionality on suicidal distress among takatāpui people in Aotearoa (Beckford, 2016; Treharne & Adams, 2017).

Privilege

The final construct within the ToD is privilege. The ToD posits that people who approximate to institutional social norms (e.g., heterosexual people approximating to heteronorms) are afforded reprieve from facets of minority stress depending on their social locality (Riggs & Treharne, 2017). Context is important to understandings heteronormativity and cisnormativity. In Aotearoa, the signing of te Tiriti o Waitangi (the Treaty of Waitangi) in 1840 was intended as a declaration of partnership between Māori and the British Crown; namely, Pākehā settlers. However, the translation of this document into te reo Māori was fraught with unequivocal concepts to those outlined within the English version, particularly discordance between *kawanatanga* and *sovereignty*, which has since been weaponised as a sanction for Pākehā to supress te ao Māori (Came & McCreanor, 2015). *White privilege* represents one ongoing process of this colonial history, defined as "the intergenerational political, economic, social and cultural benefits and advantages that colonial settlers [Pākehā] accumulate through the appropriation of Indigenous lands, natural resources and wealth" (Human Rights Commission, 2022, p. 22).

Gray et al. (2013) investigated discourses of *whiteness* and *privilege* in relation to Pākehā identification using talk from in-depth interviews with 15 Pākehā men and women, aged mid-20s to late-50s. Participants constructed a discourse of connectedness with Aotearoa through identifying as Pākehā and rejecting a "New Zealand European" identification, which represented their process of accepting the destruction caused by British colonisation. Adoption of a Pākehā identity was described by participants as relational to Māori, framing Pākehā as a term that Māori had gifted them as a notion of the relationship between the two groups (Gray et al., 2013). In their discourse of whiteness, participants highlighted a disdain towards being called "White", associating this term with inequitable access to social power and supremacy, while also contradictorily stating that the term was "meaningless". Participants talk about white privilege reflected processes of distancing oneself from this privilege; recognising that white privilege located Māori at a disadvantage, yet hesitant to articulate how they personally had benefited from white privilege. Further, Pākehā identification was used to symbolise a better understanding of the challenges Māori experience, compared with white people who shunned the label Pākehā (Gray et al., 2013). Thus, *Pākehā* identification can be thought of as a push-

pull mechanism of white privilege, functioning as connectedness to Māori and denoting one's knowledge of the disparities that Māori endure because of white privilege. Simultaneously, to be Pākehā was also to distance oneself from the privileges afforded from whiteness by attributing meaningful meaningless to the "White" label and remaining unassociated with "New Zealand European" people. To my knowledge, no research undertaken in Aotearoa has explored white privilege among Pākehā people with diverse sexualities and genders, particularly in relation to suicidality.

Summary and Gaps in the Literature

The 'at-risk' discourse positions queer and takatāpui people as passive subjects to suicidality. Counter-discourses challenge notions of these individuals as 'pathological' and 'vulnerable' by implementing research paradigms that examine explanations for suicidal distress from the perspectives of queer people. Such research highlights that suicide precipitates from multifactorial processes (e.g., the Seesaw Model; Fenaughty & Harré, 2003) located within one's social environment that transpire as imposed, and accumulating, stressors (e.g., discrimination, heteronormativity). These social stressors include both queer-specific and universal experiences but may be ameliorated through social supports. These themes and discourses of suicide 'risk' advocate for research to incorporate both queer-specific and general life factors associated with suicide risk and protection.

As the main frameworks for the current research project, I have demonstrated that the applicability of the Three-Step Theory (3ST) of suicide and the Theory of Decompensation (ToD) require further exploration. One study has examined the 3ST of suicide among transgender and gender diverse people, finding that steps one and two were utilisable to explain participants' suicidal ideation. However, the entirety of the 3ST of suicide remains untested among queer and takatāpui people. The connection between social discrimination and suicidal ideation has consistently been demonstrated in research, with emotional dysregulation and psychological pain proposed as underlying mechanisms in the trajectory from discrimination to suicidal ideation. Studies examining the influences of hopelessness on suicidality have included depressive symptoms as a related predictor variable, yielding evidence for a hopelessness-depression pathway which links queer people to suicidal distress. Though this research offers indirect support for step-one of the 3ST of suicide, further research is needed to examine the interaction term of hopelessness and pain (e.g., depression, discrimination) as

a predictor of suicidal ideation. Social support may operate as a better protective factor compared with community connectedness, having been shown to ameliorate positive associations between queer samples and suicidality, particularly when support is received from family members. Research has provided proximal evidence for NSSI as a form of acquired capacity for suicide, whereby lower pain sensation and higher pain persistence elevates the association between NSSI frequency and suicide attempts. In addition, repeated instances of NSSI are a robust predictor of subsequent suicide attempts among queer people. In sum, evidence suggests that social discrimination, hopelessness, and NSSI are risk factors, with social support as a protective factor, among people with diverse sexualities and genders. Research is yet to examine all three processes within the 3ST of suicide using these proposed risk and protective factors.

There is also a dearth of research exploring the constructs of ideologies, intersectionality, and privilege in relation to suicidality among queer and takatāpui people. To date, one study has directly applied the ToD to understand the influences of these constructs on suicide, discrimination, and pride events within these communities. The findings highlighted the invisibility of suicide in society; compounding discrimination as a contributor to suicidality; and processes of normalising queer identities through support and activism. Institutional social norms, particularly cisgenderism and heteronormativity, establish social ideals that queer and gender diverse people are unable to approximate to, thus constructing prejudicial environments that heightens their susceptibility to suicidality. Despite the ongoing colonial atrocities toward Māori in Aotearoa, intersectional research suggests that Māori identification produces a buffer against suicidal ideation and suicide attempts, which may be underpinned by processes of relational hope and whanaungatanga. As benefactors of colonisation, it is important to acknowledge how queer Pākehā people are afforded inequitable advantages through the embedded system of white privilege. In sum, the ToD provides a framework from which queer and takatāpui people's understandings of suicide can be explored using the dimensions of ideologies, intersectionality, and privilege.

Chapter 3: The Queer Agenda

In this chapter, the aims of the current research are outlined, including the hypotheses of study one and the research questions of study two. Much of the research conducted in Aotearoa has attended to investigating suicide liability among queer and takatāpui people. Specifically, studies have focused on the risk of suicidality compared with cisgender-heterosexual counterparts, as well as identifying risk and protective factors that uniquely influence suicidal distress within these communities. However, less research has explored the applicability of 1) general explanatory models of suicide, and 2) theoretical perspectives of minority stress, as frameworks for understanding suicidality among queer and takatāpui people. Of the research that has been conducted, the Interpersonal Theory of Suicide and the Minority Stress Model, or an amalgamation of the two, have predominantly been utilised. As such, the current research project aims to bridge gaps in the suicidology literature by utilising the Three-Step Theory of suicide and the Theory of Decompensation. It is anticipated that the processes in the Three-Step Theory of suicide will quantitatively explain experiences of suicidality among queer and takatāpui people, which is yet to be examined in its entirety. Further, it is proposed that the constructs of ideology, intersectionality, and privilege provide a socially orientated framework for suicide to be qualitatively explored from the perspectives of queer and takatāpui people.

Epistemological Positioning and Mixed Methods Design

The two proposed studies of the current research are expressed as two differing approaches to theory-driven research, underpinned by contrasting methods and epistemic positions. For study one, Klonsky and May's (2015) Three-Step Theory (3ST) of suicide is adapted and examined using an existing survey dataset, whereby hypotheses have been developed, and variables have been operationalised, in accordance with the three steps outlined in this theory. This empirical quantitative method is founded within the positivism epistemology, where knowledge is positioned as an objective reality that is revealed through the scientific method (Park et al., 2020). Positivists assume that knowledge is objectively measurable using numerical values and statistical analyses since reality is situated independent of one's perceptual interpretation; namely, interconnecting processes between explanatory factors (independent variables) produce observable outcomes (dependent variables) (Park et al., 2020). In contrast, study two applies Riggs and Treharne's (2017) Theory of Decompensation (ToD) as a lens to analyse

interview data using Braun and Clarke's (2022a) reflexive approach to thematic analysis. This qualitative method is underpinned by social constructionism in the current study, where knowledge is socially constructed within daily linguistic processes and differing social realities can exist according to cultural, historical, and political contexts (Tuffin, 2005). As such, epistemic and methodological tensions are intentionally imposed between these two studies, but unity is developed through the shared subject matter of suicidality and the participation of queer and takatāpui people.

Bringing together these epistemologically and methodologically differing studies is the overarching structure of a convergent triangulation design (Creswell & Creswell, 2018). This mixed methods approach is implemented through the concurrent collection of both quantitative and qualitative data to respond to a joint research aim but maintains an assumption that these represent two separate studies (Creswell & Creswell, 2018). In the current research, the point of convergence between these two studies is within the interpretation and integration of the two sets of results in the *General Discussion* chapter.

Study One: Examining the Three-Step Theory of Suicide

The first study utilises survey data to examine the applicability of Klonsky and May's (2015) 3ST of suicide as a means of explaining suicidality among a sample of queer and takatāpui people in Aotearoa. The 3ST of suicide consists of three core processes ('steps') designed to explain the emergence of suicidal ideation, amelioration of suicidal thoughts, and the underpinning mechanisms for those who progress to attempting suicide. These three steps propose the following, noting that in the original paper step-two is divided into two parts, with the second part adding specificity to the conditions in which step-two should occur:

- Step-one: Pain and hopelessness interact to precipitate suicidal ideation.
- Step-two (first part): Connectedness protects against the escalation of suicidal ideation in individuals experiencing high pain and hopelessness.
- Step-two (second part): Connectedness protects against the escalation of suicidal ideation for individuals experiencing high pain and hopelessness when connectedness exceeds pain.
- Step-three: Dispositional, acquired, and practical contributors to the capacity for suicide facilitate the transition from suicidal ideation to suicide attempts.

Adaptation and Operationalisation

The three steps were adapted using variables that have been theorised as risk factors of, and a protective factor against, suicidality. As such, another aim of the current study was to examine the flexibility of the 3ST as an explanatory model for suicidality among populations other than cisgender-heterosexual people. To add this specificity, the construct of 'pain' in step-one was defined as everyday experiences of *social discrimination*, which aligns with Klonsky and May's (2015) initial conceptualisation of pain as a form of punishment experienced in one's day-to-day life. For step-two, the construct of 'connectedness' was measured through the adequacy of *social support* received from one's family, friends, and significant others, which has been noted as an appropriate proximation of connectedness (Klonsky et al., 2021). Instead of measuring all three contributors (dispositional, acquired, practical) to suicide capacity in step-three, the current study will focus on the pathway of acquired capacity for suicide, measured as *non-suicidal self-injury* (NSSI). To maintain the conceptualisation of acquired capacity as the "habituation to pain" (Klonsky & May, 2015, p. 118), NSSI was measured by the number of different self-harm methods (e.g., cutting, burning) used across one's lifetime. The three steps were then operationalised into a series of specific hypotheses to align with the statistical analyses conducted in the current study and to ease interpretation of the results. The relevancy of each hypothesis to the three steps are as follows:

- Step-one: Hypotheses 1, 2, 3, 4, 5, and 6,
- Step-two (first part): Hypothesis 7,
- Step-two (second part): Hypotheses 8, 9, and 10,
- Step-three: Hypotheses 11 and 12.

Hypotheses

- Hypothesis 1 (H_1): Suicidal ideation will positively correlate with hopelessness and discrimination.
- Hypothesis 2 (H_2): Hopelessness and discrimination will positively correlate.
- Hypothesis 3 (H_3): Higher hopelessness will predict higher suicidal ideation.
- Hypothesis 4 (H_4): Higher discrimination will predict higher suicidal ideation.
- Hypothesis 5 (H_5): The interaction between discrimination and hopelessness will predict suicidal ideation. Specifically, an increase in hopelessness will strengthen the positive effect of discrimination on suicidal ideation, showing a moderation.

- Hypothesis 6 (H_6): The mean suicidal ideation scores will be significantly different between the three subgroups of: 1) participants with high discrimination and hopelessness (high-high), 2) participants high on either variable and low on the other variable (high-low), and 3) participants low on both hopelessness and discrimination (low-low).
- Hypothesis 7 (H_7): There will be a stronger negative correlation between social support and suicidal ideation for participants high on both discrimination and hopelessness measures (high-high) when compared with other participants (high-low & low-low).
- Hypothesis 8 (H_8): For the subgroup high on both discrimination and hopelessness measures (high-high), the mean suicidal ideation score will be significantly smaller for participants whose social support scores exceed their discrimination scores when compared with participants whose discrimination scores exceed their social support scores.
- Hypothesis 9 (H_9): For all participants low on discrimination and/or hopelessness (low-high & low-low subgroups), there will be no significant difference in the mean suicidal ideation scores between participants whose social support scores exceed their discrimination scores when compared with participants whose discrimination scores exceed their social support scores.
- Hypothesis 10 (H_{10}): The discrimination-social support difference scores will more strongly correlate with suicidal ideation for participants high on both discrimination and hopelessness measures (high-high) when compared with other participants (high-low & low-low subgroups).
- Hypothesis 11 (H_{11}): The number of novel lifetime NSSI behaviours reported will be greater for participants with a life history of suicidal ideation and attempted suicide (SI/SA) when compared with participants with a life history of suicidal ideation and no prior suicide attempts (SI/-).
- Hypothesis 12 (H_{12}): NSSI behaviours will significantly predict participants lifetime suicidality status, such that those who have experienced suicidal ideation but have not attempted suicide (SI/-) will be differentiated from those who have experienced suicidal ideation and attempted suicide (SI/SA). Further, the predictive capacity of NSSI behaviours will remain significant after controlling for current suicidal ideation.

Study Two: Applying the Theory of Decompensation

The second study will apply Riggs and Treharne's (2017) Theory of Decompensation (ToD) to explore how queer and takatāpui people understand suicide in relation to the constructs of ideologies, intersectionality, and privilege. This theory posits that socially constructed ideologies differently locate people within society according to their intersecting identity categories, whereby privileges are inequitably afforded to people who approximate to the ideals defined by institutional social norms. In contrast, people who deviate from these ideals are rendered as 'non-normative' subjects, whereby society imposes additional stressors upon them (Riggs & Treharne, 2017). Decompensation occurs when marginalised people have exhausted their compensatory resources against these social stressors, and does not reflect a deficit in self-resilience, but the failure of society to provide adequate support to these individuals.

Qualitative Design and Research Questions

Stated by Kral et al. (2012), "research participants are rarely asked to talk about their lives, or about their suicidal states, their motivations for suicide, and their recovery" (p. 237). This observation echoes the perspectives of several academics who have identified deficiencies of qualitative research and critical approaches within the field of suicidology (Hjelmeland & Knizek, 2010; Rogers & Apel, 2010; Marsh, 2015; White, 2017). As such, the scope of the current study utilised a qualitative methodology to explore suicidality from the perspectives of queer and takatāpui people who had previously experienced suicidal distress, including suicidal ideation, self-harm, and/or attempted suicide.

The theoretical framework underpinning this study was informed by social constructionism in conjunction with the ToD. A theory-driven approach to reflexive thematic analysis was utilised to analyse and interpret participants' talk, embedded within the assumption that language is an active and dynamic medium used to produce our social realities. As such, multiple truths or meanings are linguistically constructed into existence both from and within social processes between people, which are situated within historical, cultural and political contexts (Tuffin, 2005). Additionally, it was assumed that the concepts of ideology, intersectionality, and privilege provide a structure for understanding stressors that are imposed upon marginalised people in society, which results in decompensation when stress exceeds people's coping capacities (Riggs & Treharne, 2017). The following research questions were sought to be answered within this qualitative study:

- Question 1: How do queer and takatāpui people talk about the meaning of suicide within their communities?
- Question 2: How do queer and takatāpui people make sense of the intersections between discrimination and suicidality?
- Question 3: What are the different ways in which queer and takatāpui people talk about their ethnic identities as providing resilience against suicidality?

Chapter 4: Study One – Survey Methodology

Dataset and Survey Design

The dataset utilised in the current study was a subsample of the data collected within a larger research project examining potential risk and protective correlates of suicidality/self-harm among transgender and cisgender people in Aotearoa and Australia (see Treharne et al., 2020). As a research assistant for this larger project, the data pertaining to individuals living in Aotearoa ($N = 548$) was provided to me for the purpose of testing the applicability of the Three-Step Theory (3ST) of Suicide (Klonsky & May, 2015) on a sample of queer and takatāpui people. The Australian data ($N = 733$) was excluded from the current study to ensure that this research was grounded within the social climate of Aotearoa, rather than an international context. Ethical approval for the larger research project was granted by the Flinders University Social and Behavioural Research Ethics Committee (project number: 7430).

The Aotearoa dataset used within the current study was collected using a cross-sectional, non-experimental survey design. The survey was hosted by Qualtrics and was accessible online from the 15th of January 2017 until the 15th of December 2017. This survey consisted of demographic questionnaires and measures on social support, discrimination, distress, resilience, self-harm, suicidality, and flourishing, which were presented to participants in this respective order. Prior to commencing the survey questions, participants were provided with an information sheet (Appendix B) detailing the aims of the research, acknowledging that participants' responses would remain anonymous and confidential, and iterating that they could disengage from the survey at any time without their answers being retained. Given the emotional subjects covered in the questions, participants were encouraged not to complete the survey if they were feeling distressed, and to discuss the survey with accessible supports (e.g., friends or family) if they became distressed while completing it. Further, participants were provided with a list of support organisations that specialised in addressing difficulties related to suicide, self-harm, and psychological distress at both the beginning and end of the survey (Appendix C).

Data Collection and Inclusion Procedure

Information about the survey was distributed through paid Facebook advertisements, queer-based community groups, and professional organisations (see Treharne et al., 2020). A form of snowball sampling was implemented, whereby survey information was shared with personal social networks who were also encouraged to disseminate the survey with other individuals and organisations (Noy, 2008). This approach to sampling has been recognised as an effective means of accessing groups of individuals who are underrepresented within the general population, including those marginalised due to identity categories (Sadler et al., 2010). I actively contributed to this data collection process. Ethical approval for the current study was granted by the Massey University Human Ethics Northern Committee (approval reference: NOR 18/68).

The inclusion criteria for the survey were that participants lived in Aotearoa (or Australia) and were aged 18-years or older. Quotas were established for gender categories for the purposes of the larger research project, which aimed to make comparisons between cisgender and transgender people (Treharne et al., 2020). The number of cisgender females who completed the survey exceeded quotas, and were excluded from participating in the survey from November 2017 until the end of recruitment in December 2017. Once the survey had closed, participants' responses were exported from Qualtrics to SPSS for coding, variable scoring, and data cleaning. Of the measures and questionnaires included in the survey, three measures were excluded on the basis that these were irrelevant to the hypotheses of the current study. These measures were the Brief Resilience Scale (BRS), the Flourishing Scale (FS), and the Gender Minority Stress and Resilience Measure (GMSRM). Further, demographic questions pertaining to relationship status, occupation status, income, accommodation, rurality, education, and pet ownership were also excluded.

Measures and Questionnaires

Demographic Questions

Each demographic question consisted of inclusive categorical options and an open-ended textbox for participants to provide any additional information that was relevant. Gender categories were measured using 3 questions regarding gender, gender modality, and intersex status. The gender item asked participants to select which of the following options best

described their gender: “Agender”, “Female”, “Male”, or “Non-binary”. For gender modality, participants were asked if they had ever identified as transgender or similarly: “Yes” or “No”. Regarding intersex status, participants were asked if they had an intersex variation: “Yes”, “No”, or “Unsure”. These 3 questions, and participants’ responses in the open-ended textboxes, were used to create an indicator variable which categorised participants as either cisgender or transgender/gender diverse. Participants were asked to select a term which best described their sexual orientation from the following options: “Asexual”, “Bisexual”, “Gay”, “Lesbian”, “Pansexual”, “Queer”, “Questioning/Unsure”, “Straight/Heterosexual”, and “Undefined”. Noting that the larger research project encompassed participants living in Aotearoa or Australia (see Treharne et al., 2020), the following options were used as an indicator of indigeneity: “Aboriginal”, “Torres Strait Islander”, “Māori”, “Pacific Islander”, “Other First Nation or Indigenous People”, and “None of the Above”. Ethnicity was asked using the following options: “New Zealand European/Pākehā”, “Māori”, “Samoan”, “Cook Island Māori”, “Tongan”, “Niuean”, “Chinese”, “Indian”, and “Other”.

Multi-Dimensional Scale of Perceived Social Support (MSPSS)

The MSPSS is a 12-item self-report measure developed by Zimet et al. (1988) that evaluates subjective perspectives on the adequacy of social support received from 3 sources: family, friends, and significant others. Each item is presented as a 7-point Likert-scale, scored from 1 to 7 (1 = “Very strongly disagree”, 7= “Very strongly agree”), and grouped into 3 embedded subscales to denote the sources of support: family subscale, friend subscale, and significant others subscale. These 3 subscales are comprised of 4-items each, which are summed and divided by 4 to produce mean subscale scores, and the total social support score is the mean across all 12-items. A score ranging from 1 to 2.9 suggests low perceived support, 3 to 5 suggests moderate perceived support, and 5 to 7 suggests high perceived support (Zimet et al., 1988). The MSPSS has demonstrated good internal and test-retest reliability (Zimet et al., 1988), adequate factorial and construct validity across the 3 subscales (Zimet et al., 1990; Clara et al., 2003) and has been applied to samples comprised of diverse sexualities and gender identities (Meier et al., 2013; Davey et al., 2014; Jang et al., 2021). The internal consistency of the 12 items was excellent in the current study (Cronbach’s $\alpha = 0.91$).

Everyday Discrimination Scale (EDS)

Founded from the conceptualisation of *everyday racism* described by Essed (1991), the EDS was developed by Williams et al. (1997) as a measure of ongoing and less overt forms of

prejudicial treatment experienced by African American people on a day-to-day basis. The EDS has primarily been utilised within epidemiological research examining psychosocial and health disparities experienced by marginalised ethnic communities, with the number of items and the Likert-point range modified across studies (see Lewis et al., 2012; Kim et al., 2014; Gonzales et al., 2016). Within the current study, a 10-item version of the EDS was used (Lewis et al., 2012) to measure participants everyday experiences of discrimination. The items pose different prejudicial scenarios that participants respond to on a 4-point Likert-scale, which denotes the frequency in which they experience these forms of discrimination in everyday life (1 = "Never", 4 = "Often"). The EDS is not anchored to a specific timeframe and does not ask for the reason why the discrimination occurred; for example, "You have been called names or insulted". The total discrimination score is the sum of all items, ranging from 10 to 40, with larger scores denoting greater discrimination. The EDS has shown good internal consistency reliability, criterion validity (Clark et al., 2004), convergent and divergent validity (Taylor et al., 2004), and has been used to assess discrimination among queer people (Gordon & Meyer, 2007). The internal consistency of the 10 items was excellent in the current study (Cronbach's $\alpha = 0.90$).

Hopelessness: Kessler 10 Psychological Distress Scale (K10)

The K10 is a 10-item self-report measure that was developed as a short screener for nonspecific psychological distress within national mental health surveys (Kessler et al., 2002; Andrews & Slade, 2001). Each item is presented as a 5-point Likert- scale evaluating broad depressive- and anxiety-related difficulties over the past 30 days (e.g., "how often did you feel…worthless?"), which are scored from 1 to 5 (1 = "None of the time", 5 = "All of the time"). The K10 total score is the sum of all items and range from 10 to 50, which is categorised according to 4 levels of psychological distress. A total score ranging from 10 to 19 are likely to be well, 20 to 24 are likely to experience mild psychological distress, 25 to 29 are likely to experience moderate psychological distress, and 30 to 50 are likely to experience severe psychological distress (Andrews & Slade, 2001). Within the current study, a single item on the K10 will be used as an indicator of hopelessness (i.e., "how often did you feel…hopeless?"). The K10 has been found to have good construct and convergent validity, internal reliability (Hendrikx et al., 2017), sensitivity and specificity in predicting psychological illness (Kessler et al., 2003) and psychometric properties applied to the Aotearoa population as an indicator of mental health status (Oakley Browne et al., 2010). The internal consistency of the 10 items was excellent in the current study (Cronbach's $\alpha = 0.94$).

Suicidal Ideation Attributes Scale (SIDAS)

The SIDAS is a 5-item brief measure of suicidal ideation over the past month (Van Spijker et al., 2014). The 5 items are presented on an 11-point Likert-scale, scored from 0 to 10, which assess suicidal ideation in terms of frequency, controllability, intensity, closeness to attempting suicide, and impairment of daily functioning. Of note, item 2 on controllability is reverse scored. The total suicidal ideation score is the sum of all items and range from 0 to 50, with higher scores indicating greater severity of suicidal ideation. Total scores ranging from 1 to 20 indicate low suicidal ideation and the clinical cut-off of ≥21 indicates a significantly higher likelihood of suicide attempts (Van Spijker et al., 2014). Within the current study, participants who responded to the first item regarding frequency with "Never" skipped all subsequent items and were given a total suicidal ideation score of 0. The SIDAS has shown good internal consistency reliability and convergent validity (Van Spijker et al., 2014), and has been used to assess suicidal ideation in a randomised control trial evaluating a cognitive-behaviour intervention with queer women (Pachankis et al., 2020). The internal consistency of the 5 items was excellent in the current study (Cronbach's $\alpha = 0.93$).

Deliberate Self-Harm Inventory (DSHI)

The DSHI is a 17-item questionnaire that assesses lifetime engagement in deliberate self-harm behaviours (Gratz, 2001). Each of the core items are presented as a yes/no question asking participants if they have ever engaged in a specific self-harm behaviour (e.g., cutting, burning, scratching). In the current study, participants who responded to a core item with "Yes", indicating that they had engaged in that specific self-harm behaviour, were asked 5 additional questions. These pertained to the age when they first engaged in the self-harm behaviour, the number of times they engaged, the last time they engaged, the number of years they engaged, and whether the self-harm behaviour ever required medical intervention. For participants who responded to a core item with "No", embedded skip-logic meant that they were automatically moved on to the subsequent item on the DSHI. A dichotomous variable identifying lifetime self-harm was created by coding for participants who endorsed having engaged in any of the self-harm behaviours on the DSHI (see Gratz et al., 2010). A dichotomous variable indicating the presence or absence of recent self-harm behaviour was created by coding for participants who had engaged in any of the behaviours on the DSHI within the past year. Further, an accumulated variable for the different types of self-harm behaviours undertaken was created by summing participants responses across the 17 items. The DSHI has demonstrated high test-

retest and internal consistency reliability, and adequate construct, convergent and discriminant validity (Fliege et al., 2006; Gratz, 2001). The internal consistency of the 17 items was adequate in the current study (Cronbach's $\alpha = 0.75$).

Recent/Lifetime Suicidal Ideation and Suicide Attempts

A questionnaire on suicidal thoughts and attempts (STA) was created using 4 adapted questions from previous research (May & Klonsky, 2011; McNeil et al., 2012). Recent and lifetime suicidal ideation were measured using two questions with categorical response options: "Have you ever thought about ending your life?" ("Yes" or "No") and "How often have you thought about attempting suicide in the last year? ("Never", "Once or twice", "Monthly", "Weekly", or "Daily"). Recent and lifetime suicide attempts were measured using two questions requiring a numerical response from 0 to 99: "How many times have you attempted suicide in the last year?" and "How many times have you attempted suicide in total over your lifetime?". Both questions were coded into dichotomous variables to categorise participants into those who had attempted suicide, and those who had not, in the past year and over a lifetime. Within the current study, these 4 questions will be referred to as the STA questionnaire.

Data Cleaning

Ineligibility and Withdrawal Deletions

Of the 548 people in Aotearoa who commenced the survey, 8 participants (1.5%) were excluded due to being aged 17-years or younger (age ranged from 13-years to 17-years; M_{age} = 15.3) and 30 cisgender females (5.5%) were excluded after this sampling quota had been met. After reading through the information sheet, 6 individuals (1.1%) did not consent to participate in the survey, and 14 participants who gave their consent (2.6%) stopped responding part-way through the demographic questions. A completion rule of at least 75% was employed to ensure that participants were only retained if they had been in the process of completing the final measure in the survey (i.e., Flourishing Scale). As such, 153 participants (27.9%) were excluded from the final sample due to more than 25% of the total survey being incomplete (completion ranged from 2% to 70%). A further 7 participants (1.3%) were excluded on the basis that they had not responded to any of the items on one or multiple measures that were relevant to the current study. A total of 10 participants (1.8%) were retained in the sample who had not completed the entirety of the survey, and all had a completion rate of 99%. Univariate statistics for each of the measures were generated to evaluate for invalid responses that may

have occurred due to data coding assignment errors. The minimum and maximum values for all of the items and total scores were within the valid ranges for each respective measure, therefore, no data coding assignment errors needed to be addressed.

Indicator Variable Coding

An indicator variable was created to allocate the 327 participants to one of two groups for the purpose of identity categorisation. The first group consisted of participants whose gender identity ("Male" or "Female"), gender modality (i.e., transgender "No") and sexual orientation ("Straight/Heterosexual") were categorically aligned with a cisgender heterosexual identity and were coded as '0' accordingly to denote the absence of queerness. Of the 77 participants (23.5%) allocated to this *cisgender-heterosexual group*, 76 participants responded with "No" to having an intersex variation and 1 participant reported that they were "Unsure". Cisgender-heterosexual participants were excluded from all subsequent statistical analyses and hypothesis testing to align with the aim of the current study to evaluate the applicability of the 3ST of suicide on a sample of queer and takatāpui people.

The second group included all participants whose sexual orientation was not heterosexual ("Asexual", "Bisexual", "Gay", "Lesbian", "Pansexual", "Queer", "Questioning/Unsure" or "Undefined"), were gender diverse ("Agender" or "Non-binary"), identified as transgender ("Yes"), and/or had an intersex variation ("Yes"). These participants categorically aligned with identities under the umbrella terms queer or takatāpui and were coded as '1' accordingly to denote the presence of queerness. Of the 250 participants (76.5%) allocated to this *queer and takatāpui group*, 4 participants reported that they had an intersex variation, 216 participants responded with "No", and 30 participants were "Unsure" of their intersex status. Following the exclusion of the cisgender-heterosexual participants, the final sample consisted of 250 participants.

Missing values were coded according to participant omissions, and the skip logic embedded in specific measures. The value '888' was allocated to items that were missing due to embedded skip-logic which intentionally skipped items or measures that were not applicable to participants based on their initial responses. To exemplify, participants who responded to the first on the SIDAS ("In the past month, how often have you had thoughts about suicide?"), or the first item from the STA questionnaire ("Have you ever thought about ending your own life?"), with a negative response automatically progressed on to the next measure since all

subsequent items were dependent on having experienced suicidal thoughts. The value '999' was assigned to items that were missing due to participant omissions (i.e., purposefully, or accidentally skipping a question).

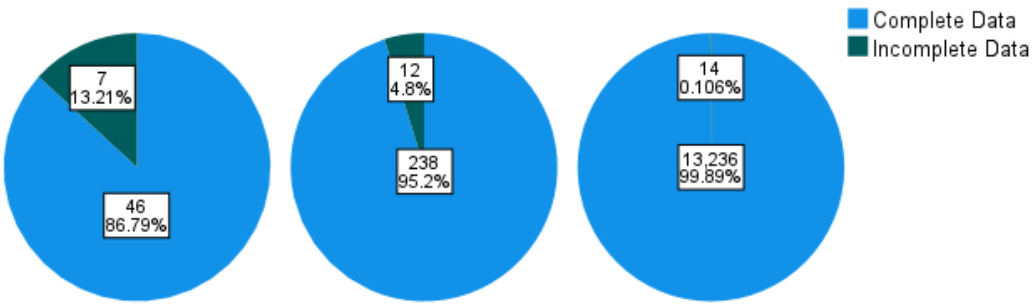
Missing Data Analyses

The issue of incomplete datasets is a ubiquitous difficulty within quantitative research (Field, 2018). Given that standard statistical approaches exclude cases with missing values from contributing to analyses (i.e., available case analysis), two problems can arise from incomplete datasets: reduced statistical power and biased estimates (Groenwold & Dekkers, 2020). The loss of statistical power diminishes the likelihood that a statistical test will detect a *true effect* (i.e., a relationship between variables), which increases susceptibility to a Type II error (Kang, 2013). The second problem occurs when missing data produces over- or under- estimations of the population parameters from sampling statistics (Kang, 2013). As such, missing values can have a detrimental impact on the validity and reliability of the results.

Following the guidelines by Schlomer et al. (2010), a missing value analysis was conducted to produce descriptive statistics on the extent of missing values and the nature of missingness. To ensure that analyses were not performed on values that were missing due to skip-logic (i.e., values coded as '888'), these missing values were substituted with '0', which would have been participants scores if skip-logic had not been employed to alleviate the burdensomeness of responding to irrelevant questions. As shown in Figure 6, 14 values (0.1%) were missing across 12 participants (4.8%) with 7 items (13.2%) containing at least one missing value. The missing data across items ranged from a low of 1 value (0.4%) on a demographic question to a high of 4 values (1.6%) on a STA question. To better understand the distribution of missingness, the number of missing values for each participant was computed into a missing data variable. Of the 12 participants with missing values, 2 participants were missing 2 values, and 10 participants were missing 1 value. The range of missing values for these participants represented a loss of 3.8% to 1.9% of their total data.

Figure 6

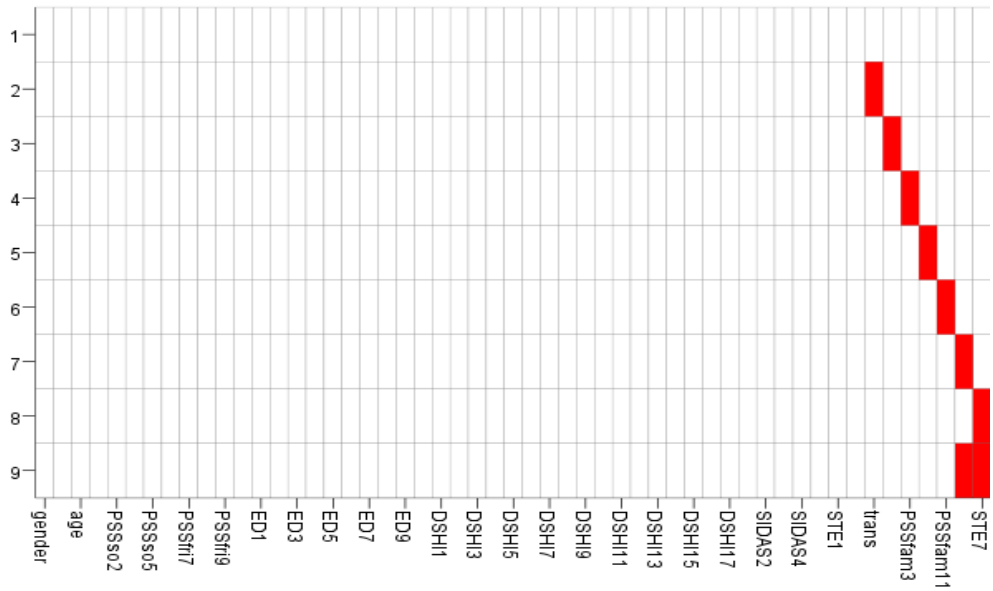
Frequencies of missing values across items, participants, and total number of values



Produced from the missing value analysis was a chart depicting the patterns of missingness (see Figure 7). A visual analysis of this chart was performed which showed a slight clustering of missing values in the lower right corner of the chart and a plot of missing values projecting upwards and rightwards towards the upper portion of the chart. This distribution of missing values can be interpreted as a nonmonotone pattern of missingness, suggesting that monotonicity was not present (Haukoos & Newgard, 2007a).

Figure 7

Chart depicting the patterns of missing values



Developing on the work of Rubin (1976), contemporary researchers generally accept 3 mechanisms of missingness to infer the extent to which missing values are *random*: 1) not missing at random (NMAR), 2) missing at random (MAR), and 3) missing completely at random (MCAR) (Schafer & Graham, 2002). Given that Figure 7 displayed a nonmonotone pattern, Little's MCAR Test (Little, 1988) was performed as a robust means of examining which distribution of randomness was most likely operating within the missing values. The demographic questions, the MSPSS, EDS, K10, DSHI and SIDAS measures, as well as the STA questionnaire, were included in this test. The result was non-significant ($\chi^2 = 95.985$, $df = 111$, $p = .844$), indicating that values were MCAR. As such, the missing values showed no systematic pattern of missingness, and were unlikely to be related to observed or unobserved variables (Schlomer et al., 2010).

Missing Data Imputation Method

The most appropriate manner to handle missing data remains a contentious issue within quantitative research, further complicated by debates on how the nature and extent of missingness should factor into this decision-making process (Dong & Peng, 2013). For example, when determining an appropriate level of missing data to draw valid inferences, Schafer (1999) proposed that values missing at a frequency of 5% or less were unlikely to bias statistical analyses, whereas Bennett (2001) argued that the president should be set at 10% or less. In contrast, researchers have suggested that the mechanisms (i.e., MCAR, MAR, NMAR) and patterns (e.g., monotone, arbitrary) of missingness have more influence on results than the extent of missing data (Dong & Peng, 2013). The consensus in literature discourages the use of deletion methods (e.g., listwise and pairwise deletion) and nonstochastic imputation methods (e.g., mean substitution, pattern-matching imputation) due to their susceptibility to biases, which lead to invalid conclusions (Schlomer et al., 2010). Instead, evidence advocates for the use of the multiple imputation (MI) method or maximum likelihood (ML) methods when addressing missing data (Kang, 2013; Schlomer et al., 2010).

The expectation-maximisation (EM) algorithm is an iterative type of ML method which alternates between two phases during each iteration to compute maximum likelihood estimates for an incomplete dataset. The expectation-phase generates conditional expectations of the missing values based on parameters that have been estimated from the observed data (Schlomer et al., 2010). Specifically, means, variances and covariances are estimated from the values that are present within the dataset. These estimated parameters are then used to compute regression

equations that function to predict the missing values. For the maximisation-phase, the new values for the missing data are imputed, and maximum likelihood estimates of the parameters are computed with both the imputed and observed values included (Kang, 2013). The expectation and maximisation phases are then repeated with each iteration until the estimated parameters converge (i.e., virtually the same with subsequent iterations).

The EM algorithm was selected as an appropriate approach for imputing missing values within the current study. This was decided on the basis that 1) the total extent of missing values was less than 5%, 2) the nature of missingness seemingly showed a nonmonotone pattern, and 3) missing values were likely operated by a MCAR mechanism. All items from the main study variables (MSPSS, EDS, K10, DSHI, SIDAS and STA questions) were included within the imputation model, with only the demographic questions having been excluded.

Demographic Information

A summary of participants' demographic information is presented in Table 3. Participants were aged 18 to 74 years (M = 27.35, SD = 11.32). Over half of the participants were aged between 20 and 29 years (57.6%) and most identified as female (40.4%). A total of 130 participants (52%) responded to the gender modality question as transgender identifying, which was combined with participants' responses to the intersex status and gender identity questions to categorise them as either cisgender or transgender/gender diverse. The majority of participants were transgender/gender diverse (59.6%) and identified with a non-heterosexual (97.6%) sexual orientation. For the indigeneity and ethnicity questions, participants' responses in the open-ended textboxes are reported in Table 3. Since participants were able to select, and disclose, as many ethnicities that were relevant to them, the percentages do not sum to 100%. Most participants did not identify with an indigenous group (83.6%) and were Pākehā/NZ European (84.4%). Of the total sample, 37 identified as Māori (14.8%), 10 as English/British (4.0%), 8 as Chinese (3.2%), and 5 identified as Pasifika (2.0%).

Table 3

Summary of demographic information for queer and takatāpui participants (n = 250)

Variable	*N*	*%*
Age		
18-19	44	17.6
20-29	144	57.6
30-39	31	12.4
40-49	13	5.2
50-59	10	4.0
60-69	6	2.4
70-79	2	0.8
Gender		
Agender	15	6.0
Female	101	40.4
Male	59	23.6
Non-Binary	75	30.0
Gender Category		
Transgender/Gender Diverse	149	59.6
Cisgender	101	40.4
Intersex Status		
Endosex	216	86.4
Intersex	4	1.6
Unsure	30	12.0
Sexual Orientation		
Asexual	13	5.2
Bisexual	48	19.3
Gay	31	12.4
Lesbian	28	11.2
Pansexual	40	16.0
Queer	54	21.6
Questioning/Unsure	12	4.8
Straight/Heterosexual	6	2.4
Undefined	17	6.8
Not Answered	1	0.4
Indigeneity		
Indigenous	41	16.4
Not Indigenous	209	83.6
Ethnicity		
Aboriginal	1	0.4
African	1	0.4
American	4	1.6
Australian	3	1.2
Baiyue	1	0.4
Canadian	1	0.4
Chinese	8	3.2
Cook Island Māori	1	0.4

Dutch	2	0.8
English/British	10	4.0
Fijian	1	0.4
Filipino	1	0.4
German	3	1.2
Hungarian	1	0.4
Indian	1	0.4
Irish	3	1.2
Italian	2	0.8
Jewish	1	0.4
Malaysian	1	0.4
Māori	37	14.8
Niuean	1	0.4
Pākehā/NZ European	211	84.4
Pasifika	5	2.0
Polish	1	0.4
Portuguese	2	0.8
Romani	1	0.4
Samoan	1	0.4
Scandinavian	1	0.4
Scottish	3	1.2
South African	3	1.2
Taiwanese	1	0.4
Tararā (Croatian)	1	0.4
Tokelauan	1	0.4
Tongan	1	0.4
Welsh	1	0.4

Participants were provided with open-ended textboxes to provide additional information regarding their gender identities, gender modality, intersex status, and sexual orientations. An informal content analysis was conducted on these open-ended responses to explore the types of constructs and additional information provided by participants (see Table 4). A total of 85 participants (33.6%) provided additional information in the open-ended textbox for gender identity, 44 participants (17.6%) responded in the open-ended textbox for gender modality, and 15 participants (6.0%) responded in the open-ended textbox for intersex status. As well, 45 participants (18.0%) provided additional information in the open-ended textbox for sexuality. Participants utilised the open-ended textbox for sexuality to disclose identities related to their sexual and romantic attractions, including “panromantic” (2.0%), “polyamorous” (1.2%), “demisexual” (1.2%), “takatāpui” (0.8%), “homoromantic” (0.4%), “homoflexible” (0.4%), “aromantic” (0.4%), and “transmasculine” (0.4%).

Table 4

Summary of content analysis, including demographic questions, constructs identified and examples

Question	Construct	Example
Gender Identity	Trans Identities	▪ Mtf transgender ▪ Trans masculine
	Transition	▪ I am starting transition ▪ Transwoman currently undergoing medical transition
	Gender Expression	▪ I identify as agender male but present mostly masculine ▪ Female-presenting, so normally presumed female and discriminated against as such
	Fluid Gender Identities	▪ Genderfluid/Androgynous ▪ Transmasculine, genderfluid or demiboy
	Rejecting Gender	▪ Autistic & can't rly conceptualize gender as a thing ▪ No gender
Gender Modality	Not Trans Enough	▪ I only identify as transgender internally. I don't feel transgender enough to take part in that community. ▪ Even though I fit the definition of trans wherein I don't identify with the gender assigned to me at birth, because I'm non-dysphoric and present "as my assigned gender", I don't generally feel "trans enough" to identify as transgender
	Consideration	▪ I considered going on testosterone to make my features more masculine til I figured out that there is no "right" way to be non-binary […] ▪ Have contemplated transition but not sure I'd comfortably identify totally as one or the other
	An Experience, not an Identity	▪ I am transsexual but consider this to be part of my experience rather than an identity in and of itself ▪ According to common perception this descriptor fits me, but I don't like the term as many think trans=transitioning. Transitioning for me has been purely a medical and legal process […]
	Knowing and Coming Out	▪ Have known I was trans for 9-10 years ▪ I've been out since 2015, and transitioning physically since mid-2016
Intersex Status	Never Tested	▪ I've never been tested, and I don't have any physical characteristics as far as I know ▪ Never had any of my sex characteristics tested
	Medical Coercion	▪ Feminising surgery at 3 months, 4yrs and 15yrs. No pubertal signs at 17yrs. Coerced into taking female hormones to induce feminising […]
	Sex Variation Signs	▪ Various physiological traits would point to such: Natural absence of Adam's apple, partial breast development at puberty ▪ Intersex runs in my family, and I show a number of signs, but I have never been karyotyped
Sexuality	Changing Labels	▪ I would say sexually fluid, queer, polyamorous, bi or pan…just whatever

		▪ Attracted to own sex from an early age, closeted, identified as gay late-teens/early-twenties, changed to bi, realised I am attracted to mtf as well in my 30s
	Preferences	▪ Bisexual, with a preference for women ▪ Preference for males (opposing gender)
	Romantic vs Sexual Attractions	▪ Asexual but homoflexible regarding romantic partners (mainly but not exclusively attracted to those of the same sex) ▪ I'm bisexual, with a large preference for physically feminine persons. I am homoromantic however (only have romantic relationships with feminine persons)
	No Labels	▪ Given up trying to define it. None of the words fit ▪ I don't relate to any sexuality identities currently

Analytic Approach

Data were analysed using the International Business Machines Corporation's Statistical Product and Service Solutions Statistics (IBM SPSS Statistics) software for Microsoft Windows, Version 28.0.1.1. The independent variables (predictors) were defined as discrimination (EDS total scores), hopelessness (K10 single item), social support (MSPSS total scores) and self-harm behaviours (DSHI total scores). The two dependent variables (outcomes) were suicidal ideation (SIDAS total scores) and suicide attempt (lifetime suicide attempt dichotomous score). Since the dataset utilised was not initially intended for the purposes of the current study, it was decided that a power analysis and assumption testing would be performed post-hoc, which are presented in Appendix D.

Step One: Social discrimination and hopelessness interact to predict suicidal ideation

For H_1 and H_2, the relationships between the key study variables were analysed using both Pearson's correlation coefficient and Spearman's rank correlation as a means of corroborating the robustness of these relationships. To directly examine step one of the 3ST of suicide, Klonsky and May's (2015) procedure was followed by centring the discrimination and hopelessness variables into Z-scores, and calculating an interaction term by multiplying these centred variables together. A hierarchical multiple regression was then conducted to analyse the main effects of hopelessness (H_3) and discrimination (H_4), as well as their interaction term effect (H_5), on suicidal ideation. Median splits were performed on the discrimination and hopelessness variables to allocate participants into three subgroups: 1) high in both variables (high-high subgroup), 2) high in either variable and low in the other (high-low subgroup), or 3) low in both variables (low-low subgroup). The mean suicidal ideation scores for each

subgroup were then displayed in a bar graph, and the number of participants who met the clinical cut-off for severe suicidal ideation (i.e., 21 and greater) were identified for each subgroup. To evaluate H_6, a one-way analysis of variance (ANOVA) was conducted to assess whether there were significant differences in the mean suicidal ideation scores between the three subgroups.

Step Two: Social support protects against the escalation of suicidal ideation in individuals experiencing high pain and hopelessness

Step two of the 3ST of suicide consists of two components. The first component assumes that social support buffers against the escalation of suicidal ideation for those high in discrimination and hopelessness. To directly examine this component, Yang and colleague's (2019) approach was employed by reallocating the participants into two subgroups using a dichotomous indicator variable: 1) those high in both discrimination and hopelessness (high-high subgroup), and 2) all other participants. The direct relationship between suicidal ideation and social support was then analysed using Spearman's and Pearson's correlations, and the strength of this relationship was compared between the two subgroups (H_7).

The second component of step two adds greater specificity and assumes that social support buffers against the escalation of suicidal ideation for those high in discrimination and hopelessness when social support exceeds discrimination. Since the formation of the current study, Klonsky and colleagues (2021) have commented on the inappropriateness of using statistical interactions to evaluate steps two and three of the 3ST of suicide. For step two, the researchers suggested, "starting with those who have or are expected to have suicidal desire and examining whether stronger suicidal desire correlates with a pain-connectedness difference score" (Klonsky et al., 2021, p. 7). In the current study, participants who had not experienced suicidal ideation during their life history were removed from all subsequent analyses, resulting in the exclusion of 23 participants (9.2%) from the total sample. Next, the social support variable was centred into Z-scores and subtracted from the discrimination Z-scores to create a discrimination-social support difference (D-SS) score, with positive scores indicating that discrimination exceeded social support and negative scores indicating that social support exceeded discrimination (Klonsky & May, 2015). To examine H_8 and H_9, a series of independent *t*-tests were conducted on the two subgroups: high-high subgroup and all other participants. Specifically, the difference in mean suicidal ideation scores were compared between participants who scored higher on discrimination and those who scored higher on

social support for each subgroup. To test H_{10}, the correlation of D-SS scores with suicidal ideation scores was compared between the two subgroups using Pearson's and Spearman's correlation coefficients.

Step Three: Acquired capacity for suicide in the form of self-harm behaviours predicts the transition from suicidal ideation to suicide attempts

The number of different methods that participants had used to self-harm within their lifetime (i.e., self-harm behaviours variable) was utilised as a measure of acquired suicide capacity. Excluding individuals who had never experienced suicidal ideation (n = 23), participants were coded into two subgroups: 1) those with histories of suicidal ideation but not suicide attempts (SI/- subgroup), and 2) those with histories of suicidal ideation and attempted suicide (SI/SA subgroup). For H_{11}, an independent t-test was performed to compare the self-harm behaviours between these two subgroups, with an expectation that the number of different self-harm methods would be significantly larger for the SI/SA subgroup than the SI/-. Finally, to examine H_{12}, a binary logistic regression was conducted to determine whether self-harm behaviours significantly predicted participants subgroup membership (i.e., SI/- or SI/SA) when controlling for current suicidal ideation (SIDAS total scores).

Chapter 5: Study One – Survey Results

Descriptive Statistics

Descriptive statistics are displayed in Table 5, including frequencies of recent and lifetime suicidality and self-harm. The variables of recent suicidal ideation, suicide attempts, and self-harm were all measures of participants' experiences within the past year, while the lifetime variables were based on participants' life history. 38 participants (15.2%) had attempted at least once within the last year, and 123 participants (49.2%) reported attempting suicide within their lifetime. For participants who had attempted suicide, the number of attempts made within the past year ranged from 1 to 10 and ranged from 1 to 34 for lifetime attempts.

Table 5

Descriptive statistics of the study variables and frequencies of suicidality and self-harm

Variable	*N*	*%*
Recent Suicidal Ideation (STA single item)	189	75.6
Recent Suicide Attempts (STA single item)	38	15.2
Recent Self-Harm (DSHI)	121	48.4
Lifetime Suicidal Ideation (STA single item)	227	90.8
Lifetime Suicide Attempts (STA single item)	123	49.2
Lifetime Self-Harm (DSHI)	203	81.2
	***M* (*SD*)**	
Age (years)	27.35 (11.32)	
Discrimination (EDS)	23.68 (6.98)	
Hopelessness (K10 single item)	2.82 (1.25)	
Social Support (MSPSS)	4.77 (1.24)	
Suicidal Ideation (SIDAS)	14.28 (14.19)	
Self-Harm Behaviours (DSHI)	3.29 (2.74)	

The variable of self-harm behaviours represented the number of different methods that participants had used to self-harm across their lifetime (see Table 5). For participants who had self-harmed at least once (n = 203), the number of behaviours endorsed ranged from 1 to 11 (M = 3.29). An open-ended textbox was provided for participants to disclose any self-harm methods that were not present in the DSHI. A total of 78 participants (31.2%) responded with novel methods, including self-strangulation, punching objects, bodily mutilation (e.g., castration, removing fingernails), overdosing, self-neglect (e.g., starvation, personal hygiene), and self-induced vomiting.

A total of 227 participants (90.8%) had thought about ending their life at some point, and 189 participants (75.6%) had contemplated attempting suicide within the last year. In the past month, 191 participants (76.4%) had thoughts about suicide and the mean SIDAS score being 14.28 for all participants. For participants who experienced suicidal ideation in the past month, the mean SIDAS score was 18.69 (SD = 13.44). Further, 83 participants (33.2%) had scores that were above, or equal to, 21 (cut-off score) on the SIDAS (M = 32.01, SD = 7.39), which is indicative of elevated risk of suicidal behaviour.

Step One: Hypotheses 1, 2, 3, 4, 5 and 6

Pearson's, Spearman's and point-biserial intercorrelations between the study variables are displayed in Table 6. All the study variables were significantly correlated with one another at the $p < .001$ level across each correlational analysis, with magnitudes ranging from weak (.20-.39) to strong (.60-.79) relationships. For hypothesis 1, it was predicted that both discrimination and hopelessness would positively correlate with suicidal ideation to a significant degree. As predicted, there was a significantly weak positive relationship between discrimination and suicidal ideation (r = .330, r_s = .315), and a significantly strong correlation between hopelessness and suicidal ideation (r = .675, r_s = .673). For hypothesis 2, it was predicted there would be a significant positive correlation between discrimination and hopelessness. Results indicated that there was a significantly weak positive relationship between discrimination and hopelessness, which was consistent for Pearson's (r = .275) and Spearman's (r_s = .264) correlations.

Table 6

Intercorrelation matrix of the study variables using Pearson's, Spearman's and Point-Biserial

Variable	Correlation Type	Correlations					
		1	2	3	4	5	6[a]
1. Discrimination	Pearson's r	–					
	Spearman's rho						
2. Hopelessness	Pearson's r	.275**	–				
	Spearman's rho	.264**					
3. Social Support	Pearson's r	-.254**	-.273**	–			
	Spearman's rho	-.289**	-.274**				
4. Self-Harm Behaviours	Pearson's r	.362**	.316**	-.242**	–		
	Spearman's rho	.362**	.333**	-.294**			
5. Suicidal Ideation	Pearson's r	.330**	.675**	-.322**	.447**	–	
	Spearman's rho	.315**	.673**	-.338**	.496**		
6. Suicide Attempt[a]	Point-Biserial	.395**	.305**	-.311**	.436**	.448**	–

Notes. ** $p < .001$ (2-tailed), $N = 250$, [a] Because the suicide attempt variable was a dichotomous measure of lifetime attempted suicide, point-biserial corrections are reported.

For hypotheses 3 and 4, it was predicted that the main effects of discrimination and hopelessness would both significantly predict suicidal ideation. Additionally, for hypothesis 5, it was predicted that an increase in hopelessness would increase the effect of discrimination on suicidal ideation, and vice versa. To test these hypotheses, a hierarchical multiple regression with a two-block entry method design was conducted. The standardised predictor variables, (discrimination and hopelessness) were first entered into the regression model, followed by the interaction term. A significant regression equation was found ($F(3, 246) = 75.041$, $p < .001$), with an R^2 of .478. In the final model (see Table 7), hopelessness ($B = 8.948$, $SE = .681$, $p < .001$) and discrimination ($B = 2.188$, $SE = .692$, $p = .002$) were significant predictors of suicidal ideation. Results indicated that the interaction term ($B = .149$, $SE = .637$, $p = .815$) was not a significant predictor of suicidal ideation after controlling for the main effects of discrimination and hopelessness. The final model accounted for 47.8% of the variance in suicidal ideation, with the interaction term adding no additional explanation (R^2 change = .000) to the variance beyond the main effects.

Table 7

Multiple hierarchical regression results for the main effects and the interaction term effect

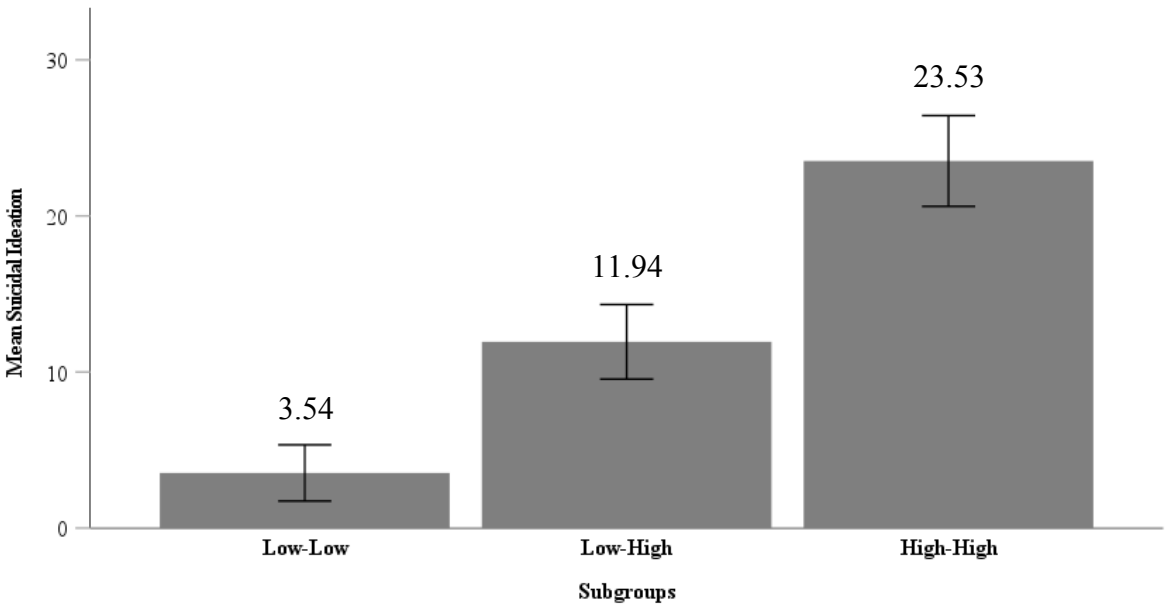
Variable	*B*	*SE B*	*β*	*t*	*p*
Hopelessness	8.948	.681	.631	13.142	< .001
Discrimination	2.188	.692	.154	3.163	.002
Interaction term	.149	.637	.011	.234	.815

Notes. Dependent variable: Suicidal ideation, $N = 250$.

Median splits were performed to create high and low scores for the discrimination and hopelessness variables. Participants were then trichotomized into three subgroups: 1) high-high subgroup ($n = 91$, 36.4%), 2) high-low subgroup ($n = 103$, 41.2%), and 3) low-low subgroup ($n = 56$, 22.4%). The mean suicidal ideation scores for each subgroup are presented in Figure 8. For each subgroup, 56 participants (22.4%) in the high-high subgroup met the cut-off score indicative of severe suicidal ideation (i.e., ≥21), 23 participants (9.2%) in the high-low subgroup met threshold, and 4 participants (1.6%) in the low-low subgroup met threshold.

Figure 8

Effect of discrimination and hopelessness on suicidal ideation



For hypothesis 6, a one-way ANOVA, with a Games-Howell post-hoc test, was performed to determine if there was a difference in mean suicidal ideation scores between the three subgroups. Results indicated that there was a significant difference in mean suicidal ideation

scores between at least two subgroups ($F(2, 247) = 51.854$, $p < .001$), with a large effect size ($\eta^2 = .296$) observed. These results remained consistent across the Welch ($F(2, 162.493) = 69.594$, $p < .001$) and the Brown-Forsythe ($F(2, 59.977) = 226.864$, $p < .001$) robustness tests. Since the Levene's test for the equality of variances yielded a significant result ($p < .001$), indicating heterogeneity of variance, the Games-Howell post-hoc test was used to compare the mean suicidal ideation scores between each combination of the three subgroups. Results showed significant differences between each pairing, whereby suicidal ideation was significantly greater for participants in the high-high subgroup compared with the high-low subgroup ($MD = 11.586$, $SE = 1.895$, $p < .001$) and the low-low subgroup ($MD = 19.992$, $SE = 1.717$, $p < .001$). Further, suicidal ideation was significantly greater for participants in the high-low subgroup compared with the low-low subgroup ($MD = 8.406$, $SE = 1.503$, $p < .001$).

Step Two: Hypotheses 7, 8, 9 and 10

For hypothesis 7, it was predicted that a significantly stronger negative correlation between social support and suicidal ideation would be observed for participants high on both hopelessness and discrimination (high-high subgroup) when compared with other participants. To test the first component of step two (Yang et al., 2019), participants were reallocated into these two subgroups, and Pearson's and Spearman's correlations were performed. Results from Spearman's coefficient indicated that the relationship between social support and suicidal ideation was stronger for the high-high subgroup ($r_s = -.301$, $p = .004$, $n = 91$) when compared with all other participants ($r_s = -.216$, $p = .006$, $n = 159$). However, the relationship between social support and suicidal ideation showed a negligible difference in correlational strength between the high-high subgroup ($r = -.269$, $p = .010$, $n = 91$) and all other participants ($r = -.250$, $p = .001$, $n = 159$) based on Pearson's coefficient.

To test the second component of step two (Klonsky et al., 2021), participants who had not experienced suicidal ideation during their lifetime were excluded from all subsequent analyses, resulting in a new sample size of 227. The social support variable was standardised and then subtracted from the standardised discrimination variable to create D-SS scores, with positive scores denoting higher discrimination and negative scores denoting higher social support. Next, two-sample unpaired *t*-tests were performed on the two subgroups (i.e., high-high subgroup and all other participants) to examine whether the mean suicidal ideation scores significantly differed between those higher on discrimination compared with those higher on social support.

For hypothesis 8, it was predicted that the mean suicidal ideation score would be significantly smaller for participants in the high-high subgroup whose social support score exceeded their discrimination score compared with participants whose discrimination score exceeded their social support score. As displayed in Table 8, results indicated that suicidal ideation scores were significantly smaller for the 22 participants in the high-high subgroup with higher social support scores (M = 16.14, SD = 13.49) compared to the 66 participants with higher discrimination scores (M = 26.95, SD = 12.62) [$t(86) = 3.42$, $p < .001$, $d = .84$]. Additionally, for hypothesis 9, it was predicted that the mean suicidal ideation scores would not significantly differ between all other participants (i.e., those not in the high-high subgroup) with a higher discrimination score and all other participants with a higher social support score. Regarding these participants, results indicated that there was no significant difference in suicidal ideation scores between the 93 individuals with higher social support scores (M = 9.75, SD = 11.41) and the 46 individuals with higher discrimination scores (M = 11.24, SD = 12.01) [$t(137) = .479$, $p = .479$].

Table 8

Independent t-tests comparing suicidal ideation between participants higher in discrimination and participants higher in social support across two subgroups

	Higher Discrimination			**Higher Social Support**					
	n	***M* (*SD*)**	***SE***	***n***	***M* (*SD*)**	***SE***	***df***	***t***	**Cohen's *d***
High-High Subgroup	66	26.95 (12.62)	1.55	22	16.14 (13.49)	2.88	86	3.42**	.84[a]
All Other Participants	46	11.24 (12.01)	1.77	93	9.75 (11.41)	1.18	137	.479	.13[a]

Notes. Dependent variable: Suicidal ideation, ** $p < .001$ (2-tailed), [a] Leven's test for equality of variances was non-significant.

For hypothesis 10, it was predicted that the significant positive correlation between the D-SS score and suicidal ideation would be stronger for participants in the high-high subgroup compared with all other participants. Pearson's and Spearman's correlations were conducted to test this hypothesis, which further examined the second component of step two. Neither Spearman's (r_s = .133, p = .119) or Pearson's (r = .158, p = .064) coefficients yielded significant results for the 139 participants who were not in the high-high subgroup. In contrast,

Spearman's (r_s = .256, p = .016) and Pearson's (r = .233, p = .029) coefficients showed that the relationship between the D-SS score and suicidal ideation was stronger for the 88 participants in the high-high subgroup compared with all other participants and reached significance.

Step Three: Hypotheses 11 and 12

To examine step three of the 3ST of suicide (Klonsky & May, 2015), the 227 participants were categorised into two subgroups: 1) those with histories of suicidal ideation but not suicide attempts (SI/- subgroup), and 2) those with histories of suicidal ideation and suicide attempts (SI/SA subgroup). For hypothesis 11, it was predicted that the number of novel self-harm behaviours would be significantly larger among the SI/SA subgroup (n = 123) compared to the SI/- subgroup (n = 104). A two-sample unpaired t-test was conducted to compare self-harm behaviours between these two subgroups. Results showed a significant difference in self-harm behaviours between the SI/- subgroup (M = 2.42, SD = 2.29) and the SI/SA subgroup (M = 4.50, SD = 2.70), with a MD of -2.08 indicating that the number of different self-harm methods was significantly higher for participants in the SI/SA subgroup ($t(225) = -6.196$, $p < .001$, d = -.83).

For hypothesis 12, it was predicted that self-harm behaviours would significantly predict participants lifetime suicidality status (i.e., SI/- or SI/SA group membership) even when controlling for current suicidal ideation. Since lifetime suicidality status was measured as a dichotomous variable, a binary logistic regression analysis was performed, with both suicidal ideation and self-harm behaviours entered into the regression equation simultaneously. Results showed that the null regression model (i.e., predictor variables excluded) correctly classified 54.2% of participants suicidality histories under the assumption that all had attempted suicide in the past. The full regression model was statistically significant ($\chi^2(2) = 53.285$, $p < .001$) with a Negelkerke's R^2 of .280, indicating that 28% of the variability in lifetime suicide attempt was accounted for by suicidal ideation and self-harm behaviours. Since the Hosmer-Lemeshow test was non-significant (p = .484), the predictive capacity of the full regression model was interpreted as adequate for the observed dataset. Regarding differentiation between the two subgroups, the full regression model correctly classified 74 participants (71.2%) belonging to the SI/- subgroup with 30 false positives, and correctly classified 90 participants (73.2%) belonging to the SI/SA subgroup with 33 false negatives. The predictive capacity of the

regression model increased from 54.2% to 72.2% classification accuracy with the inclusion of suicidal ideation and self-harm behaviours. Results indicated that the odds of having attempted suicide in the past increased by 1.29 (95% *CI* = 1.13-1.46) for a one unit increase in self-harm behaviours when controlling for current suicidal ideation (see Table 9). This predictive capacity was larger than that of current suicidal ideation, which showed an odds-ratio of 1.05 (95% *CI* = 1.02-1.07) when controlling for self-harm behaviours.

Table 9

Predictive capacity of suicidal ideation and self-harm behaviours on lifetime suicidality status

Variable	*β*	*SE*	Wald's χ^2	*p*	OR	95% *CI*
Suicidal Ideation	.048	.012	15.539	< .001	1.05	1.02-1.07
Self-Harm Behaviours	.250	.066	14.566	< .001	1.29	1.13-1.46

Notes. Dependent variable: Lifetime suicidality status, $N = 227$.

To further explore the individual predictive capacities of current suicidal ideation and self-harm behaviours on lifetime suicidality status, the two variables were analysed separately using binary logistic regression. The full regression equations for suicidal ideation ($\chi^2(1) = 36.747$, $p < .001$, Negelkerke's $R^2 = .200$) and self-harm behaviours ($\chi^2(1) = 36.303$, $p < .001$, Negelkerke's $R^2 = .198$) were both significant. A classification table comparing the predictive accuracies of the regression models for current suicidal ideation (SI) and self-harm behaviours (SHB), and a model with both variables included, was constructed (see Table 10). Comparisons showed that the regression model with only self-harm behaviours included correctly classified 74.8% of the participants belonging to the SI/SA subgroup, which was larger than the predictive accuracy of the model with only current suicidal ideation included (65.0%) and the model with both variables included (73.2%). As expected, the regression model with only current suicidal ideation included was a more accurate predictor of participants in the SI/- subgroup (68.3%) when compared to the model with only self-harm behaviours included (57.7%). However, the predictive accuracy increased to 71.2% correctly classified as belonging to the SI/- subgroup when the regression model included both variables.

Table 10

Predictive accuracies of each regression model measured in percentage correctly classified

	SI Model	SHB Model	SI and SHB Model	Null Model
SI/-	68.3%	57.7%	71.2%	–
SI/SA	65.0%	74.8%	73.2%	–
Overall	66.5%	67.0%	72.2%	54.2%

Notes. Dependent variable: Lifetime suicidality status, $N = 227$.

Chapter 6: Study Two – Qualitative Methodology

In this chapter I outline my theory-driven approach to Braun and Clarke's (2022a) reflexive thematic analysis as underpinned by the assumptions of social constructionism and the Theory of Decompensation. As an initial steppingstone, I begin with an overview of social constructionism (Gergen, 1973, 1985; Tuffin, 2005; Burr, 2015), and exemplify using social constructions of sexuality and gender. I then weave together social constructionism and the Theory of Decompensation (Riggs and Treharne, 2017), highlighting the continuity between the two. Next, I discuss Braun and Clarke's reflexive approach to thematic analysis and demonstrate how the practice of reflexivity is congruent with social construction and decompensation theory. I summarise the ethical considerations and processes that arose before and during data collection, which were informed by the Māori Ethical Framework (Pūtaiora Writing Group, 2010) and Māori centred research principles. Further, I detail the procedures for participant recruitment and data collection and conclude by detailing my application of Braun and Clarke's six phases.

The Theoretical Framework: Weaving a Conceptual Foundation

Social Constructionism

The paradigm of social constructionism reorientates the conceptualisation of ontology, epistemology, and methodology from perceptually represented (e.g., observable, visual) to linguistically constructed (e.g., text, speech) (Tuffin, 2005). From the stance of positivism, 'truth' (e.g., 'authentic knowledge') is positioned as an objective reality that can be revealed through the scientific method. In contrast, Gergen (1973) argues that observations of social life seldomly transcend the historical timeframes in which they are observed. Instead, social behaviour is historically and culturally bound, whereby data represent a segment in time that is embedded within the social norms (Gergen, 1973). The nuance in this reorientation shifts focus away from examining predictors of human behaviour under experimental conditions to exploring factors which influence behaviour within applied contexts.

Social constructionism posits that knowledge is constructed from and within daily social processes (e.g., communication, negotiation, talk, words) between people (Gergen, 1985). As

such, individuals can hold different meanings for the same objects, subjects, and events depending on their social interactions. When understandings about the world are shared between people, we are provided with insights into human social patterns, including socially sanctioned and discouraged behaviours (Gergen, 1985). As the basis for all social processes, language is the core component of social constructionism and the mechanism by which we construct what is 'known' (Gergen, 1985).

Language has previously been constituted as a reflective and passive means of communicating perceptual experiences, in which the use of words functioned as a mirror of objectivity. Moving away from positivism of an 'objective reality', the adoption of social constructionism has seen the reconceptualisation of language as an active medium by which we construct our realities (Tuffin, 2005). "Language is the tool of habit; language is the very currency through which all our other activities and relationships are negotiated; and language provides the medium through which the majority of our important social activities take place" (Tuffin, 2005, p. 66). Epistemologically, perception and thought are preceded by language, whereby social processes are meaning-making, and the act of communicating is in of itself world-building (Tuffin, 2005). It is in this linguistic ontology where we come to develop our *social realities* and negotiate our understandings of phenomena and concepts using words and symbols.

Language does not exist within a vacuum, but is given specificity from historical, political, and cultural contexts (Burr, 2015). Using gender to exemplify, people who ascribe to biomedical perspectives may define gender as the binary categorises of 'male' and 'female' (Burr, 2015). Yet, the word *girl* has changed from historically meaning, young person – with *gay girls* referring to young women and *knave girls* referring to young men – to now meaning, female child. It is this taken-for-granted knowledge that social constructionists challenge by arguing that shared language generates and maintains certain social actions and social expectations, while excluding others (Burr, 2015). This is not to say that such ways of knowing the world remain stable, but are provisional and performative in nature since social interactions expose our meanings to negation and novel information (Burr, 2015). As such, meaning-making is a continuous process, with knowledge coming into existence and changing throughout both times and spaces.

Burr (2015) further illustrates how language constructs social realities using sexuality to illustrate. From an evolutionary perspective, sexuality is reduced to an inherent 'sex drive', in

which humans procreate to ensure that the species perseveres, and genes are passed on to subsequent generations (Burr, 2015). This conceptualisation of sexuality fails when one considers the diversity of sexual practices and sexual orientations, with the dissemination of new ideals changing the meanings for sex within cultures and historical periods (Burr, 2015). The intersection of religion and sex poses a conundrum from an evolutionary perspective since the concept of marriage represents an abstract barrier to reproduction by condemning those who engage in premarital sex as 'sinful' and 'immoral'. Yet, to people who abstain from sex due to sexual preference, their constructed meanings of sex are likely to differentiate from those who are celibate due to religious rationales (Burr, 2015). Further, the social practice of equating queerness with pathology has lessened with time, particularly since the DSM was amended in 1973; though gender diverse people remain pathological subjects within biomedical frameworks. This positions sexuality as an unstable construct that is talked into existence, whereby meanings wax and wane through social interactions rather than inherently located within a *fixed reality* (Burr, 2015).

In sum, social constructionism actively rejects the idea of an objective reality, positing that *a single truth does not exist*. Rather, multiple social realities are constructed from and within social processes, with language functioning as the medium by which these occur. Knowledge about the world is contextually located within historical, cultural, and political points, such that meaning-making is continuous. Multiple people can hold different meanings for the same phenomena and concepts, indicating that truths are provisional and performative since language is at the basis of all social processes. Language is neither passive nor reflective; instead, an active mechanism that can both maintain social realities through shared understandings and alter truths through negotiation. Social constructionism is easier to conceptualise when examining how abstract concepts are talked into existence from different perspectives (e.g., sexuality), or highlight how *given knowledge* (e.g., gender) can hold different meanings when located to various historical contexts.

Theory of Decompensation

In this section, I weave together social constructionism with the Theory of Decompensation (ToD), discussing concordance between these two paradigms using ideologies as an example. The ToD posits that 'minority' stress is inherently social, resulting from institutional social norms that enact upon marginalised people (Riggs & Treharne, 2017). Reconceptualising Meyer's (2003) engineering analogy of minority stress, stress is arguably not located within

the stressed individual but is rather localised to "ideologies that render one's existence as unintelligible" (Riggs & Treharne, 2017, p. 600). From a social constructionist paradigm, these ideologies are constructed from social processes, in which the exchange of language brings into existence the concept of *personhood*; namely, who is, and is not, constituted as a person (Burkhart, 1989). It is through social negotiations where meanings of personhood are constructed as provisional truths (Tuffin, 2005), and by extension, people come to make sense of what is 'normative' within their historical, political, and cultural contexts (Riggs & Treharne, 2017).

The ToD primarily focuses on ideologies that define the ways in which people are socially located according to identity categories. These categories include ability, ethnicity, sexuality, gender, and the human body, and arguably existing as ontological illusions (Harré, 1986), such that arbitrary and symbolic boundaries are socially constructed to differentiate and amalgamate people into identity collectives. Social constructions of identities can be underpinned by agendas of socioeconomic capital, politicisation (e.g., citizenship, legislative rights), as well as social movements and collective agency (Cerulo, 1997). As people are socialised into identity collectives, so too is space created for social comparisons to be made between these groupings. Specifically, as values and beliefs are linguistically negotiated within each identity collective, different linguistic epistemologies (i.e., knowledge about the world) become apparent when these are not shared by other identity collectives (e.g., transgender vs cisgender). It is with regards to social comparisons where Riggs and Treharne (2017) position institutional ideologies, whereby these "enshrine particular bodies or identities as the norm, against which all others are compared" (p. 596). As such, ideologies are defined by shared social constructions of what is *normative* and who is given *personhood*, which the authors highlight using racism, sexism, and cisgenderism as examples (Riggs & Treharne, 2017).

Reflexive Thematic Analysis: A Process in a Sea of Many

Thematic analysis (TA) can be understood as a family of methods that share broad attributes regarding, theoretical flexibility; processes for coding and developing themes; analytic orientations; and adaptability to code for sematic or latent meanings (Braun & Clarke, 2022b). The processes and conceptual tools for analysing and interpreting qualitative data can vary depending on which approach to TA is adopted. Broadly, these approaches can be categorised into three types: coding reliability, codebook, and reflexive (Braun et al., 2019). In the current

study, Braun and Clarke's (2022a) reflexive approach to TA; aptly named, *reflexive TA*, was adopted, providing the epistemological flexibility to apply social constructionism and the ToD concurrently. The processes of reflexive TA offered the conceptual tools for a theory-driven critical analysis to be undertaken, in which patterns of meanings for suicide, discrimination, and resiliency could be captured and positioned within the constructs of social norms, intersectionality, and privilege.

The researcher's subjectivity is at the core of reflexive TA. It is the active practice, and integration, of reflexivity throughout the research journey which distinguishes reflexive TA from other forms of TA (Braun & Clarke, 2019). Braun and Clarke (2022a) argue that the researcher cannot function as a *neutral conduit of information* but is instead an active participant in the research process; whereby knowledge and meanings are situated within, and inevitably influenced by, the researcher's positionings and assumptions about the world. In this regard, reflexive TA parallels the elements of social constructionism, whereby meaning-making occurs through social engagement and interaction with language. Under either of these orientations, it can be stated that our use of language builds our concepts of *self*, our assumptions about the world, and the meanings we attribute to other's use of language (i.e., themes).

As a framework for contextualising the marginalisation and privileging of peoples, the ToD lends itself to the processes of reflexive TA. The practice of reflexivity entails locating oneself within the research, acknowledging theoretical assumptions, attending to contextual factors which influence analyses, and awareness of personal reflexivity (Braun & Clark, 2022a). For reflexive TA, this is evident in the practice of personal reflectivity (Wilkinson, 1988); actively self-reflecting on one's own personal history, political and ideological stances, and intersecting social identities, which inform our assumptions about how we make sense of the world and perceive ourselves as researchers (Braun & Clark, 2022a). Similarly, the ToD asserts that intersectionality, the concurrence of multiple social identities (Crenshaw, 1991), shapes how people experience the social world, whereby institutional social norms differentially act upon individuals depending on whether their identities occupy social positions of privilege or marginality (Riggs & Treharne, 2017).

I have reflected on my personal and social positionings within society, and the assumptions I have about the world, throughout the research process. These reflexive notes are distributed

throughout the remainder of this chapter, presented in *plain italicised text*. I have also used these reflections as a way of describing the social context of Aotearoa at various stages of the research project, as these pertain to having influenced my thinking at the time.

Aims and Research Questions

When discussing reflexive TA with other doctoral researchers, I was often confronted by statements framing TA as, "easy", "simple", and "uninteresting". I get it, the six-phases of reflexive TA imparts the sentiment that you are informed by a set of 'instructions' which will result in a predetermined 'product' if followed meticulously. With its rise in popularity, reflexive TA has an allure for those (including myself) who are dipping their toes into qualitative research for the first time. This is likely due to Braun and Clarke's simplistic, yet comprehensive, articulation of reflexive TA. When reading their 2006 article, it is like having your supervisors sitting next to you and saying, "everything will be fine, we'll do this research together". Within the high-pressure environment of academia, and surrounded by qualitative methods that read like they fell from outer space, who wouldn't want beacons of clarity and simplicity to guide them? However, these ideas undermine the deep, rich, and nuanced analyses that can be produced while using the processes of reflexive TA. As Braun and Clarke (2022a) highlight, "analysis happens at the intersection of the dataset, the context of the research, and researcher skill and locatedness" (p.52).

My primary aim for this qualitative study was to explore the ways in which queer and takatāpui people understand suicide, discrimination, and resilience. Using a theory-driven approach to reflexive TA, I aimed to captured how participants understandings were socially constructed and influenced by institutional social norms, intersectionality, and privilege. These aims are operationalised in the following research questions:

- Question 1: How do queer and takatāpui people talk about the meaning of suicide within their communities?
- Question 2: How do queer and takatāpui people make sense of the intersections between discrimination and suicidality?
- Question 3: What are the different ways in which queer and takatāpui people talk about their ethnic identities as providing resilience against suicidality?

Māori Principles and Ethical Processes

As a person of Māori whakapapa (Te Ātiawa, Ngāi Tahu), it is important to acknowledge that my identity does not inherently afford the current study status of kaupapa Māori research. My approach to research is still grounded within the Eurocentric practices and theories that were taught throughout my tertiary education. Thus, the incorporation of mātauranga Māori and Māori-centred research principles reflects my collaboration with Dr Tassell-Matamua as a Māori cultural advisor, and my engagement with several resources pertaining to Māori ethical processes and research practices. Though I have presented my process of information gathering as a section in this chapter, it is better conceptualised as an ongoing process throughout the entire study (and beyond). For example, my engagement with each participant shaped the ways in which I undertook subsequent interviews, such as adapting the language I used to present and explain key concepts.

Guided by the Māori Ethical Framework outlined in Te Ara Tika Guidelines, I aimed to embed the ethical principles of Māori-centred research into the conceptualisation of my study (Pūtaiora Writing Group, 2010). This framework outlines four key principles that uphold tikanga Māori and mātauranga Māori: 1) **Whakapapa**: the quality of relationships, 2) **Tika**: purposeful research design, 3) **Manaakitanga**: responsibilities to the rights of persons, and 4) **Mana**: justice and equity (Pūtaiora Writing Group, 2010). I was also informed by the Massey University Code of Ethical Conduct, which outlines ethical standards for research conducted with people, characterised by a **high trust** in researchers to thoughtfully apply ethical standards and give deep consideration when interpreting these (Massey University, 2017). **Trust** became a basis for much of my ethical considerations and overlaps with the principle of manaakitanga, which emphasises the researcher's responsibilities to conduct research in a culturally and socially safe manner and to uphold respect for persons, including **whakapono** – to believe and trust others (Pūtaiora Writing Group, 2010). Through ongoing consultation with Dr Tassell-Matamua, my thinking was orientated towards the practicalities of 1) developing **whanaungatanga** with potential participants, and 2) ensuring that all members of the population of interest had an **equitable** opportunity for participation. In the subsequent paragraphs, I discuss my ethical processes for upholding the human rights of people who participated. I have divided this section into three components regarding the rights to: Safety and Wellbeing; Justice and Autonomy; and Confidentiality and Informed Consent.

Ethical approval for this study was obtained from the Massey University Human Ethics Northern Committee on January 7th, 2019 (approval reference: NOR 18/68).

The Rights to Safety and Wellbeing

My initial ethical consideration was mitigating potential risks of harm to participants. Given the sensitive nature of the topics being discussed, I researched whether interviews would inadvertently elicit psychological distress. Research within suicidology indicates that talking about, and assessing for, suicidality does not increase people's risk for subsequent suicidal distress (Dazzi et al., 2014; Harris & Goh, 2017), and may have benefits regarding the reduction of suicidal ideation (Blades et al., 2018). Further, Smith et al. (2010) found that 3-months following their participation in suicide-based research, none of the participants had self-harmed or attempted suicide.

I implemented inclusion criteria based on the ethos of high trust and respect for persons (Massey University, 2017). As such, peoples own **self-determination** and **self-awareness** were the basis for whether the study was appropriate for them to participate in. I encouraged participants to consider their current psychological wellbeing, and to discuss participating in the research with whānau and support persons, before consenting to take part. To uphold people's safety, I established the exclusion parameters as people who had self-harmed, attempted suicide, and/or contemplated taking their own life within the past 12-months; who did not consider their mental health to be in a suitable state to participate at present; or who anticipated that the subject of suicidality would adversely affect them. Additionally, participants could bring whānau, friends, or support persons to their interview for comfort and support.

Acknowledging my responsibility for people's safety, I wrote a safety protocol (Appendix E) on processes to be undertaken if participants became distressed during their interviews. Briefly, this protocol outlined indicators of potential distress (e.g., changes in behaviour); grounding techniques; the supportive roles of research supervisors; and procedures for involving healthcare providers when appropriate. Dr de Terte (Clinical Psychologist, co-supervisor) reviewed and approved the safety protocol. Additionally, I gave participants a list of local and national mental health and support organisations (Appendix F) at the beginning of the interview and reorientated them to it at the end. I tailored this list for each participant according to the services available within the region/area in which they lived.

As a means of bridging the spatial gap between myself and potential participants, I positioned my pepeha as the opening statement in the research information sheet (Appendix G). I also disclosed my self-identity as a cisgender queer man and my academic role as a student researcher. Given that my first contact with potential participants was through emails, I thought of my written replies as an interface to convey the identities representative of me. Thus, implicitly inviting people interested in the research to share with me their sense of self and experiences, as well as building connections through the mutual identities and experiences that we shared – **whakawhanaungatanga**. As such, I intended for my self-disclosures to create a sense of familiarity for participants, and to breakdown some of the power structures embedded within the researcher-participant dynamic.

The Rights to Justice and Autonomy

The principles of **justice** and **whakapapa** were significant ethical considerations while initially designing this study. Academia has historically undertaken research **on** marginalised communities rather than **with** them. As such, I actively engaged with queer- and takatāpui-based community groups and organisations in the Wellington region. For example, I consulted with InsideOUT and Gender Minorities Aotearoa who provided feedback on the language I used in my draft research documents (e.g., advertisement, interview schedule), ensuring that the terms were accepted within communities and affirmative to those with diverse identities. To contribute to the **tūmanako** (aspirations, hopes) of these organisations, I asked if there were any topics related to suicidality that I could incorporate into my research on their behalf. Alcohol and drug use as contributors to suicidality, and the role of whānau as a support system, were noted by these organisations and incorporated into the interview schedule (Appendix H).

Justice also influenced my rationale for this study and how I developed my interview questions. I see my research as a space for queer and takatāpui to share **their** meanings of suicide, discrimination, and resilience, which I hope will construct future suicide interventions and inform mental health practices in Aotearoa. Queer and takatāpui people have an ongoing history of being pathologised (e.g., Lev, 2013; Treharne & Adams, 2017; Davy & Toze, 2018; Grey, 2022). As such, I actively challenged pathologisation by exploring what the language of 'risk factors' meant to participants and asked them how imposed 'social norms' enacted discrimination against, and marginalised, groups of people.

I designed the recruitment process to maintain the **autonomy** of participants. To achieve this, I developed procedures which positioned participants' as the **decision makers** regarding the interviews. The times and dates for interviews were negotiated through back-and-forth discussions, factoring in the availability of other participants within the region if I needed to travel across the country. Participants were able to decide: the places and geographical locations where the interviews took place; when we took pauses during the interviews; to not answer any questions if they chose; and to withdraw from the study without consequences. My role as the researcher was one of flexibility and adaptability to ensure that I could facilitate participants' decisions, while recognising that collaborative decision-making was needed when determining the times and dates for interviews.

The Rights of Confidentiality and Informed Consent

My ethical considerations and actions regarding confidentiality and informed consent are outlined under the 'Data Collection' section within this chapter. This includes my procedures for data storage, data access, and anonymising potentially identifying information. Specific to informed consent, my ethical process was to ensure that there was transparency between my research intentions and potential participants. As such, my research information sheet outlined procedures for audio recording the interviews, anonymising participants' data, and their rights as participants in the study (e.g., did not have to answer questions). In addition, I provided copies of the interview questions (Appendix I) and the consent form (Appendix J) prior to participating in the study, which highlighted what subjects could be discussed in the interviews, how participants' data would be used within the research, and how participants could access their own data.

Recruitment Process

In 2018, the Auckland Pride controversially proposing that the NZ Police and Corrections do not partake in the 2019 Auckland Pride Parade. This proposition was seemingly spawned from debates surrounding the authenticity of representation within the Pride Parade, particularly regarding the tokenistic inclusion of takatāpui, Pasifika and transgender communities. Heavily fronted by the People Against Prisons Aotearoa (PAPA) organisation, reports on the overrepresentation of violence towards trans people in prisons and police brutality towards Māori and Pasifika peoples were entangled with discussions calling-out the Pride Parade as a mechanism for corporate advertisement rather than a celebration of diversity. Following a

hui in November 2018, the Pride Board voted in favour of police officers being able to participate as individuals but without adorning their police uniforms – a statement of including people and excluding the NZ Police institution – a symbol which has represented oppression and injustice for many marginalised communities. This formed a divide across communities on whether the Board's decision represented progression or regression for queer and takatāpui people, which carried into 2019. This stood as the backdrop for the decisions I made regarding my inclusion criteria and recruitment process.

The intended participants of the study were people who self-identified with an identity term that aligned with the pan-descriptors of 'takatāpui' and/or 'queer'. This included, but was not limited to, LGBTQIA+, MVPFAFF, nonbinary, genderqueer, intersex, asexual, pansexual, questioning, diverse gender identities, diverse sexualities, and/or people who did not identify as cisgender and/or heterosexual/straight. To participate in the study, people were required to be aged 18-years or older; have experienced suicidality at some stage in their life (e.g., deliberate self-harm, suicidal thoughts, attempted suicide); considered themselves to have recovered from suicidality; and be in a good state regarding their psychological wellbeing.

The incorporation of the **Mana** principle (Pūtaiora Writing Group, 2010) is reflected in my decision to actively prioritise interviewing takatāpui people. Given that takatāpui people have been grossly underrepresented within research pertaining to suicidality (Beckford, 2016), I positioned Māori in equitable footing with Pākehā during the recruitment process. I created an equitable opportunity for takatāpui people to participate in the current study by commissioning a freelance digital designer, who was queer identifying, to create two advertisements for the current study. The first advertisement (Appendix K) was designed to capture the attention of all individuals who did not self-identify as cisgender and/or heterosexual/straight, such as the incorporation of a rainbow spectrum in the background and the inclusion of serval sexuality and gender identity terms. The second advertisement (Appendix L) was created to specifically recruit Māori and ensure that takatāpui perspectives of suicidality would be represented within the study. As such, the colour palette predominantly consisted of the national Māori colours (mā, whero and pango) and a weaving pattern was utilised as the banner of the advertisement.

The recruitment process commenced in early February 2019 and was concluded in late October 2019. I decided not to limit recruitment to any one geographical location to ensure that all queer and takatāpui people living in Aotearoa had an opportunity to participate. Potential participants

were identified using digital advertisements disseminated online through social media platforms (e.g., Facebook, Instagram), national organisations (e.g., InsideOUT, Gender Minorities Aotearoa, RainbowYOUTH), regional community groups (e.g., Taranaki LGBTQ), as well as university clubs (e.g., UniQ Massey, UniQ Otago). I placed physical advertisements in the form of posters throughout the three university campuses located in the Wellington region (i.e., Massey University Wellington, University of Otago Wellington, Victoria University of Wellington), and I enlisted the help of friends and colleagues around Aotearoa to distribute physical advertisements within their local communities. Further, I utilised snowball sampling and word-of-mouth techniques by circulating the advertisements to friends and colleagues who were members of, or connected to, queer and takatāpui communities. Regarding people who expressed an interest in participating, I replied with a brief statement about myself, answered their questions, and attached copies of the research information sheet, the interview questions, and the consent form. I encouraged potential participants to read through these documents, and to discuss participating with their whānau or close supports, prior to deciding to partake.

Participants

I interviewed a total of 20 queer and takatāpui people from across Aotearoa. I invited participants to share the language they used to describe their identity categories, including their age, sexuality, gender identity, ethnicity, and intersex status. For takatāpui participants, I asked about their whakapapa Māori to iwi and hapū. In the following paragraphs, I present participants' information in an aggregated format to ensure that their anonymity and right to privacy is maintained.

Participants' ages ranged from 18 to 55 years (M = 26.2). The distribution of ages was: one participant aged between 18 and 19; fourteen participants aged between 20 and 29; three participants aged between 30 and 39; one participant aged between 40 and 49; and one participant aged between 50 and 59. *The first three participants I interviewed were over the age of 30. I recall being pleasantly surprised by this, since much of the literature I had read on suicidality was centred on the 'youth' age bracket. I would say that these earlier interviews were influenced by my curiosities on the social changes that they may have experienced across time*. Participants described their sexual orientations using the following terms: 'queer' (n = 8);

takatāpui (*n* = 5); lesbian (*n* = 5); bi or bisexual (*n* = 5); pan or pansexual (*n* = 4); gay (*n* = 4); rainbow (*n* = 1); asexual (*n* = 1); and aromantic (*n* = 1).

My active prioritisation of recruiting takatāpui people resulted in the final sample consisting of 11 participants identifying as Māori and 9 categorised as Pākehā. Participants referred to themselves using the following ethnicity terms: Māori (*n* = 11); Pākehā (*n* = 9); New Zealand European (*n* = 5); New Zealand Māori (*n* = 2); Samoan (*n* = 2); Cook Island Māori (*n* = 1); Chilean (*n* = 1); British (*n* = 1); and White (*n* = 1). Takatāpui participants affiliated with several iwi and hapū: Kāti Huirapa; Muaūpoko; Ngāi Tahu; Ngāi Tūhoe; Ngāpuhi; Ngāti Hau; Ngāti Hauiti; Ngāti Hine; Ngāti Hinemanu; Ngāti Hinepare; Ngāti Kahungunu; Ngāti Kahungunu ki Te Wairoa; Ngāti Kopaki; Ngāti Pakau; Ngāti Porou; Ngāti Raukawa; Ngāti Tamarangi; Ngāti Tautahi; Ngāti Te Upokoiri; Ngāti Toa; Ngāti Ueoneone; Ngāti Whakaue; Rongomaiwahine; Rongowhakaata; Te Arawa; and Te Ati Haunui-a-Pāpārangi.

Regarding gender modality, 11 participants were trans and/or gender diverse identifying and 9 were cisgender identifying. At the time that interviews were conducted, participants used the following terms to describe their genders: female/woman/girl (*n* = 6); male/man/guy (*n* = 5); nonbinary (*n* = 4); trans male/man (*n* = 2); takatāpui (*n* = 2); queer (*n* = 2); they/them (*n* = 2); genderfluid (*n* = 1); trans masculine (*n* = 1); trans woman (*n* = 1); tāhine (*n* = 1); and wāhine (*n* = 1). None of the participants identified as having an intersex variation.

Data Collection

The interviews were undertaken between February 14th and October 31st, 2019. Participants were able to decide where their interviews took place, provided that the selected location was easily accessible, while private enough to allow for conversations to occur without being overheard or interrupted. The locations of interviews ended up including, bookable rooms in community spaces (e.g., public libraries), tertiary education campuses (e.g., study rooms), and participants' living accommodations (e.g., homes, sheds). Three participants attended their interviews with another person for support.

Prior to commencing each interview, I provided participants with copies of the research information sheet and consent form to read through again. Following the Hui Process (Pitama et al., 2017), I opened the space for mihimihi (greeting and engagement) by introducing myself

(e.g., my identity, whakapapa), and my background (e.g., where I am from, education), which participants reciprocated by introducing themselves. To build whakawhanaungatanga (connections), I spent time getting to know each participant and developed rapport through informal conversations, making connections between our shared interests. I attended to the kaupapa (purposes of the encounter) by reiterating the purpose of the study, informing participants of their rights, and asked if they had any questions about the interview process (Pitama et al., 2017). After responding to any questions, participants completed and signed the consent form. I then offered participants an opening karakia (a spiritual incantation) to state the intentions and hopes for the hui ahead, and subsequently asked if they were comfortable with starting the interview.

I conducted kanohi ki te kanohi (face-to-face) discussions with participants, guided by an open-ended semi-structured interview schedule (see Appendix H). This ensured that I asked the same key questions during each interview, while providing the flexibility to follow-up on ideas and ask additional questions to elicit depth from discussions or approach subjects in different ways. The interview schedule consisted of nine components: 1) positioning questions, 2) understandings of social norms, 3) experiences of discrimination, 4) functions of self-harm, 5) contributing factors to suicidal thoughts and suicide attempts, 6) social understandings of suicide, 7) strategies for suicide prevention, 8) an opportunity to contribute additional information, and 9) poroaki/whakamutunga (closing the interview). Prior to undertaking interviews with participants, I completed a pilot interview using a draft-version of the interview schedule with an associate who was queer and Māori identifying and historically experienced suicidality. Based on the feedback they provided, I restructured the interview schedule to improve the flow. Also, they described having felt comfortable during the interview because I had self-disclosed my Māori and queer identities from the onset. *I elaborate on the therapeutic 'use of self' as a means of connecting with others in my Research Case Study* (see Appendix M). At the end of each interview, I offered participants a closing karakia, and gave them a $30 supermarket voucher and a block of chocolate as koha for their participation.

Participants consented to having their interviews audio recorded, and all interviews were transcribed verbatim by me. It was pertinent that I personally transcribe the interviews to maintain participants' confidentiality and to fully emerge myself within the data. Interviews ranged from 31 minutes to 135 minutes in duration, with a median length of 59 minutes and an average of 62 minutes. My transcription process retained all social hesitations (e.g., 'um'),

linguistic fillers (e.g., 'you know', 'like'), contextual sounds (e.g., noises that disrupted conversations), and I included participants' communicative behaviours (e.g., use of hand gestures to emphasis a point), which I had noted during the interviews. Afterwards, I anonymised the transcripts by removing participants' personal details and altered identifying information, such as the names of locations, people, events, services, and occupations. I developed my own notation style that made it easy for me to distinguish between different linguistic and behavioural features, as follows:

- **"***text***"** (sarcastic, mimicry, or hypothetical speech),
- **[***text***]** (anonymised words substituted for descriptive phrases),
- **…** (pauses in speech),
- **[…]** (omitted sections of speech),
- **(***text***)** (descriptors of contextual sounds or communicative behaviours),
- *Text= =Text* (overlapping speech),
- **Bold text** (what I said),
- Plain text (what the participant said),
- CAPITALISED TEXT (stress or emphasis placed on words),
- (inaudible) (unable to discern what was said).

On the consent form, participants selected whether they wished to review and edit their transcript, or not. For participants who requested this option, I emailed them an anonymised version of their transcript, and stated that they had three weeks to review, edit, and send me a revised version of their transcript if they had made changes. I reassured participants that our speech was not always grammatically correct, and we often use filler words (e.g., 'like', 'you know'), which were normal language practices. Instead, I encouraged participants to check for any potentially identifying information that I may have missed. Of the seven participants who reviewed their transcripts, only one participant opted to remove a statement about their life circumstances. All audio files and transcripts were stored within my Microsoft OneDrive, which was supplied by Massey University. This cloud/remote backup service was password protected and required multi-factor authentication to access. Participants' signed consent forms were stored in a locked cabinet within my office at Massey University, Wellington.

Data Analysis

Conceptual and Design Thinking

I have conceptualised stress as the enactment of discrimination upon marginalised communities, namely queer and takatāpui people in Aotearoa. My conceptualisation of intersectionality remains consistent with the descriptions provided in the ToD, as does my understanding of ideologies as institutional social norms constituting which identities are defined as 'normative' (Riggs & Treharne, 2017). I share the notion that the intersectional nature of identities transpires as discrimination effecting people differently, depending on whether their identities occupy spaces of privilege or marginalisation (Riggs & Treharne, 2017). Further, I conceptualise decompensation as one's risk for experiencing suicidality – whether in the form of suicidal ideation, self-harm, and/or attempts to end one's life.

I take a critical orientation to this research by examining how queer and takatāpui people construct their understandings of suicide, discrimination, and resilience. I use a theory-driven approach to analysing the dataset, whereby the decompensation concepts of social norms, intersectionality, and privilege have shaped my perspectives and influenced my practices of analysing and interpreting the data. As a means of maintaining conceptual coherence, my interpretations of the data are from a latent exploration of meanings at the implicit level, rather than assuming that their words are representative of explicit or semantic meanings (e.g., language as representations of objective reality). In the following sections I present my application of Braun and Clarke's (2006; 2013; 2019; 2021) reflexive approach to TA using the six phases as guidelines, informing how I analysed the dataset. These six phases consisted of: 1) familiarisation, 2) coding the data, 3) generating potential themes, 4) constructing themes, 5) refining, defining, and naming themes, and 6) writing my findings.

Phase One: Familiarisation

Familiarisation began while I was conducting the interviews, during which time I took notes on participants' ideas that I wanted to explore further within our discussions. While transcribing the interviews, I added to these initial notes by writing down participants' words and phrases that intrigued me. Once I had reviewed and finalised all transcripts, I began immersing myself within the data by reading and re-reading the transcripts while simultaneously listening to the interview audio recording. In doing so, I was trying to construct

a mental representation of the content as a whole dataset, with congruencies and conflicts between 'datapoints', rather than just perceiving transcripts as 20 independent interviews.

While the process of immersion was relatively comfortable, I found it challenging to then create 'distance' between myself and participants' words. Since lockdown prevented me from accessing my university office, I came to think of the dataset and I as physically occupying the same repetitive space, which mirrored the repetitive thoughts and interpretations that I had about the data. Adding to the challenge of critical engagement was my positioning as an insider researcher. I made sense of the data as 'relatable' to my own life experiences and slipped into the frame of mind that participants' meanings were a 'given'. This conflicted with a social constructionist epistemology, and it was not until my supervisor put forward the question, "so what", that I started to critically engage with the data.

The intention behind the question of, "so what", was not to undermine or dismiss, but rather to elicit my thoughts around the 'bigger picture' within the dataset. I started by writing about statements in the transcripts that I found to be impactful and ones that elicited emotional reactions in me. Additionally, I made notes on participants' assumptions about the subjects we discussed, which I had initially taken-for-granted (Burr, 2015), and considered how this knowledge may be framed differently among varied positionings (e.g., cisgender-heterosexual people).

Phase Two: Coding

Coding can be conceptualised as a process of tagging the segments of data that relate to the research questions with a code label that one has generated (Braun & Clarke, 2022a). The function of this code label is to succinctly summarise the meaning, concept, or idea that one has produced from a segment of data. When referring to codes I adopt Braun and Clarke's (2022a) definition, as the smallest analytic units and outputs which capture meanings within the dataset. My process entailed a focused approach to coding by assigning codes to segments of data that were relevant to my research questions. I asked a vast array of questions on several different topics during interviews, and I acknowledge that participants' talk on self-harm, social media representations, alcohol and drug use, social supports, and whānau, are intentionally not presented in this thesis.

At first, I attempted a coding process by highlighting segments of text in a Microsoft Word document and using the 'comment' feature to add code labels; a process I had used for my honours dissertation. However, after realising that I was creating numerous different codes, I found it difficult to keep track of these all in a practical manner. So, I took the time to learn how to use QSR International's NVivo Release 1.0 (2020 version) software, which provided me with a user-friendly interface to create codes and keep track of these.

I used a systematic approach to coding the dataset, starting with the first interview I conducted and moving through to the twentieth interview. My initial coding approach was to identify broad similarities and differences in the ways participants described suicide, discrimination, and resilience. I generated code labels summarising 'what' made these segments of data alike or dissimilar. This provided me with a framework to start redefining my code labels from broad answers of 'what', to instead stating patterns regarding 'why' these congruencies or contrasts were evident to me.

I used a theory-driven orientation by coding for latent patterns of meaning that I thought were indicative of the influences from social norms, intersectionality, and privilege. I developed code labels that captured 'how' different and similar meanings of suicide, discrimination, and resilience had been socially constructed from positions of intersectionality and privilege, as underpinned by social norms. As such, my new code labels communicated the nuanced patterns I identified with the dataset, whereby a single code was applied to multiple segments of text to show that these data shared similarly, or differently, constructed meanings.

Phase Three: Generating Potential Themes

Once I had finished coding the dataset, I started the process of generating my potential themes by clustering the codes into groups which were based on meaning patterns. I was mindful to avoid 'domain summaries', which are summaries of topics within the dataset, and do not constitute as themes (Braun & Clarke, 2021). The groups of codes allowed me to read through the data extracts (i.e., coded data) in a systematic manner, reviewing each group of codes to assess the data for meaningful cohesion. After realising these initial groupings seemed, to me, to lack central concepts to unify the codes, I opted to develop a thematic map (Braun & Clarke, 2013). I deconstructed and reconstructed my thematic map several times using different combinations of codes that seemed to be meaningfully connected to one another. After several iterations, I settled on a thematic map that conceptualised my five potential themes: 1) suicide

is common; 2) accumulated discrimination; 3) cis-gay men are the loudest; 4) society places "risk" upon marginalised communities; and 5) resiliency vs responsibility.

Phase Four: Constructing Themes

Upon revision, I identified issues regarding my potential themes. Firstly, these themes 'directly' answered my research questions, appearing as though I had placed data extracts underneath each research question, rather than considering what the themes meant and why they mattered. Related to the first issue, the potential themes lacked depth and nuance, communicating quite literal/superficial ideas about suicide, discrimination, and resilience without acknowledging broader social influences (e.g., intersectionality). As such, the third issue was that I had neglected the overall 'story' that I was trying to convey with these themes. Specifically, I had not constructed an overarching theme (Braun & Clarke, 2022a), such as an idea or concept, which linked all the themes together.

With these three issues in mind, I re-engaged with all my codes by writing them on post-it notes and developed a new thematic map, with social norms, intersectionality, and privilege, acting as my 'preconceived' central concepts. As I formed and re-formed my thematic map, I started to feel more confident and removed the 'preconceived' concepts. After I had constructed new themes, I checked that the codes within each theme connected coherently to communicate meaningful patterns within the dataset. At this stage, I re-engaged with all the coded data extracts, and the dataset as a whole, to assess that I had: 1) constructed themes that were connected to one another, but had defined boundaries between them; 2) developed a central concept for each theme that my codes built upon; 3) enough data extracts for each theme to demonstrate that the pattern of meaning was multi-faceted; and 4) produced coherent themes that were contained and not too diverse (Braun & Clarke, 2022a).

Phase Five: Refining and Defining Themes

To refine, define and name each theme, I frequently switched between phases four and five (and sometimes phase six), which I will now exemplify. Upon review, two of my themes were too constrained and overlapped around the same central concept. As well, I thought that one of these themes was more adjacent to my research questions, so I deconstructed it and integrated some of the codes into the other themes; producing, *"Social Norms Require a Deviant Group"*. Another of my themes initially did not include subthemes, but as I was writing (phase six), I noticed that the data extracts pertaining to Māori experiences had features that were dissimilar

to the experiences of Pākehā. Data extracts from both Māori and Pākehā were organised around the central concept that ethnicity contributes to resiliency, but Māori participants' discussed colonisation as a social force to resist against, whereas colonisation had socially positioned Pākehā as privileged. As such, I wrote these perspectives as two subthemes under a single theme, *Ethnicity and Resilience to Suicidality*.

Phase Six: Writing My Findings

Phase six is presented in the next chapter (Chapter 7), where I have outlined my constructed analytic outputs (i.e., my themes) and interpretations. In total, I produced five themes and five subthemes. The concepts of ideology, intersectionality, and privilege directly informed the development of the interview schedule, which provided participants with opportunities to consider and discuss suicidality in relation to the social norms they experienced, their own intersecting identities, and the privileges afforded to them. These concepts are neither at the core of each theme, nor were they incorporated into the five themes at the expense of shared understandings and meanings. Further, while I never asked participants to disclose how they had previously experienced suicidality, these experiences were inevitably discussed as participants explained how they made sense of suicide. As such, I have not included these accounts in this thesis since 1) the purpose of this study was to capture suicide as subjecthood rather than experiential, and 2) the sensitive nature of participants' experiences would be inappropriate to include in academic literature. I have written Chapter 7 in a third-person perspective to signify that my themes have been constructed from participants' words, and to denote that they are the people who gave substance to my interpretations.

Chapter 7: Study Two – Qualitative Analysis

The themes presented in this chapter are linked by an overarching idea that queer and takatāpui people understand suicide as a socially tangible presence within their communities, which is experienced because of enacted social norms and given subjecthood through social connections with peers who share experiences of discrimination and suicidality. Across themes one, two, three, and four, the voices of takatāpui Māori and queer Pākehā are presented in an aggregated format to highlight the collective understandings of suicide and 'risk', as well as the ways that social discrimination are experienced and contribute to suicidality. Within theme five, the standpoints of takatāpui Māori and queer Pākehā are separated into two subthemes to outline the different ways in which each participant spoke to their own ethnic identities as contributing to resiliency against suicide.

The first theme, *"Not just this Amorphous Subject"*, refers to the unique meanings given to suicide by queer and takatāpui people. Participants discussed suicide as *common* and *connecting* among marginalised people because of shared *understandings* on the role that society plays in precipitating suicidality. Theme two, *"You're Removing the Responsibility of the Society"*, expands upon this idea, whereby the language of 'risk factor' was described by participants as a term that called for queer and takatāpui people to receive greater support, while deflecting responsibility away from society, thus framing them as responsible for being 'at-risk' of suicidality. The third theme, *"Social Norms Require a Deviant Group"*, highlights participants' talk on the functions of social norms as agents that permit people to discriminate against queer and takatāpui on the basis of deviating from dominant social ideals. In the fourth theme participants utilised the idiom, *"the Straw that Broke the Camel's Back"* as an analogy for the idea that the weight of discrimination compounds which, in turn, places accumulated stress on queer and takatāpui people, such that suicide was perceived as one opinion to alleviate such distress. *Ethnicity and Resilience to Suicide* encompasses the ways in which participants framed their ethnic identities as resiliency against suicide; for Māori, active resistance against the colonial powers in Aotearoa, and for Pākehā, passive recipients of privileges afforded from ongoing processes of colonisation. These five themes are summarised in Table 11.

Table 11

Summary of developed themes

Theme One	"Not just this Amorphous Subject"
Subtheme One	*Suicidality is Socially Common*
Subtheme Two	*The Connectivity of Suicidality*
Subtheme Three	*Understandable Suicide*
Theme Two	"You're Removing the Responsibility of the Society"
Theme Three	"Social Norms Require a Deviant Group"
Theme Four	"The Straw that Broke the Camel's Back"
Theme Five	Ethnicity and Resilience to Suicidality
Subtheme One	*Whakapapa of Resistance*
Subtheme Two	*Individualist Privilege*

Theme One: "Not just this Amorphous Subject"

The first theme represented how queer and takatāpui people understood suicide as a subject that proliferated through their social circles. This theme of *"Not just this Amorphous Subject"* was organised around the core idea communicated by participants that suicide is known to be a common occurrence within queer and takatāpui communities and therefore acts as a connecting presence among members of these communities. Participants spoke of suicide as a collective social phenomenon, whereby the loss of a peer to suicide was not an individualised experience, but rather a shared grief upon all queer and takatāpui people. This idea was built through participants' talk that related suicide to commonality, connectivity, and understandability, which have been divided into three subthemes, *Suicidality is Socially Common*, *the Connectivity of Suicidality*, and *Understandable Suicide*. As such, participants had constructed a collective understanding of suicide as a shared experience embedded within their communities. Within some discussions, this understanding of suicide was framed as an omnipresence, produced from participants talking of suicide as an inevitability among queer and takatāpui people.

Subtheme One: Suicide is Socially Common

Participants frequently referenced suicide as statistically and anecdotally prevalent among their communities, in some instances, referring to loved ones that had taken their own lives. The

language used to describe suicide highlighted that it was a "*common*" and "*prominent*" experience among queer and takatāpui people. This developed a dialogue of suicide as a subject which was known about:

> Interviewer: Thinking about yourself, in what ways does being white, genderqueer and a bisexual individual shape your understanding of suicide?
>
> Austin (18): I think it does in the sense that I'm aware of the fact that [suicide is] something that a very disproportionate amount of queer people go through, so it kind of almost made me feel more at ease with starting it in the first place […].

Reflecting upon their own experience, Austin highlighted the overrepresentation of suicidality among queer and takatāpui people. As a bisexual and genderqueer person, Austin talked about their familiarity with suicide having eased their own experience with suicidality, which may not be as natural for people who have never been exposed to suicide. This construction of suicidality seemingly evoked a sense of social expectation that suicidality is a likely option among queer and takatāpui communities, and thus, ordinary for member of these communities to engage in.

Referring to suicide as prevalent was equated to the idea of suicidality as a subject that connected community members through shared experiences. Participants discussed these experiences as normalised within their communities, which are not typical within the hegemonic population. For example, Austin positioned the language of psychological distress and suicide as prominent within society and paralleled this to the commonality psychological distress within queer and takatāpui communities. As such, this prevalence was framed as shared experiences which unify these communities:

> I think [suicide] definitely does bring the community a little bit closer together […] I don't think you'd find many people in the world who are not at the very least well versed in the language of depression and suicide. I don't fuck with statistics and shit, but I know for a fact that probably most queer people have gone through some sort of depression or anxiety, or some other form of mental illness that can very much be traced back to […] the fact that they are queer in this society – Austin (18).

While discussing suicide as a unifying conduit among queer and takatāpui people, Austin drew connections between social language practices and experiences of psychological distress. Austin's excerpt acknowledges that the prominent use of language regarding psychological distress and suicide constructs the idea of both as common occurrences within society. Building upon this, Austin talked about how most queer and takatāpui people likely had experienced

psychological distress in some form, and then positions this as an outcome of being marginalised within society, rather than an innate attribute of these people. As such, the language of suicide, as well as experiences of suicidality, contributed to participants' understanding of suicide as a point of connection.

Expanding upon the commonality of suicide, participants described suicidality as an internalised psychological concept that may even be used to define oneself and one's relationships with others. In turn, the shared experience of suicide functioned as a medium that facilitated connections with other queer and takatāpui people. The following excerpt by Taylor highlighted how the relational aspect of suicide was independent of one's temporal relation to their own experiences of suicidality:

> It's just something that is so present in our lives whether it was more of a thing in the past and you're moving on from it. It's still something that defines you and defines your friends and is something to connect over, or you might have someone that you know who's dealing with those thoughts now, and it's just another connection – Taylor (24).

Whether historical or ongoing, Taylor framed suicidality as an ever-present subject and experience, incorporated not only into one's sense of self but also their social relationships. This speaks to the profoundness of suicidality as a connecting force within queer and takatāpui communities.

Subtheme Two: The Connectivity of Suicidality

Throughout the interviews, the idea of connectivity was illustrated using relationships with people who had been, or were currently, suicidal. Participants explained that members of queer and takatāpui communities would likely know of at least one peer who had attempted to end their own life, or who had died by suicide. These relationships were noted to personalise the subject of suicide and function as a point of commonality when developing connections with other queer and takatāpui people:

> […] so, then there's probably that personal thing. Probably everyone can think of somebody and so therefore you're like, suicide equals that person not just this amorphous concept – Frankie (35).

As highlighted by Frankie, a construction of suicide could be built from people's social relations with other queer and takatāpui people, particularly those who had ended their own lives. This personalisation of suicide attached saliency to the subject matter, whereby the abstract concept of suicide was represented as someone who was known.

> I'm pretty sure that everyone knows someone who's been there if it's not themselves. I think it's more open about in the queer community because they are trying to find things to relate to with other people, and having the queer label, so to speak, puts them in a space where they meet other people with the same label where they can then share things that fit in – Tanner (22).

The overlay between the commonality and connectivity of suicidality is illustrated in the excerpt above from Tanner. One's personal experiences of suicidality, or connections with those who had been suicidal, are described as a means of relating with other members of queer and takatāpui communities. Thus, Tanner speaks of these experiences, and the shared identities as queer and/or takatāpui, as relational characteristics, which are positioned as more openly discussed among those who are marginalised within society.

Participants developed meanings for suicide as an internalised knowing within queer and takatāpui communities, rather than an externalised, distal subject. This idea was produced by emphasising shared experiences regarding suicidality and highlighting participants knowledge of suicidal responses from queer and takatāpui people. As such, participants constructed definitions for suicide through their knowledge of experiences and phenomena that negatively impacted upon queer and takatāpui people:

> I think, as assumptive, if someone commits suicide or experiences homophobic violence, and then often people post about it on [social media], and it's like their own grief as well because I think we know that that person wasn't a bad person, so they got beaten up, or that person wasn't a mental person, so they killed themselves. […] that person was in a similar situation to what we're in, and in that case it equalled X – Frankie (35).

For Frankie, the understanding of suicide was the ability to see oneself mirrored within the negative social circumstances experienced by queer and takatāpui people, constructed as victims of suicide and violence. Within this understanding, suicide was framed as a rejection of the moral judgements imposed upon the decision to end one's own life. This was exemplified by linking suicide with homophobic violence, describing that queer and takatāpui people recognised that neither were attributable to moral justice, but were caused by the social conditions in which these people were situated. Frankie's talk touched on power disparities between the hegemonic population and marginalised communities, whereby constructions of morality ("*bad person*") and self-liability ("*mental person*") underpinned the ways discrimination and suicide were perceived within mainstream society. In contrast, Frankie positioned the knowledge of suicide as a personal grief among queer and takatāpui people, in

other words, a shared understanding that ongoing exposures to prejudicial social conditions drives the occurrence of suicidality.

Similarly, Skyler described suicide as a "*visceral knowing*," implying that the knowledge of queer and takatāpui people who had completed suicide was physically and emotionally felt throughout these communities. This understanding was framed using the idea that these individuals had shared experiences of the social conditions which precipitated suicide:

> […] it is just knowing; a visceral knowing of the reality of suicide for our community. It's not just a topic, a risk factor, a thing that is around, it's actually felt quite deeply by that community and I would say that a lot of it is because of the conditions, the precipitating things that happen, are the things that we deal with every day, and in certain spaces the things that we advocate against […] or advocate for, we do those things because we know that this is a possible reality and we know it because we've experienced it by having to bury people in our community, or knowing people who have buried people because of those things […] – Skyler (31).

The excerpts from both Frankie and Skyler are connected by the strongly implied sense of injustice towards, and shared frustration for the occurrence of suicide within, their communities. For Skyler, suicidality was understood as tangible feelings and experiences, maintained by daily exposure to the social conditions that precipitated suicide and burying members of queer and takatāpui communities who had taken their own lives.

Subtheme Three: Understandable Suicide

The understandability of suicide was illustrated through the use of emotive language and discussions on individuals' personal connections with this subject matter. Words such as, "*empathetic*", "*compassionate*", and "*understandable*" were coupled with terms of quantitative value, seemingly to illustrate that members of queer and takatāpui communities held "*more"* understanding towards suicide than others. In some instances, participants contrasted their understandings of suicide against the perspectives of people who hold different self-identities (e.g., cisgender, heterosexual) or were from different communities (e.g., religious denominations, wealthier, older generations, rural/smaller communities). This emphasised disparities between the understandings of suicide held by queer and takatāpui people compared to those with religious/conservative beliefs. At the core of these disparities was an assumption that such people lacked insights into the factors that contributed to suicidality among queer and takatāpui people and misattributed the act of taking one's own life as one of selfishness and

sinfulness. In contrast, participants viewed the subject of suicide through a lens of empathy, rejecting the social climate that judges marginalised identities as invalid:

> I think a lot of people are really angry and obviously hurt when someone decides that they don't want to be here anymore, and I think now I have a lot more empathy about why people make that choice; about how mamae it is to just live with that amount of self-hatred. To just try and exist in a world that tells you that you shouldn't, obviously, is deeply painful and it makes me sad that people make those choices, but I can understand […] – Atawhai (23).

Within Atawhai's excerpt, the societal message that queer and takatāpui should not exist was described as creating a social climate that precipitated and perpetuated suicide. In turn, this perspective was internalised as self-hatred and mamae (hurtful, painful) among members of these communities. Atawhai distanced themself from notions of anger towards people who had taken their own lives, and instead framed their understanding of suicide as one of empathy; felt as sadness towards those who had made this choice. Similarly, Morgan spoke of an explicit distinction between how suicide was understood within religious communities compared with queer and takatāpui communities:

> […] I think most queer people I know are a bit more empathetic because they are constantly thinking about these, not necessarily about mental health, but just about [suicidality]. One big difference between that and a church community is that suicide is not seen as a selfish rude choice […] I think it's probably more understanding of where [suicidality] may have come from, and there are a lot of shared experiences within the queer community that people can see your road. Not necessarily in its entirety, but they can see where you've come from and empathise with that because they've had similar experiences […] – Morgan (26).

For Morgan, religious beliefs were understood to frame suicide as a selfish choice and emphasised that queer and takatāpui communities did not share this sentiment. Instead, the latter were described as more understanding of where precipitants of suicide originated from. As such, Morgan framed the experience of suicidality as empathetically understood among queer and takatāpui communities because of their shared and similar experiences of hardships. Both Atawhai and Morgan spoke of the levels of understanding, including lived experiences of the causes and consequences of suicide. Finally, highlighted was how suicide was empathetically felt among queer and takatāpui people through these experiences.

The idea of suicide as an inevitability among queer and takatāpui communities was discussed by relating marginalised identities to the rate of suicide within Aotearoa. For some participants, suicide was described as an unstoppable phenomenon, equating it to an omnipresence within these communities or an ever-present thought. Charlie spoke of their personal experience with

suicidality across their life and positioned the idea of suicide as linked with one's self-identities, going as far to emphasis an attachment between the two constructs:

> I've battled throughout my life with ideas of suicidality and have worked hard to understand why and what that means for me, but I think certainly being lesbian there's a strong attachment to that idea of suicide – Charlie (55).

Within this excerpt, Charlie expressed how they developed their understanding of suicide through insights into why they had experienced suicidality (i.e., precipitants) and deriving meanings from these experiences. Similar notions were spoken about by other participants who explained that the links between suicide and queer/takatāpui identities were attributable to embodying such marginalised identities. Participants described suicide as a subject matter that was personal and connecting within their communities; contrasted against the perception that suicide was misunderstood by external communities. As such, suicide was positioned as an inevitable and enduring phenomenon, embedded through what it meant to be marginalised individuals within mainstream society:

> I see suicide as an inevitability, like a tragedy that's going to keep happening for the next few decades or longer. Whereas I think straight, and cis people see it as a thing that a sad teenager would do, or a stressed-out businessman […] they don't think about it as a minority who's been pushed down too many times to stand back up again. […] I doubt that any straight-cis person has gone, 'I'm probably going to commit suicide because of these statistics', whereas minority people probably have thought of this […] – Sloan (24).

Suicide was described as a concept that was often thought of by queer and takatāpui people; framing it as statistically prevalent and a phenomenon that was precipitated by the compounding discrimination of marginalised identities. For Sloan, suicide was thought of as something that would endure for the foreseeable future, like an inevitable tragedy for queer and takatāpui people. This was then contrasted against the idea that such notions were not conceivable for heterosexual and cisgender people, who instead seemingly attributed suicide to less nuanced and simpler causes, such as the sadness of adolescence or occupational stress. As such, one's understanding of suicide existed within the social climate in which one was exposed to; such that their frames of reference for suicide hinged upon how lived experiences varied among different communities.

In sum, suicide was defined as both a personal and a relational construct embedded within queer and takatāpui communities. Participant's descriptions of suicide were laden with notions that suicidality was both prominent within their communities and functioned as a means of

forming connections with fellow queer and takatāpui people through their shared experiences. In turn, these shared experiences elicited empathetic responses towards peers who had or were experiencing suicidality. The perspectives held by non-marginalised identities were described to highlight that queer and takatāpui people had greater awareness of the causes and consequences of suicide by comparison. For some, suicide was understood as inevitable within their communities due to embodying marginalised self-identities. Expanding upon the ideas within Theme One, Theme Two outlines the manner by which marginalised identities are positioned as responsible for vulnerability to suicide when labelled as "risk factors".

Theme Two: "You're Removing the Responsibility of the Society"

The current theme was developed from talk on the social use of 'risk factors' and is expressed as *"You're Removing the Responsibility of the Society"*. Participants denoted two ideas on the labelling of queer and takatāpui identities as risk factors for suicidality. Firstly, risk factors were deemed to be an appropriate term to describe suicide liability among people with marginalised identities (i.e., sexuality, gender and/or ethnicity) within certain contexts, which highlighted the need for these communities to receive greater support. Secondly, the language of risk factors was described by participants as being laden with connotations of judgement, understood to position marginalised people as responsible, or at fault, for their vulnerability to suicidality. Participants suggested that labelling phenomena as risk factors was devoid of an understanding as to *why* and *how* suicide was more prevalent among marginalised communities compared with dominant identities. Specifically, the label did not account for the role that discrimination played within developing suicide liability among queer and takatāpui people. Though seemingly incongruent, the two perspectives were linked by the idea that suicide *risk* reflected the impact of contemporary and historical societal ideologies (i.e., social norms), particularly hegemonic groups who act to marginalise through actions of racism, heteronormative, and cisgenderism. As such, participants rejected the idea of risk as an inherent attribute to their identities.

Participants talked about the contextual use of risk factors when applied to marginalised identities. Participants highlighted their awareness of the high prevalence of 'risk factors' being used to describe queer and takatāpui identities and included Māori within their discussions as well. This overrepresentation was linked with clinical definitions of risk factors, identifying elements which increased people's likelihood of experiencing suicidality. In some interviews,

risk factors were explored within the framework of assessments undertaken by mental health professionals and focused on the appropriateness of categorising marginalised identities as risk factors and subsequently disclosing this identified risk:

> I guess [risk factor] is context dependent. In a clinical setting, I'm more than happy for it to be called that. But, in kind of front facing, let's say mental health services, we should probably avoid using that term because of the self-fulfilling prophesy thing […] – Sawyer (24).

Within the above excerpt, a distinction was formed by Sawyer between clinical and mental health contexts. Sawyer denoted that risk factors was an appropriate term to be used within clinical contexts and discouraged its use when discussing suicidality face-to-face with a marginalised individual. Sawyer proposed that explicitly labelling marginalised identities as risk factors may result in this label being utilised as a point of reference for subsequent suicidality; explaining that knowledge of one's vulnerability to suicide may eventuate as a self-fulfilling prophesy. Illustrated is the idea of policing the language used when referring to suicidality and acknowledging the context in which one labels elements linked with suicide vulnerability.

Expanding upon the idea of contextualising risk factors, participants explained that queer and takatāpui people would have varying degrees of comfort with their identities being associated with this term:

> […] I guess if we think of tailoring [diagnoses] to takatāpui, some will think fine, research has said that if I have X, Y, Z, it's a risk factor; what can I do about it? Yet others might not want to wear any clinical terms and just want to deal with things as best they can. But I guess I'm a bit fence sitting there. For some, fine, for me it's fine, but for others, they might feel like it's pathologising them – Rongo (41).

Rongo equated risk factor to a diagnostic label in which takatāpui people could accept or reject. The way Rongo described risk factor as a label worn by the bearer positioned this term as one which may be internalised, akin to a manner of self-identifying. This description was similar to Sawyer's excerpt, whereby obtaining knowledge of one's vulnerability to suicidality reoriented one's perspective on the available solutions that could minimise such vulnerability, particularly when framed as arising from marginalised self-identities. For Rongo, this knowledge was framed as a deterministic inevitability in which garnering solutions was not possible (i.e., "*what can I do now?*"); a sense of hopelessness as such. This was contrasted against the idea that some takatāpui people may perceive the label of risk factor as denoting that their identities were pathologies. For these individuals, Rongo outlined that the rejection

of risk factor was linked with self-determination to cope with one's own vulnerability to suicide. As such, assimilating the label as a risk factor into one's sense of self was framed an active decision and by extension, the meanings attributed to this label (e.g., solution-focused, pathologising).

While discussing their comfort levels with the term risk factor, participants reflected on aspects missing from the understanding of suicide vulnerability. For Tanner, risk factor was understood to denote *what* or *who* was at risk, but neglected an explanation of *how* and *why* such risks existed:

> I don't think there is a term that is going to fit everyone, but I think it could be more so looked at as how, as opposed to what are the factors […] how do these exist, why do these exist, as opposed to what are the risks. It could be like, why are these people feeling this way […] and trying to create more solutions rather than putting it down as, you're a high risk […] – Tanner (22).

Tanner detailed a solution-focused approach to understanding risk and rejected the idea of an umbrella term (i.e., risk factor) for defining the elements that contributed to suicide vulnerability. Risk factors as an assessment exercise (e.g., "*what are the factors*") was critiqued as an unhelpful approach to understanding suicide, and thus, so to was attaching a label to such contributing factors. Instead, Tanner proposed that one's attention should focus on the dynamics which underpinned what was meant by risk; namely addressing what they called "*how*" and "*why*" risk existed, as a means of garnering solutions for suicidality. To label queer and takatāpui people as risk factors was framed as a means of placing responsibility on those who embodied marginalised identities and deflected away from understanding 'why' these individuals felt suicidal and 'how' this came to be. As such, Tanner discussed the need to develop solutions through understanding 'how' and 'why' marginalised identities were at elevated risk for suicidality. A similar sentiment was shared by Emerson, who equated the label of risk factor to an indicator of the need for greater societal support:

> I'd say that if [marginalised identities] are described as a risk factor than there should be more done to support them and make them feel included in society – Emerson (31).

The recognition of societal discrimination as a significant contributor to suicidality within marginalised communities was ubiquitous among participants. These discussions primarily focused on the lack of acknowledgement afforded to processes of discrimination when labelling marginalised identities as risk factors. Participants utilised metaphorical language

when talking about discrimination, equating it to a force which acted upon queer and takatāpui communities. This was exemplified through phrases including, "*beating down*", "*impacting on*", and "*pushing down*"; framing discrimination as both distressing to experience and a construct burdened upon marginalised identities.

The classification of marginalised identities as risk factors was understood to trivialise the subject matter of suicide vulnerability and posture queer and takatāpui identities as mere statistical phenomena. Participants described that the language of suicide risk failed to identify broader societal constructs which contributed to this suicide vulnerability:

> […] being in marginalised groups shouldn't be the risk factor, it's the corrosion that comes from the enforcement of social norms that should be considered the risk factor. So, the risk isn't that I'm Māori, the risk is that people hate Māori. The risk isn't that I'm trans, the risk is that people don't like that I'm trans, and that sucks, and it makes me feel terrible – Jordyn (20).

Jordyn highlighted how vulnerability to suicide resulted from dominant social norms that were enacted upon marginalised identities through the negative manner in which people would react towards these individuals. Jordyn reflected on the punitive views held by people towards their intersectional self-identities and paralleled these views with the enforcement of social norms, which oppressed both Māori and trans people. Thus, Jordyn positioned discrimination, or more broadly the prejudicial actions of the powerful against the powerless who do not fit within dominant social norms, as the contributor to suicide vulnerability within marginalised communities. This reframing of language was shared among participants who discussed how risk factor situated marginalised identities as responsible for their vulnerability to suicide.

Skyler also spoke of the complexities regarding the use of risk factor to describe marginalised identities and positioned institutional social norms as responsible for suicide vulnerability among these communities:

> […] people aren't born and then have some inherent thing that's going to develop inside of them to commit suicide or have suicidal ideation […] there's an environment around them that grows and develops or forces things upon them. […] [Marginalised groups] are risk factors to the system and its norms, but the way that people talk about it in terms of putting responsibility back onto these groups; it's super dangerous to label them as risk factors. You're telling me that because I've now done this massive work inside of myself and claimed an identity that is true to myself, that now that puts me at risk. […] In labelling these minority groups as the risk factor then you're removing the responsibility of the society, the wider context, and you're

> being complicit in maintaining that perspective that the problem lies with these minority groups and not the wider system – Skyler (31).

Skyler rejected the idea of suicidality risk as an inherent attribute located within marginalised people, instead emphasising that social "*forces*" from one's environment acted upon individuals and precipitated this liability. This notion was outlined in a manner which paralleled debates on *nature versus nurture*; common within scientific research endeavouring to explain human behaviours. Skyler framed people with marginalised identities as contrasting against dominant social norms and described these communities as threats to "*the system*" of society because their existence implied that these social norms needed to change in order to develop an inclusive social climate. The label of risk factor was understood to perpetuate the status quo of positioning marginalised people as responsible for their vulnerability to suicide, thus deflecting responsibility away from the impact of an unjust society. As such, the language of *risk* deemed who were *responsible* for suicide vulnerability within society.

In sum, participants outlined two perspectives on the social use of risk factor as a means of denoting factors which contributed to suicide vulnerability. On one side, participants explained that identifying risk factors held clinical utility, and that for some, this label would orientate their perspectives towards a solution-focused approach. The caveats to labelling individuals at risk for suicidality were notions that this may result in a self-fulfilling prophesy or interpreting risk factor as pathologising their self-identities. As such, risk factors were best to be identified, but not spoken of, when assessing queer and takatāpui people within mental health settings. On the other side, participants recognised that the language of suicide vulnerability focused on *who* and *what* was at risk but neglected a deeper understanding of *how* and *why* such risks existed for marginalised people; describing that risk factors should coincide with greater support. The labelling of marginalised identities as 'risk factors' was overtly rejected by some participants who reflected on social norms which placed queer and takatāpui people within positions of greater risk for suicidality, manifested by experiences of discrimination. By reframing the use of risk factors, participants explained that this label should be used to describe discrimination and social norms, since both were responsible for suicide vulnerability.

Theme Three: "Social Norms Require a Deviant Group"

Theme three, *"Social Norms Require a Deviant Group"*, encompasses the ways in which participants drew connections between institutional social norms and experiences of

discrimination as one pathway towards suicidal distress. These norms were understood to regulate what was deemed to be socially acceptable, constructed in relation to the ideals implied by heteronormativity and cisgenderism, which prohibited queer and takatāpui people membership to the dominant mainstream. Instead, people with marginalised identities were socially positioned as the "*deviant group*", a collective group who did not approximate to social ideals, thus permitted to be discriminated against by the dominant majority. Participants recognised that suicidal distress arose in the absence of acceptance and belongingness, even for people who repressed their marginalised identities as a means of adhering to social ideals.

Participants recognised that social norms functioned by creating conformity among the majority of the population. Queer and takatāpui people, who did not align with these social ideals and expectations, were socially positioned as the 'deviant group' and subjugated to the margins of the societal mainstream:

> Essentially because social norms require a deviant group to function, queer people almost universally end up in that deviant group and therefore excluded from things. Legally discriminated against, and even then, it isn't just the law. Those social norms are enforced through social behaviours, so we get excluded from groups, we get bashed, we get flyer campaigns about how we're threatening women's rights […] – Oakly (20).

As outlined by Oakly, social norms were understood to function by identifying a collective group of individuals in which to discriminate against. This may be thought of as an *in-group out-group* dynamic, whereby queer and takatāpui people formed the out-group to cisgender-heterosexual people's in-group. Oakly described these individuals as suffering discrimination across multiple contexts, including legally, socially, and physically. The multifaceted nature of discriminatory experiences highlighted the pervasiveness of discrimination, wherein social norms governed what was and was not acceptable. As such, discrimination (in form of what Oakly called, "*social behaviours*") serves the purpose of enforcing social norms as a means of perpetuating what was expected within the population.

Participants discussed the ways in which queer and takatāpui people do not adhere to social norms. Participants explained that individuals were expected to conform to social conventions, such as forming an intimate relationship with a person of the opposite binary gender, displaying congruency between gender expression and gender identity, as well as identifying with the sex one was assigned at birth. Breaking these social norms was understood to permit discrimination against queer and takatāpui individuals at both the micro- and macro- levels of daily life, from

interpersonal conflicts (e.g., verbal, and physical abuse) to broader systemic oppressions (e.g., exclusion from decisions on legislation). The following excerpt from Sloan outlined their personal experience of receiving adverse reactions from their whānau after having come out:

> What [discrimination] looked like to me was family members being angry, upset, or fearing for my safety because they knew of all these social norms and how people react when they're broken. It can look like physical violence, online harassment and there are things even up to, we're not there with the law making around [queer rights] and we always get pushed to the bottom of everything else – Sloan (24).

Shared among all participants, Sloan described discrimination as a spectrum of variating forms. At the micro end of the spectrum, Sloan was subjected to adverse reactions from family members, elicited from the disclosure that their gender identity did not align with gendered social norms. Underlying these adverse reactions were concerns for Sloan's wellbeing, recognising that by not conforming to the gender binary and cisgenderism Sloan may experience discrimination within their life. At the macro end of the spectrum, Sloan highlighted the exclusion of queer and takatāpui people from the creation of legislation and aligned this idea with the continual repression of these individuals. Both ends of the discriminatory spectrum functioned to uphold social norms, whether grounded within concern for one's wellbeing and safety, or exclusion from decisions regarding legislation which set the precedence for queer and takatāpui people's subjugated positions within society.

Participants spoke of the nuances regarding the social exclusion of queer and takatāpui people, reflecting on the concepts of *acceptance* and *belonging*. Dissecting these concepts, social exclusion from the mainstream society, on the basis of violating social norms, issued membership to the 'deviant group' and marginalised these individuals. In other words, rejection from the mainstream population (i.e., discrimination) categorised one as belonging to this external group. While discussing the development of suicidality, participants described the internalisation of social messages that queer and takatāpui people did not belong within mainstream society. This internalising process was driven by the notion that acceptance was an unobtainable process:

> Isolation, discrimination, marginalisation, feeling of not fitting in and it's their fault. When they feel like they're a disappointment to the entire world, and when you've got no support, you go down those roads and you get those thoughts of, 'well no one's going to ever accept me, so I might as well not be here'. I think that is such a dangerous pattern that a lot of people in the LGBT+ community end up in – Tanner (21).

Tanner highlighted the sense of self-blame that queer and takatāpui people experienced due to feeling as though they do not fit into society and being subjected to multiple forms of prejudice. This social positioning as "*a disappointment*" to others, compounded by the absence of social support, was understood to elicit a trajectory towards passive suicidal ideation. Tanner paralleled the idea of acceptance as an unobtainable experience with contemplation that one was better to cease to exist. As such, experiences of discrimination positioned marginalised individuals as not belonging to the mainstream society, precipitating suicidal thoughts for those who take onus for this type of social rejection. Similar notions were shared by Charlie, who explained their experiences of receiving both implicit and explicit messages of not belonging:

> I think that since I was very young and I realised I was a lesbian, it's like society was saying you don't belong here, and logically, if you don't belong here, as in within our society, then people would literally say, 'go to hell'. So, I think there's a subliminal and direct message of you're not welcome, which literally means die […] – Charlie (55).

Charlie spoke of an embedded ideology within society that propelled the social exclusion of queer and takatāpui people, manifesting as active discriminatory social messages against these individuals ("*go to hell*"). The pervasiveness of these discriminatory social messages was highlighted by Charlie, feeling as though they did not belong within mainstream society since a young age, and by extension, insinuating that marginalised people should cease to exist.

For some participants, the idea of being accepted, and belonging, within mainstream society were thwarted when confronted with rejection, or the anticipation of rejection. These participants described how being rejected, or the anticipation of rejection, was seen as a precipitant of suicidality. As such, social norms imposed a pressure upon queer and takatāpui people to remain closeted as a means of avoiding such rejection:

> When I was sixteen, I was having these thoughts that I may be gay, so I thought I'm going to kill myself. I'm not going to be able to overcome this or I'm not going to be accepted in my family, my father, my brother; I just don't want to go through that. So, it was just the answer really – Emerson (31).

Within Emerson's excerpt, the phrase, "*not going to be able to overcome this*" could be interpreted in two ways. Firstly, an inability to overcome rejection from family members if Emerson were to come out, or secondly, an inability to overcome/change their queer sexuality to align with heterosexuality. By either interpretation, the contemplation of their gay identity and coming out elicited suicidal thoughts for Emerson due to the anticipation that disclosure would entail familial rejection. As such, the idea of ending one's own life was understood to

function as a solution to such anticipated discrimination. Expanding upon discussions of rejection, Atawhai spoke of belongingness and acceptance as significant aspects towards validating marginalised identities:

> Whānau rejection is a big one. Just rejection in general from wider society. Being closeted and not having a community around you that can validate your identity, especially for those of our whānau who grow up in rural and isolated communities where takatāpui people exist but are not visibly out there doing things – Atawhai (23).

Atawhai described both whānau rejection and broader societal rejection as significant contributors to suicidality. For closeted takatāpui people, a sense of community was understood to be an important source of validation towards their marginalised identities, particularly for those in geographically isolated areas whereby other takatāpui people may not be visible. As such, rejection not only from the hegemonic group, but also an inability to be accepted by the out-group when still closeted. Similar sentiments were shared by other participants who spoke of the significant role that validation played during the process of formulating their sexualities and gender identities, including the act of coming out. Within Atawhai's excerpt, visibility to groups of individuals who shared marginalised identities formed a basis for such validation, which in turn may be understood as belonging to the 'deviant group'.

In contrast to the rejection raised by Emerson and Atawhai, other participants discussed ways in which queer and takatāpui could avoid being constructed as part of the 'deviant group' despite holding marginalised identities. This process entailed assimilating into mainstream society through enacting widely held social conventions:

> In New Zealand you can escape that deviance if you're like a married, white-picket fence queer – Oakly (20).

Within Oakly's excerpt, social acceptance was garnered from an expectation of queer people to perform normativity through enacting conventional lifestyle practices, such as marriage. Conformity to being a "*white-picket fence queer*" was recognised as a protective factor against discrimination, and by extension, relinquished one's degree of "*deviance*" from social norms by intersecting with ideals established within the hegemonic group. Oakly later discussed how imposed pressures to conform to these social norms may elicit suicidal thoughts among queer and takatāpui people who are unable to assimilate social ideals and expectations:

> […] if you're out and you get excluded from things and bashed, it's going to take a toll on you. You're actively regulated by society and a lot of those messages are you conform, or you die,

> and for people who aren't able to conform, die is the option, and so you start to think, 'well what if I did? – Oakly (20).

Oakly framed social and physical forms of discrimination as the means by which society projects the message that queer and takatāpui people need to conform to social norms or die. Within this instance, the social message of *conform or die* represented an imposed dichotomous choice regarding *how* one would be regulated by mainstream society. To note, the idea of resisting these social messages was neglected from Oakly's example, which may have taken the form of embracing one's belongingness to the 'deviant group' rather than actively avoiding it. This would pose a further dichotomy, whereby one could be out and proud about their identities, thus rejecting hegemonic social ideals, or to try and fit in, which positions queer and takatāpui identities as inherently shameful.

Adding a contrasting perspective to the idea of conformity, Frankie discussed the consequence that arise from repressing one's marginalised identities as a means of conforming to social norms:

> I didn't grow up with the notion of gay is bad, but I did grow up with some quite conservative notions of sexuality and desire […], and then that conservative religious stuff, I think all of those were like habits of mind which meant I tried to control my sexuality. […] I think my theory is that I was bi, but I didn't allow myself to know it, and I think if you shut down any part of your identity, you shut down the whole thing. […] I think that means that your psychological resources; and even just knowing what you want, you're more vulnerable to anything […] – Frankie (35).

For Frankie, conservative religious ideologies were positioned as tools that could be utilised to control and repress their marginalised sexuality. Marginalised sexualities and gender identities were framed as integral components of queer and takatāpui people, referring to the repression of these as an act of *shutting down* one's whole self. Frankie then highlighted the decompensations that occur to one's psychological faculties and decision-making abilities through repressing the self, such as vulnerability to stressors. As such, to conform to social norms was to deny or closet one's true self, which revoked belonging to the 'deviant group', but also placed one within a position of vulnerability to suicidality due to a lack of self-acceptance.

Participants reflected on larger ideas of what it meant to be individuals discriminated against because of their sexualities and gender identities. Again, at the superficial level, these

experiences of discrimination manifested as rejection and social exclusion from mainstream society due to deviating from social norms. However, within these discussions participants spoke of deeper understandings on how disconnection, even from the 'deviant group', unfortunately resulted in trajectories towards suicide through an inability to envision a meaningful future:

> I think something about being connected to whatever communities you want to be in. Those communities support your future and suicidality is about not seeing that, not connecting to a future, not feeling valued as a person. I think it's when you've got multiple not-connections, that'll lead to suicide […] – Charlie (55).

Within this excerpt, Charlie spoke of individual desires to be positioned within specific communities, which may have represented sources of both acceptance and belongingness. One's value as an individual and connection with a future were linked to these communities, whereby disconnection was framed as a severing of one's own future. The phrase, "*multiple not-connections*", highlighted the complexities regarding disconnection as a precipitant for suicide and the nuances of belonging within a community. In particular, Charlie emphasised that these connections were pluralistic, contributing to an individual's ability to see themself in the future. Expanding upon the idea of connection, Charlie discussed the role of existential thoughts within the trajectory towards suicide for queer and takatāpui people:

> It's very hard to know why somebody tips into actually carrying out suicide but I think an existential thing is a big factor and we carry in our community an existential vision, and if you're not connected to that, it can be a reason not to live. […] I think for us, in our community, it can be that we're okay, that we have a future, and if that gets knocked about, I think people are more inclined to kill themselves for relief – Charlie (55).

Understanding an individual's decision to take their own life was framed as a multifaceted process, such that the absence of an existential vision constituted one contributing factor. Charlie spoke of an existential vision embedded within the collective queer and takatāpui community (i.e., "*our community*"), which reflected that group members could envision a hopeful future existence ("*we're okay*", "*we have a future*"). In turn, suicide was framed as a means of alleviating the distress that accompanied one's inability to envision this hopeful and meaningful future constructed from within the 'deviant group'.

In sum, the 'deviant group' denoted queer and takatāpui as a collective of individuals subjected to discrimination on the basis that they deviated from dominant social norms regarding sexuality, gender expression, and identity. These social norms were understood to regulate

conformity within society by enforcing the ideals of heteronormativity, the gender binary and cisgenderism. The 'deviant group' represented the antagonist to social ideals by the ways in which they violated these social norms, positioning queer and takatāpui people as *rejected* and *socially excluded* from mainstream society, as well as whānau in some instances. Both implicit and explicit social messages proliferated the idea that these marginalised individuals did not belong within mainstream society and should cease to exist, creating the mentality of an *in-group* and an *out-group*. The concepts of *acceptance* and *belongingness* were obstructed by both active and anticipated forms of rejection, representing a disconnection from people who were able to provide validation to marginalised identities. In turn, these experiences of rejection and invalidation were framed as catalysts for suicidal ideation. Contrastingly, remaining closeted or enacting normative practices, such as same-sex marriage, was framed as a means of escaping the 'deviant group' through conformity to social norms. However, this presented a caveat, whereby repressing aspects of one's own self (i.e., identity) was understood to place them within a position of being vulnerable to suicidality. Multiple disconnections from communities were described as catalysts within the trajectory towards suicide by the way these severed 'the deviant group' from envisioning a meaningful future where they existed.

Theme Four: "The Straw that Broke the Camel's Back"

The centralising concept for theme four was the idiom, *"the Straw that Broke the Camel's Back"*, used as an analogy for the idea that compounding discrimination functioned as a precipitant for suicidality. In turn, when one's capacities to compensate (e.g., resist, cope) were exceeded by accumulated stress, decompensation occurred, such that suicide was perceived as one option to escape from distress.

Experiences of discrimination and the invalidation of one's sexuality and gender identities were positioned by participants as significant sources of stress for queer and takatāpui people. This was conceptualised as cumulative across time. As such, stress was understood to "*build-up*" to an extent which exceeded one's capacity to cope, thus eliciting a trajectory towards actions to end one's life:

> It's like a build-up; the straw that broke the camel's back because I don't think many suicide attempts are simple. I don't think they come from single causes. I think there's this whole laundry list of things that have gone wrong or have continued to go wrong for years that just

> build up […] part of drastically reducing suicide is removing those systemic factors that are adding to the laundry list until someone can't cope anymore – Archer (24).

As indicated in this excerpt by Archer, suicide attempts were understood by participants to be precipitated by multiple stressors rather than a singular one. Archer subsequently described "*systemic factors*" as contributors to suicide, implying that stress may be imposed upon queer and takatāpui people from external stressors rather than internal attributes.

Participants acknowledged that the trajectory from suicidal ideation to suicide was complex and nonlinear. Participants rejected the notion that there was a formulaic quality or quantity of stressors that elicited people's trajectory towards attempting suicide. Instead, participants highlighted that precipitating stressors could vary in terms of magnitude, ranging from smaller incidents (e.g., remarks from strangers, instances of rejection, "*micro-societal-aggressions*") to larger incidents (e.g., physical and verbal abuse, traumatic events). As well, varying in terms of the number of stressors that one could tolerate before stress levels would exceed coping capacity:

> I think everyone has their limit, like a breaking point, and that's the great unknown. So, for some people the straw that broke the camel's back is I told my aunty that I was feeling this way and she didn't listen. That could be the difference for one person. Yet, it could take a decade of build-up for someone else to get to that point […] – Rongo (41).

As outlined by Rongo, both the chronicity and types of stressors which could precipitate suicide attempts were recognised as heterogenous among queer and takatāpui people. The "*breaking point*" was understood by Rongo, and other participants, to be unique for every individual and determined by one's capacity to compensate for accumulated stress. Across interviews, the term 'breaking point' seemingly referred to the point in which individuals went from contemplating suicide (i.e., suicidal ideation) to then acting upon these thoughts by attempting to end their own lives.

When discussing the concept of the 'breaking point', participants identified a number of ideas regarding the function of suicide in relation to accumulated stress. These included the idea that suicide functioned as a form of escapism from aversive situations; a viable solution for psychological distress; and a reaction to anticipated ongoing discrimination when reprieve was perceived as unachievable. Within the following excerpt, Atawhai explained their experience of reaching their 'breaking point', speaking to ideas relating suicide to both escapism and difficulties with problem-solving:

> These little instances of discrimination, or instances of rejection, that then just became this mountainous thing that I couldn't escape anymore. I think you get to a point where you're just tired of having to deal with all this external shit […] and when you you're continuously in that space, and you can't find a way out of that space, it exhausts you – Atawhai (23).

Atawhai framed their trajectory towards attempted suicide as having been precipitated by external stressors, reinforcing the idea of stress as an external force imposed upon queer and takatāpui people. This excerpt brings in the notion of hopelessness, whereby Atawhai described a sense that no alternative solutions existed for them to leave the "*space*" of ongoing exposure to stressors. The cumbersomeness of chronic discrimination, and continuously seeking a means of escaping it (i.e., problem-solving), precipitated suicidality for Atawhai and other participants.

In sum, 'the straw that broke the camel's back' was used as a metaphor for suicide resulting from accumulated stress. Participants discussed discriminatory experiences as a source of stress and in turn these stressors could cumulate with time. The qualities and quantities of stressors were described as variable, as well as the sources of these stressors (e.g., smaller and larger incidents of discrimination). Each individual's tolerance for stress was recognised as differing, wherein one's 'breaking point' to attempting suicide was when one's coping capacity was exceeded by their distress. While discussing the functions of suicide, participants outlined notions relating suicide to escapism, problem-solving and anticipation of ongoing discrimination without reprieve.

Theme Five: Ethnicity and Resilience to Suicidality

The theme, *Ethnicity and Resilience to Suicidality*, was developed from the dual perspectives discussed by Māori and Pākehā participants. The central idea was a shared understanding among participants that ethnic identities contribute to queer and takatāpui people's resilience to suicidality. Participants explicitly spoke to their own ethnicities, which presented differing ways in which Māori and Pākehā conceptualised their relationships to resilience against suicidality. Specifically, differences arose as participants talked about where sources of resilience were positioned within society and themselves, and how resilience was produced from their ethnicities. These discussions are captured within the two subthemes, *Whakapapa of Resistance* and *Individualist Privilege*.

The views expressed by Māori and Pākehā participants can be thought of as complimentary, rather than conflicting beliefs on how resilience should be defined or enacted. Participants spoke of this resilience from the positions of their own ethnic identities, rather than speaking on behalf of other ethnic identities that they did not intersect with. From the perspectives of takatāpui participants, Māori were characterised as a collectivist social structure, placing importance on the principles of resistance to colonisation through connectivity with whānau, whenua and tūpuna. From Pākehā participants, the social structure of Pākehā was characterised as individualistic, emphasising one's social independence and privileged social status when compared with Māori. These discussions did not function to pit the two cultural worldviews against one another, but rather acknowledged the different ways in which ethnic identities bolstered queer and takatāpui peoples' resilience against social factors that precipitated suicidality.

Subtheme One: Whakapapa of Resilience

For Māori participants, their resiliency as takatāpui people was garnered through the historical actions undertaken by their tūpuna which ensured the continuation of their whakapapa despite colonial devastation:

> I think we have this really beautiful way of looking at the world […and] connectedness. My mum always said your tūpuna fought really hard for you to be here. When I learned our history, and I learned more about being Māori, I found it really hard to want to isolate myself, and to want to hurt myself, because there was this whole history and all of these people that contributed to me being here […] – Atawhai (23).

For Atawhai, obtaining mātauranga on Te Ao Māori and the colonial history of Aotearoa represented a point of healing from their social isolation and self-harm. This perspective framed Māori resiliency not only as the action of looking to the past, but also connecting with the past, as a means of moving forward from suicidality. By understanding the resistance of their tūpuna who had come before, Atawhai explained that their desires to isolate and self-harm lessened. Similar sentiments and ideas were also shared by Skyler, who reflected on the connections between the intentions of colonisation and contemporary Māori resistance:

> I think for me, the deepening of my understandings of colonisation and the massive resistance that Māori continue to have against colonising powers, that history is empowering when you think about it as a whakapapa into your own bloodstream. Those things that have happened allow me to be able to stand and know that I whakapapa to these iwi; that's huge, and the more I understand the gravity and context, the bigger that becomes as a point of resilience inside of

> me. So, we're talking about it in relation to suicide, if you think about colonisation the point of it is to wipe out people, and so in a way committing suicide helps with that. I'm not saying it's a colonising act or an act of someone who has been colonised. But for me, coming so close to having done that and then not, and now being able to framework things, […] but to know that and then be like, 'oh I didn't, I'm here', and every day that I breathe is an act of Māori resistance to that colonising power – Skyler (31).

Skyler framed two pieces of knowledge on Aotearoa's history as a source of resilience against suicidality for takatāpui people. First, an understanding that colonisation aimed to both eradicate and assimilate Māori; and second, that Māori resisted these colonial processes. Thus, Skyler described the existence of Māori as a representation of the ongoing Māori resistance against the Eurocentric power structures embedded within contemporary society. Further, Skyler paralleled suicide with the functions of colonisation, and positioned whakapapa as the mechanism which connected takatāpui people to their capacity to overcome suicidality. As such, Skyler explained that one's Māori identity garnered resiliency from meaningful connections to the past (i.e., whakapapa) and in turn feeling empowered from the knowledge that tūpuna resisted colonisation.

Takatāpui participants spoke of the attributes embedded within their Māori identities that enhanced their resilience to suicidality. These attributes were framed as strengths that formed the foundation of modern Māoridom, which included advocacy, determination, creativity, and empowerment from connections with atua and whenua. To exemplify, Winter spoke of the necessity of indigenous voices within queer spaces as a means of creating changes:

> Advocacy. Making an impact. It's ingrained in us to be strong and the creativity as well. Resiliency against suicide. Being that voice within those communities because I think voices from Māori and Pacific communities, who are from rainbow communities, I feel they should standout more, and I'm not talking about race or colour, but I'm talking about; because it is ingrained in indigenous people to have a strong voice […] – Winter (21).

Winter framed takatāpui people as strong, creative, and advocative individuals, recognising that these strengths were ingrained within their identities as Māori. The voices from queer Māori and Pasifika people were positioned as unique from the overarching perspectives held within queer communities and in turn were ones that should be heard amongst these communities. Emphasis on providing indigenous queer voices with the space to standout was not based on these individuals' ethnicities or skin colour, but instead regarding the strength held within these voices to advocate and usher in social change.

While discussing the intersection of Māori and queer identities, Jordyn reflected on what it meant to be takatāpui within contemporary society:

> Being Māori in the modern day, having an intense and unshakable belief in our self-determination, I think the principles of modern Māoridom, Te Ao Māori, really gives us a lot of strengths. While sometimes it can be hurt by the fact that not everyone in the Māori community accepts takatāpui yet, that unshakable belief is so important for our resilience to everything that happens. I think my resilience to transphobia and homophobia are a sprout or a branch of my staunch Māori-ness […] – Jordyn (20).

Jordyn described dichotomous perspectives on takatāpui people's relationship with their Māori identities. Emphasis was primarily placed on the staunch self-determination embedded within the principles of modern Māoridom, which contributed to one's resilience to suicidality and discrimination in the forms of homophobia and transphobia. From this, one's Māori identity was conceptualised as a protective factor against the contemporary social climate which discriminated against takatāpui people. In the same vein, Jordyn highlighted that takatāpui people were not fully embraced within Māori communities, forming a rift between their source of resilience and their source of discrimination. Despite this dual positioning, Jordyn ultimately framed one's Māori identity as an intrinsic component of takatāpui people's resilience to suicidality.

Subtheme Two: Individualist Privilege

For Pākehā participants, resilience to suicidality was identified as a socially embedded construct within Aotearoa, manifesting as affirming social norms regarding their ethnic identities. Through the ongoing process of colonisation, Māori had been displaced into the social position of 'minorities' within Aotearoa, which in turn established Pākehā and Eurocentrism as the pinnacle of social ideals. As such, the contemporary social climate afforded Pākehā access to privileges that were not readily available to Māori:

> I think White privilege is unfortunately a really big thing in New Zealand. I think as a European person, I am taken more seriously than someone of colour. I think it's wrong, but I think you kind of get a resiliency by the fact that you don't get attacked for race or ethnicity, because you've got that privilege of being European […] – Tanner (21).

Within Tanner's excerpt, Pākehā voices were implied to hold more authority and to be more socially accepted in comparison to the voices of people of colour (POC). The statement of "*more seriously*" implied a devaluing of the perspectives from POC, which reinforced the

higher social status inequitably given to Pākehā. Tanner described that resilience to suicidality was garnered from the absence of racism towards one's Pākehā identity, representing an underpinning of White supremacy within Aotearoa. Participants further acknowledged the effects of intersectionality on the relationship between Pākehā identities and resilience:

> As a Pākehā, I don't have to face; because minorities stack, and when you have the effects stack it isn't necessary nice, and I don't have to deal with the disproportionate amount that; because there's already the racial wage-gap and there's the queer wage-gap as well, and there's that you're far more likely to be harassed or discriminated against verbally and physically if you are non-White and queer. That's just an added societal risk factor that happens – Sloan (24).

Sloan referenced the compounding discrimination experienced by those who intersected with multiple marginalised identities. This took the forms of economic inequities, as well as verbal and physical abuse; added effects on the basis of being both being queer and non-white. In contrast, Sloan identified that Pākehā were not subjected to the same disproportionate experiences of discrimination, framing these as risks imposed by society. As such, the social norms of Aotearoa fell in favour of Pākehā queer people through diminishing the layers of adversities these individuals experienced.

Pākehā participants spoke of an individualistic approach to familial bonds that underpinned the social structure of Pākehā culture. One's family was acknowledged as a source of resilience through social support for some participants, while also recognising that the loosening of familial bonds was not uncommon for Pākehā. While discussing the role of family within suicide prevention, Oakly outlined dichotomous views on individualism:

> […] I mean this may be an overgeneralisation cause I'm White, but Pākehā people put less emphasis on family helping each other, real individualistic social structure. On one hand that was a benefit because it did mean that I was able to not speak to my [family member] for a year in order to recover, but on the other hand it also meant that I was on my own functionally. […] I think that if I'd had a good family, being Pākehā would still have been a bit of an impact because we're less inclined to honour those bonds – Oakly (20).

From one aspect, disinclination towards honouring family bonds afforded Pākehā the capacity to sever ties with family members who invalidated their queer identities. Oakly attributed this to a reduced obligation to help family members within Pākehā society. Regarding the other aspect, Oakly described a caveat to individualism, whereby to socially isolate from family meant a reduction in one's access to social support. Oakly highlights the valuing of independence within Pākehā culture, which bolstered resilience to suicidality through one's

autonomous decisions rather than directly drawing upon an established social collective (i.e., family). Participants further emphasised the greater access to resources afforded to Pākehā on the basis of their ethnic identities being privileged:

> I guess White queer people have a certain level of luxury in terms of social capital and economic capital to access help, and I think that makes us more resilient because we can access help in a more readily and timely fashion. I don't think there's anything necessarily innate about Pākehā culture, but I think it's just we have the luxury of getting help quicker – Sawyer (24).

Sawyer spoke of their experience with accessing mental health services during a period of experienced psychological distress and suicidal ideation. Resilience was not positioned as an innate quality of Pākehā culture, but instead defined by social norms which privileged those who identified as Pākehā. Within Sawyer's excerpt, this resilience was characterised as access to social and economic capitals which eased the process of obtaining mental health resources.

In sum, participants described resilience to suicidality from the perspectives of their own respective ethnic identities. Rather than their explanations being in conflict with one another, Māori and Pākehā participants spoke of the unique ways in which their cultural norms garnered them resilience. For Māori participants, the *Whakapapa of Resistance* was established through their tūpuna whom had resisted the colonial processes of eradication and assimilation. These takatāpui participants discussed their connections to this history which provided them with a sense of strength, whereby the existence of Māori within contemporary Aotearoa represented their ongoing resistance to colonisation. As such, takatāpui participants' resilience was characterised by self-determination and advocacy for change, which challenged transphobia and homophobia. For queer Pākehā participants, resilience was defined by the sentiment of *Individualist Privilege*, which reflected the inequitable benefits afforded to Pākehā through White privilege and protection from racism. Pākehā participants described the Pākehā social structure as individualist, whereby autonomous decision-making was valued as a means of severing ties with those who invalidated one's queer identities. Further, society was understood to facilitate their access to mental health resources through social and economic capital. In turn, their resilience was characterised by acquired external privileges, rather than innate attributes. Overall, this theme demonstrates that both Māori and Pākehā experience resilience to suicidality relating to their ethnicities.

General Discussion: The Big Picture

From Theories to Findings

In this thesis, I endeavoured to answer an overarching question, *how can suicidality among queer and takatāpui people be explained and understood?* On the background of past research conducted in Aotearoa, I aimed to further our knowledge of suicidality among queer and takatāpui people 1) from the perspectives of these individuals, and 2) through modelling the pathways from suicidal ideation to attempting suicide. I utilised two methodological approaches to undertake this aim, one quantitative study and one qualitative study, informed by the Three-Step Theory of suicide and the Theory of Decompensation, respectively. In this chapter, I begin by situating the findings from these two studies within the broader literature regarding suicide and integrate these findings into their respective theories as applicable. Next, I discuss implications for clinical practice and suicide prevention in Aotearoa, and subsequently outline the strengths and limitations of my research. I make suggestions for future research directions, reflect on my research journey from 2018 until 2023, and end with my concluding thoughts.

To date, research conducted in Aotearoa has extensively shown that people with diverse sexualities and genders are significantly more likely to experience suicidality compared with cisgender-heterosexual counterparts (Fergusson et al., 1999; Skegg et al., 2003; Fergusson et al., 2005; Lucassen et al., 2011; Clarke et al., 2014; Lucassen et al., 2015; Chiang et al., 2017; Spittlehouse et al., 2020; Tan et al., 2021). With exception to a few studies (e.g., Fenaughty & Harré, 2003; Schimanski & Treharne, 2019), attempts to understand and explain experiences of suicidality among queer and takatāpui people using theoretical frameworks have not been undertaken in Aotearoa. Thus, my research bridged some of this gap between experiential suicidality and potential underpinning mechanisms by applying Klonsky and May's (2015) Three-Step (3ST) of suicide and Riggs and Treharne's (2017) Theory of Decompensation (ToD).

Modelling Suicidality as Processes

In study one, the three steps from the 3ST of suicide were operationalised into 12 hypotheses to examine their applicability to 250 queer and takatāpui people. For step-one, it was anticipated that the interaction of social discrimination with hopelessness would predict recent suicidal ideation. Consistent with hypotheses 1 and 2, both discrimination and hopelessness were positively correlated with suicidal ideation, as well as positively correlated with one another. However, the results for hypotheses 3, 4, and 5, showed mixed support for step-one in the 3ST. Both hopelessness and discrimination independently predicted recent suicidal ideation, eliciting increases of 8.95 and 2.19, respectively. Contradictory to hypothesis 5, the interaction of hopelessness and discrimination did not significantly predict suicidal ideation, which is inconsistent with prior examinations of the 3ST (Dhingra et al., 2018; Wolford-Clevenger, 2021). These findings indicate that while experiencing social discrimination and feeling hopeless may independently drive suicidal ideation among queer and takatāpui people, the simultaneous occurrence of both does not seem to influence the strength of eithers effect on suicidal ideation. One explanation is that social discrimination and hopelessness may be better conceptualised as two separate pathways to thoughts of suicide, whereby other mechanisms account for their associations with suicidal ideation, such as, psychological pain (Peterson et al., 2021) or depressive symptoms (Langhinrichsen-Rohling et al., 2011; Mustanski & Liu, 2013; Hirsch et al., 2017).

One further explanation of the null finding for hypothesis 5 may be the type of hopelessness measured within the current study. Salentine et al. (2020) examined the mediating effect of "hopelessness regarding thwarted belongingness" (p. 19) on the relationship between experiences of discrimination and suicidal ideation among 178 queer people. Results showed that the positive association between discrimination and suicidal ideation (B = .52, p = .005) was indirectly mediated by this form of hopelessness (Salentine et al., 2020). In relation to the current study, the belief that one's future will be characterised by disconnection from others (i.e., hopelessness towards belonging) could more strongly influence the positive association between discrimination and suicidal ideation among queer and takatāpui people, compared with generally feeling hopeless. Future research is required to examine whether this claim amounts beyond speculation. To further explore how discrimination and hopelessness related to suicidal ideation, participants were grouped according to their discrimination and hopelessness severity. Consistent with hypothesis 6, suicidal ideation was greater among queer

and takatāpui people with high discrimination and hopelessness scores compared to participants with low discrimination and/or hopelessness scores. This finding is consistent with Klonsky and May's (2015) original examination of step-one of the 3ST.

For step-two, it was anticipated that social support would buffer against the escalation of suicidal ideation: 1) among participants with high discrimination and hopelessness, and 2) when social support exceeds social discrimination. To examine these two independent stipulations of step-two, hypotheses 7, 8, 9, and 10 were developed, which were informed by the analytic approach utilised in Yang et al. (2019). Consistent with hypothesis 7, the negative relationship between social support and suicidal ideation was stronger for participants who experienced high discrimination and hopelessness compared with other participants. As anticipated for hypothesis 8, among participants who scored high on discrimination and hopelessness, suicidal ideation was less severe when their social support exceeded their experiences of discrimination, compared with participants whose discrimination exceeded their social support. Aligning with hypothesis 9, there was no significant difference in suicidal ideation severity among all other participants irrespective of whether social support exceeded discrimination. Overall, these findings support the applicability of step-two in the 3ST among queer and takatāpui people (Klonsky & May, 2015; Yang et al., 2019; Wolford-Clevenger et al., 2021), and provide a novel approach to applying and understandings the concept of connectedness within these communities.

Rogers et al. (2021) found that higher levels of connectedness with queer communities strengthened the moderated pathways from social discrimination to internalised homophobia, and internalised homophobia to suicidal ideation, rather than lower levels. This finding seemingly contrasted with the process of connectedness as a protective factor against suicidality. As such, the current study applied social support and results were indicative of a buffering effect from higher social support; suggesting that the underlying protective mechanism is not in regard to social connections alone, but rather, whether these connections provide support towards queer and takatāpui people (Liu & Mustanski, 2012; Trujillo et al., 2017; Treharne et al., 2020).

For step-three, it was anticipated that acquired capacity for suicide would differentiate between past suicidal attempts and suicidal ideation. Here, acquired capacity was specified as the number of different non-suicidal self-injury (NSSI) methods that participants had undertaken

in the past. Consistent with hypothesis 11, queer and takatāpui people with histories of both suicidal ideation and suicide attempts had used more novel NSSI methods compared with those who had only experienced suicidal ideation. In hypothesis 12, the capacities of NSSI and suicidal ideation to predict suicidality status were compared and showed that NSSI was a stronger predictor of past suicide attempts compared with suicidal ideation. In addition, the predictive capacity of NSSI was more accurate at classifying participants with histories of attempted suicide (74.8%), when compared with suicidal ideation as the predictor (65%) or when both NSSI and suicidal ideation were used as predictors (73.2%). These findings support the applicability of step-three in the 3ST to queer and takatāpui people, and align with past research showing that engaging in NSSI may contribute to subsequent attempts of suicide (Reisner et al., 2014). Unfortunately, there is currently a dearth of research examining how NSSI may function as a form of acquired capacity for suicide among people with diverse sexualities and genders. Studies conducted with general samples suggest that repeated instances of NSSI may desensitise one to the experience of pain, having shown that a lower sense of pain and higher pain threshold contribute to the NSSI-attempt pathway (Ammerman et al., 2016; Law et al., 2017).

The 3ST of suicide has been tested in samples of adolescents in Aotearoa (Schimanski et al., 2017), community members (Pachkowski et al., 2021) and psychiatric inpatients in Canada (Tsai et al., 2021), university students in China (Yang et al., 2019) and the UK (Dhingra et al., 2018), and transgender people in the USA (Wolford-Clevenger et al., 2021). In the current research project, I examined a novel adaptation of the 3ST of suicide (Klonsky & May, 2015), which builds upon these past works in several ways. Firstly, with exception to one study that approximated schizophrenia liability to a form of pain (Schimanski et al., 2017), prior applications of the 3ST have predominantly used measures of psychache. Here, I theorised that social discrimination was a painful experience for queer and takatāpui people; thus, shifting the application of pain from perceptual (i.e., psychological pain) to experiential (i.e., Everyday Discrimination Scale). Though my findings only partially supported the applicability of step-one in the 3ST, results indicate that both discrimination and hopelessness contribute to suicidal ideation among queer and takatāpui people. Secondly, prior evaluations of step-three in the 3ST have employed the Suicide Capacity Scale (Klonsky & May, 2015) and the Acquired Capacity for Suicide Scale (Van Orden et al., 2008) to measure suicide capacity. Rather than relying upon these two broader measures, I applied a specified form of acquired suicide capacity, lifetime methods of NSSI, which was shown to be a robust predictor of attempted

suicide (Kiekens et al., 2018; May & Victor, 2018; Griep & MacKinnon, 2022). Thirdly, the current study directly expanded upon the research conducted by Wolford-Clevenger et al. (2021) in two ways; 1) a larger sample size (n = 250) was employed, of which 59.5% were gender diverse, and 2) all three steps in the 3ST were examined, rather than step-one and step-two in isolation. As such, the findings from my study provide unique insights into how Klonsky and May's (2015) 3ST of suicide may be adapted to explain suicidality among queer and takatāpui people in Aotearoa.

Frameworks for Understanding Suicide, Discrimination, and Resistance

In study two, the ToD was used to inform a qualitative approach to understanding suicide from the perspectives of 20 queer and takatāpui people who had experienced suicidality. To do so, the language of decompensation was developed into an interview schedule pertaining to suicide, discrimination, and resilience. As well, a reflexive form of thematic analysis was used to code and interpret interview data, underpinned by the constructs of ideology, intersectionality, and privilege. In the subsequent sections, I will discuss the five themes that I developed, situating these within the ToD and broader literature regarding suicidality.

Meanings for Suicide and 'Risk Factor'

While participants talked about suicide within the context of their own personal experiences of suicidality, their understandings of suicide were seemingly orientated towards social processes embedded within their communities. Starting with the subjecthood of suicide, such as describing what suicide was, participants progressed to discussing how suicide was experienced among queer and takatāpui people. In turn, 'suicide' was constructed both subjectively and experientially, whereby the topic of suicide became a 'tangible' entity through the ways that queer and takatāpui people held shared meanings towards it. As such, the first theme highlighted that suicide was "*Not just this Amorphous Subject*", but rather known by participants to be a common phenomenon, mentioning the higher rates of suicidality within queer and takatāpui communities (Fergusson et al., 1999; Skegg et al., 2003; Fergusson et al., 2005; Spittlehouse et al., 2020; Tan et al., 2021). The commonality of suicide provided a basis for the language and experience of suicidality to function as a point of connection with other queer and takatāpui people. In this regard, participants framed suicide as a relational resource, such that shared experiences of suicidality, either within oneself or knowing others who were suicidal, could build connections with people who had the same identity labels.

An interesting point arose during these conversations on connectivity. Participants recognised that suicide was more openly discussed within queer and takatāpui communities, compared with the hegemonic society. This perspective aligns with my prior research where queer and takatāpui people positioned suicidality as a stigmatised subject within Aotearoa society, repressed by hegemonic masculinity and restrictive media reporting laws (Schimanski & Treharne, 2019). Other research on the meaning-making of suicide has also indicated that suicide is constructed as a stigmatised subject since the action violates the social norm that life is valuable, spoken of in privacy rather than openly (Conrad & Coohey, 2023). One explanation is that there exists a social discordance between the perceptions of suicide within the macro-climate of Aotearoa and the way suicide is understood within the micro-climates of queer and takatāpui communities. This idea was reinforced by participants talk on a "visceral knowing" of suicide, in which they rejected social judgements of suicide as attributable to people's immorality ("bad person") and self-liability ("mental person"). Instead, participants spoke of their insights into why suicide occurs among queer and takatāpui people, which were described with notions of "empathetic" and "compassionate" understanding. Specifically, participants shared an understanding that suicide occurred amongst their communities because of the ongoing prejudicial social conditions that they were subjected to during their day-to-day lives.

Participants contrasted their understandings of suicide against people positioned at other intersections, including cisgender-heterosexual, religious denominations, older generations, and those within rural communities. Participants spoke of suicide as an understandable action among queer and takatāpui people since they had experienced the same precipitants which had driven members of their communities to take their own lives. In contrast, religious and conservative beliefs were understood to frame suicide as a selfish and sinful act. Discursive research has described punitive judgements towards suicidal subjects as a process of othering, whereby people distance themselves from suicide in order to reduce the distress that accompanies losing someone to suicide, and to protect against the existential contemplation of one's own life (Roen et al., 2008). Additionally, the subject of suicide has been acknowledged as coinciding with a rationalisation process in which people conceptualise motives and reasons to explain why suicide occurs, such as a 'choice' or 'last resort' to overwhelming life circumstances, producing an understanding on how suicide fits within one's existence and reality (Roen et al., 2008). In the current study, participants made sense of suicide through their shared experiences with other queer and takatāpui people, positioning social discrimination as

the central mechanism that elicited suicidality within their communities, such that the rationales for suicide were external to oneself but not distally located.

The second theme, "*You're Removing the Responsibility of the Society*", contributes to the body of literature challenging the idea of marginalised identities as inherently pathological and passive recipients of suicide risk (e.g., Bryan & Mayock, 2012; McDermott & Roen, 2016). Within this theme, participants presented two perspectives on who or what should bare the label of 'risk factor', which are best thought of as two sides of the same coin. While acknowledged by participants as useful within clinical contexts, particularly to identify those who required greater social support, the language of suicide vulnerability disregarded the larger social context in which queer and takatāpui people are situated. To label marginalised people as 'risk factors' was understood by participants to position these individuals as risks themselves, detracting from any deeper understanding of how and why this disparity existed at all. Similar perspectives have been found within other qualitative studies in which participants actively denounced the idea of suicidality as caused by one's queer sexuality or gender identity, instead recognising that suicidal distress arises from within aversive social conditions (McDermott et al., 2015). Further, attributing suicidality to monocausal explanations, such as 'non-normative' identities, has been argued to reduce suicidality among queer people to simplistic and deterministic explanations, rather than acknowledging the complex and nuanced factors that produce suicidal distress (Bryan & Mayock, 2017).

If queer and takatāpui people are risks, to whom or what are they risks to? From one perspective, one could reject this question entirely and state that it is not *risk to*, but rather, *at risk of* suicidality. From another perspective, one could accept the notion of risk to, and reflect upon where the onus of responsibility was positioned. For participants, to have their marginalised identities labelled as 'risk factors' implied that these were responsible for suicide risk, and had an undertone that risk was inherent to those who embodied these identities (McDermott & Roen, 2016). In rebut, participants argued that suicidality was a product of institutional social norms which permitted the hegemonic group to discriminate against queer and takatāpui people. Thus, when contextualised within broader social contexts, risk was not inherent to people exposed to precipitants of suicide, but rather, risk was localised within discrimination and social norms; both of which held the responsibility for imposing suicide vulnerability upon queer and takatāpui people. In the following section, the relationship

between social discrimination and suicidality is explored further, adding depth as to how this trajectory plays out among queer and takatāpui people.

Pathways from Discrimination to Suicidal Distress

The third theme encompassed the idea that institutional "*Social Norms Require a Deviant Group*", whereby the hegemonic society both developed and worked in unison with social ideals, such as heteronormativity and cisgenderism. Participants discussed how people who did not conform to these institutional norms were socially positioned within the "deviant group", conceptualised as an out-group subjugated to the margins of mainstream society. Queer and takatāpui people were socially located within this deviant group, which permitted them to be discriminated against through the ongoing enforcement of 'normative' behaviours, including expectations that one would develop an intimate heterosexual relationship, express gender congruency, and identify as the sex they were assigned at birth. As such, participants described the different ways in which ideologies were enacted to produce discriminatory social climates, which occurred at both the macro- (e.g., exclusion from political and legislative decisions) and micro- (e.g., victimisation, microaggressions, prejudicial abuse) levels of their everyday lives.

The link between institutional social norms and experiences of discrimination among people with diverse sexualities and gender has been well established (e.g., Riggs et al., 2015; Riggs & Treharne, 2017; Treharne & Adams, 2017; Tan et al., 2020a; Marzetti et al., 2022). As discussed by participants, heteronormativity and cisgenderism were framed as among the central ideologies that influenced how discrimination was enacted against queer and takatāpui people. Under the assumptions of the ToD, these ideologies represent the privileging of people who align with heterosexuality and the gender binary, rendering these individuals as the 'normative' ideals, while people who deviate are deprived of a personhood status (Riggs & Treharne, 2017). In the current study, participants seemingly used the idea of deviating from social norms as a demarcation between themselves and cisgender-heterosexual people, which coincided with discussions on rejection.

Participants articulated that membership to the 'deviant group' was issued through rejection from mainstream society, represented by an inability to conform with social ideals. For some participants, the inability to be accepted within this hegemonic society was framed as something to which queer and takatāpui people may feel at fault for, such as feeling as though they were a "disappointment" to all (i.e., self-blame). This rhetoric aligns with research

identifying discourses of ‘shame’ and ‘self-blame’ within queer peoples’ talk on suicide and self-harm, whereby amounting pressures to conform to social ideals leads to self-blame for deviating from institutional social norms (Fullagar, 2003). In turn, self-blame for nonconformity could be understood to detract away from critiquing and critically evaluating institutional norms and social expectations, instead, redirecting shame towards oneself that results in contemplating suicide (Fullagar, 2003). Here, participants discussed that the absence of social support (e.g., whānau rejection), or inability to access queer and takatāpui community members who could validate one’s diverse identities, could elicit a pathway to suicidal thinking and questioning why one exists. In this regard, suicidal ideation was framed as being socially produce through a lack of acceptance from one’s social climate and barriers (e.g., rural location) to establishing a sense of belongingness with empathetic others.

Against the backdrop of rejection from the hegemonic society, participants highlighted the different approaches that queer and takatāpui people may employ to relinquish some of their deviance. These approaches entailed adhering to social conventions, such as marriage and performing the “white-picket fence queer”. This phrase evokes the imagery of queer and takatāpui people conforming to a lifestyle consisting of a middle-class nuclear family within a ‘safe’ suburban neighbourhood, synonymous with the American Dream (Samuel, 2012). One underlying inference is that adherence to the ideologies of heteronormativity and cisgenderism precedes acceptance into the hegemonic society; a sense of relinquishing one’s queerness to better align with the traditions of cisgender-heterosexual ideals. Another approach discussed by participants was to closet one’s marginalised sexuality and gender, which entailed “shutting down” facets of one’s sense of self. Participants explained that repressing one’s identities coincided with vulnerability to suicidality through a decompensation process, whereby one’s psychological faculties (e.g., decisiveness about wants) also ‘shut down’.

Several studies have explored the difficulties that accompany queer and takatāpui people who remain closeted and the performative practices that these individuals enact to conceal their identities. In some regards, being closeted can be understood as a way of concealing one’s ‘shameful’ self through performing an acceptable identity to others who represent sources of social discrimination (Fullagar, 2003; McDermott et al., 2008). From another perspective, self-preservation becomes a means of coping with the discordance between one’s sense of self and the social constructs embedded within their day-to-day environments (e.g., schooling, work, family), whereby one masks their queerness by mirroring the norms according to contexts

(Rivers et al., 2018). The approaches of conforming and closeting can be thought of as compensatory reactions to the discrimination that queer and takatāpui people endure at the hands of the hegemonic society, demonstrating ways of forming façade connections between oneself and institutional social norms (Riggs & Treharne, 2017). However, as outlined within the ToD, decompensation (e.g., suicidality) emerges as practices of compensation are exhausted (Riggs & Treharne, 2017).

Participants identified several mechanisms by which experiences of social discrimination eventuated in suicide among queer and takatāpui people. Prominently spoken of were ideas pertaining to disconnection and isolation, which included not only rejection from the hegemonic society but also distancing from the 'deviant group'. Talk was organised around the notion of a humanistic desire to belong within communities that enabled one to envision a meaningful future. Participants used the language of hopefulness and optimism to describe the envisioned future embedded within queer and takatāpui communities, with "multiple not-connections" to these communities and a future vision precipitating suicide. The dichotomy of hopefulness and hopelessness has long been understood to significantly influence suicidality (Beck et al., 1974; Lawson-Te Aho, 2016; May & Klonsky, 2016). Unique to the current study is where participants positioned these two constructs, locating hope within the social climates of queer and takatāpui communities rather than internalised within individuals. As such, this may be thought of as a collective hopefulness, whereby connecting with queer and takatāpui communities, and by extension, an envisioned future of "we're okay", was to connect with hopefulness.

The fourth theme further builds upon participants discussions regarding the links between social discrimination and suicidality. Participants recognised that experiences of social discrimination resulted in the accumulation of stress across time and was expressed using the turn of phrase, "*the Straw that Broke the Camel's Back*". Many models of suicide have positioned stress as a central concept for explaining the occurrence of suicidality including, a problem-solving deficit model (Schotte & Clum, 1987), the clinical model of suicidal behaviour (Mann et al., 1999), and the two-stage model of outward and inward directed aggression (Plutchik et al., 1989). The amalgamation of these models, and others, has contributed to the theoretical underpinnings of diathesis-stress frameworks of suicidal behaviour (Van Heeringen, 2012). These frameworks posit that the accumulation of stressors (e.g., adverse life events) precipitate suicidality, particularly among individuals with

psychological, biological, and neurological predispositions (Van Heeringen, 2012). As such, diathesis-stress frameworks conceptualise that suicidality is elicited from an interaction between stress and diatheses (i.e., vulnerabilities).

Participants explained that multiple stressors contribute to suicide attempts, rather than being attributable to monocausal explanations (Bryan & Mayock, 2012). The quality and quantity of stressors that queer and takatāpui people could compensate for was described as complex and nonlinear, such that each person's "breaking point" was individualised. Participants defined this 'breaking point' as a juncture when suicidal ideation progressed to attempting suicide and reflected the point when cumulative stress exceeded one's capacity to compensate for social discrimination (Riggs & Treharne, 2017). Research has demonstrated that the accumulation of life stressors is associated with elevated suicidality and has been framed as a possible mechanism that distinguishes suicidal ideation from suicide attempts (Fairweather et al., 2006; McFeeters et al., 2015). Such research aligns with the ideation-to-action framework, which posits that suicidal ideation and attempts to end one's life have distinctive underlying processes and explanations (Klonsky et al., 2018). In application, diathesis-stress frameworks have shown a degree of applicability for explaining psychopathology and suicide attempts experienced by people with diverse sexualities and genders, particularly in relation to discrimination-based stressors (Burns et al., 2012; Green et al., 2021).

Most compelling was the degree to which participants conceptualisations of accumulated stress aligned with Riggs and Treharne's (2017) ToD. Participants located stressors as external to queer and takatāpui people, acknowledging that experiences of social discrimination were systemic by nature and therefore imposed upon these individuals. Aligning with the engineering analogy (see Riggs & Treharne, 2017), participants identified that stress accumulated and compounded upon queer and takatāpui people's capacities to compensate for discriminatory environments, which has similarly been found within past appraisals of the ToD (see Schimanski & Treharne, 2019). Novel to the current study was the way in which participants explained the function of suicide; namely, as a means of escaping ongoing stressors (i.e., escapism). The idea of suicide as escapism is shared with other explanatory frameworks of suicide, including the works of Baumeister (1990), and Williams and Pollock (2000; 2001).

Actively and Passively Resisting Suicidality

The fifth theme, *Ethnicity and Resilience to Suicidality*, was organised around the differing ways in which participants framed their ethnicities as strengths that bolstered queer and takatāpui people to resist against suicidality. Since participants spoke from the perspectives of their own ethnic identities, two parallel narratives were presented. One subtheme of Māoritanga (Māori cultural identity) and one subtheme of Pākehā culture, which were related through a mutual understanding that ethnicity contributed to resiliency.

For Māori participants, resilience was framed as *connectedness* with their whakapapa through the colonial history of Aotearoa. Specifically, the mātauranga (Māori knowledge) that their tūpuna (ancestor) fought against the colonising forces of invading Pākehā to ensure that rangatahi (younger generations) would prosper into the future was described as protective against isolation and self-harm. Māori participants talked of an *empowerment* that arose from this connectedness "as a whakapapa into [their] own bloodstream", whereby the existence of Māori within contemporary society was understood to be an act of resistance against colonisers since the eradication of Māori was an intention of the colonial insurgency. Colonisation has been established as an underlying cause of suicidality among Māori, with inequitable distributions of power and acculturative stress as some of the mechanisms through which colonisation remains ongoing within contemporary Aotearoa (Lawson-Te Aho & Liu, 2010). When contextualised within mātauranga, whakamate (suicide) can be constructed as a severance from whakapapa, which encompasses tūpuna, whānau, hapū (subtribe), and iwi (extended kinship tribe) and represents a central organising social structure within traditional Māoritanga (Lawson-Te Aho & Liu, 2010; Cameron et al., 2017). Here, one interpretation is that Māori participants were outlining their processes of building *whanaungatanga* with their whakapapa through understanding the actions of resistance against colonisation that had been undertaken by their tūpuna. Highlighted by Hamley et al. (2021), whanaungatanga represents a dynamic restorative healing in which takatāpui people bolster their hauora (Māori philosophy of health and wellbeing) through practices of relationality with whānau, daily activities, Māori history, and takatāpui legacies. As such, the multidimensional nature of whanaungatanga has been conceived as a continuous and daily process that enhances Indigenous flourishment, self-determination, and a sense of takatāpui identity among takatāpui people (Hamley et al., 2021).

The intersection of Māori and queerness was described by Māori participants as a space dichotomised by strengths and hardships. On one accord, Māori participants identified that

takatāpui people were not fully accepted by all members of the Māori community, and yet, also recognised that their Māoritanga was embedded with strengthening characteristics that enabled them to resist suicide. These characteristics were described as holding strong voices to champion advocacy within rainbow communities and self-determination as a principle of contemporary Māoridom. Similar dichotomies have also been presented in other intersectional studies, wherein Māori participants have spoken of the difficulties that entail being takatāpui, such as access to healthcare and discrimination, but positioned their Māoritanga as a source of resilience (Scorringe et al., 2015). This is further exampled in suicidology research where queer people fair worse on outcomes of suicidality compared with cisgender-heterosexual people, but those who intersect with Māori and queer (i.e., takatāpui people) have comparatively lower odds of suicidality than queer Pākehā (Chiang et al., 2017; Roy et al., 2021). The perspectives presented within the current study run counter to outdated notions of 'double jeopardy' or the idea of 'additive' marginalisation by intersecting with multiple 'minority' identities. Instead, Māori participants highlighted that more pertinent is the manner in which takatāpui people are socially positioned within Aotearoa society (Riggs & Treharne, 2017) and the strengthening attributes that they garner from their Māoritanga.

Pākehā participants spoke of the ways in which their ethnic identities afforded them privileges within contemporary Aotearoa society. These discussions were organised around notions of inequitable power relations, resource distributions, and institutional social norms, which favoured Pākehā and positioned Māori as comparatively powerless. In relation to resiliency against suicide, Pākehā participants described the privileges that they held within their positions as members of the social majority, such as being "being taken more seriously" when compared with people of colour and the ability to access help in a timely fashion when experiencing psychological distress. Complimentary, Pākehā participants also spoke of the social hardships that they were not subjected to because of their social positioning, which included protection from race-based inequities, such as the racial wage-gap and racist social discrimination (e.g., physical and verbal abuse). As recognised within several pieces of literature, systemic power and governance shifted to the hands of Pākehā following the Crown's failure to uphold partnership obligations detailed within Te Tiriti o Waitangi, such as the undermining Māori tino rangatiratanga (self-determination and sovereignty) (Moewaka Barnes & McCreanor, 2019; Crawford & Langridge, 2022). The ongoing processes of colonisation reassert this power imbalance through the established systemic structures which organise modern day Aotearoa, including the Westminster model of governance and the

English common law system (Crawford & Langridge, 2022). Pākehā participants identified that their privileges were not inherent to their Pākehā cultural identities, *per se*, but were rather socially produced through these systemic structures which were enacted through embedded institutional social norms. These norms encompassed ideologies of White supremacy, Eurocentrism, and racism.

Implications for Clinical Practice

Fortune and Hetrick (2022) have rightfully critiqued the use of 'predictive' risk factors (e.g., age, psychopathology, prior suicide attempt) within the context of suicide risk assessments. Despite evidence showing that the complexities and nuances of suicidal distress do not lend to clinical prediction (Carter et al., 2017), the field of mental health still places a heavy emphasis on training clinicians to use psychometrics regarding suicide liability (e.g., Columbia Suicide Severity Rating Scale) and frameworks for stratifying levels of suicide risk (see Turner et al., 2022). Further hindering suicide risk assessments are calls for suicidality to be conceptualised as psychopathology, such as the proposed Suicide Behaviour Disorder (Fehling & Selby, 2021). This is problematic since a contemporary understanding of suicide is that it does not represent a discrete condition (Fortune & Hetrick, 2022), but rather an expression of dynamic underlying processes that ebb and flow with time (Klonsky et al., 2021). Even approximations of suicide intent, some of which fall under the umbrella of suicidality, have been described as insufficient indicators of whether an individual will subsequently attempt to end their own life, including suicidal planning, impulsivity, and self-harm behaviours (see Fortune & Hetrick, 2022). This leaves us at somewhat of an impasse since much of the current clinical practices within mental health are organised around quantifying, classifying, and predicting suicidality during suicide risk assessments (Carter et al., 2017).

The ethos of my research is that *suicide is socially produced, wherein the precipitants of suicidality exist external to queer and takatāpui people*. This ethos runs counterintuitive to the standards of a traditional suicide risk assessment, which is typically structured as a clinician-client dyad, with the client subjected to questioning about their individualised circumstances (e.g., personal hardships) and internal experiences (e.g., 'distorted' cognitions). As such, traditional risk assessments function within a give-and-take paradigm, with the client giving over their negative experiences and circumstances, which the clinician takes and assesses to identify risk factors for determining whether their distress poses an imminent, or future, threat

to their own life (Sommers-Flanagan & Shaw, 2017). *During my clinical psychology internship, approaches that weighed heavily on the individual and internal were framed as the 'gold-standard' of suicide risk assessment. Techniques such as psychometric evaluation, FIDO (frequency, intensity, duration, onset), subjective units of distress, and assessing for static and dynamic risk factors, became incorporated into my interview structures, informed my clinical judgements, and had weight when constructing safety plans*. However, traditional suicide risk assessments that operate on risk factors as predictors of subsequent suicidality are insufficient and offer little clinical utility (Large & Ryan, 2014; Sommers-Flanagan & Shaw, 2017; Fortune & Hetrick, 2022).

At first glance, it may seem as though my research has reinforced traditional clinical practices of suicide risk assessment. In study one, I applied *specific* variables (i.e., social discrimination, social support, NSSI) and tested whether these were sufficient determinants of suicidality among queer and takatāpui people. Additionally, for study two, I applied the broad constructs of ideology, intersectionality, and privilege to *specific* phenomena (i.e., discrimination, risk factor, ethnicity) and captured queer and takatāpui people's perspectives on these. However, rather than framing these specific variables and phenomena as 'risk' and 'protective' factors for suicidality, more pertinent is to consider how the *processes* of suicidality, and *co-appraisal* of stressors and mitigators, in this thesis can be incorporated into the corpus of suicide risk assessment. In the following paragraphs, I provide my thoughts on how Klonsky and May's (2015) Three-Step Theory (3ST) of suicide, and Riggs and Treharne's (2017) Theory of Decompensation (ToD), align with contemporary approaches to suicide risk assessments.

Processes of Suicide

A misconception about theories of suicide is that these are intended to predict suicidality among people. Such is not the case. As iterated by Klonsky et al. (2021), the 3ST of suicide outlines a series of conditions which may foster suicidal ideation and suicide attempts, which are designed to *explain* suicidality, not predict it. In other words, theories of suicide add structure to the *processes* of suicidality, and in the case of the 3ST, offers a broad framework for applying these processes. For example, the concept of *pain* is not bound to any single form (Klonsky & May, 2015), but can be applied fluidly to any phenomena that one experiences as painful, including psychical, emotional, psychological, and spiritual. Some of the troublesome aspects of using risk factors to predict suicide are that 1) there exists a myriad of risk factors that have been identified, 2) these do not accurately distinguish suicidal from non-suicidal people, and

3) classification of suicide risk (i.e., low, moderate, severe) does not transfer to subsequent suicidality (Sommers-Flanagan & Shaw, 2017; Fortune & Hetrick, 2022). In the 3ST of suicide, the variables of pain, disconnectedness, and capacity for suicide, are not framed as predictive risk factors, *per se*, but rather dynamic processes that influence the social conditions in which suicidality may arise from (Klonsky et al., 2021). Sommers-Flanagan and Shaw (2017) advocate for clinicians to incorporate these variables into the suicide risk assessment as part of gaining an empathetic and more holistic understanding of the client's current experiences.

Fortune and Hetrick (2022) raise concerns regarding theories of suicide, stating that these reinforce the idea of a linear progression from suicidal ideation to suicide attempts and create a preoccupation with quantifying transition variables. I agree that neither of these practices constitute a well-informed suicide risk assessment, but I also think these arguments neglect the role that processes of suicidality play. The 3ST of suicide does stratify suicidality into three 'steps', but this is not intended to imply that suicide is based in linearity (Klonsky et al., 2021). Rather, each step represents the processes that intensify or mitigate aspects of suicidality, which remain subject to the changes in one's circumstances, environment, and self.

Co-Appraisals of Suicide Risk

Suicide risk assessments based upon *co-appraisal* are gaining momentum within clinical practice. Two formal examples of these are the Prevention-Oriented Risk Formulation (see Pisani et al., 2016), and the Collaborative Assessment and Management of Suicidality (see Jobes et al., 2012). Co-appraisal to assessing suicide risk conceptualises the clinician-client dyad as a collaborative and transparent therapeutic alliance, rather than a give-and-take paradigm, and discourages the positioning of clinicians as experts on the client's suicidal distress and sole decision makers on appropriate interventions (Sommers-Flanagan & Shaw, 2017; Swift et al., 2021). Grounded within a *social constructionist* approach to collaborative decision-making (Sommers-Flanagan & Shaw, 2017), co-appraisal shares features with the ToD and the findings from study two.

Co-appraisal approaches de-emphasise the role of diagnostic assessment, shifting away from biomedical frameworks, and instead, emphasise suicidality as an outcome of distress (Sommers-Flanagan & Shaw, 2017). As discussed by participants in the current research, the language of 'risk factor' positions queer and takatāpui people as the risks and implies that their

marginalised identities are responsible for their experiences of suicidality, which detracts from deeper understandings on *how* and *why* suicidal disparities exist. Instead, a co-appraisal approach to suicide risk ushers the notion of *depathologising* queer and takatāpui people as inherently 'at-risk' and 'vulnerable' to suicidality (McDermott & Roen, 2016) and locates suicidality within the framework of stress (Sommers-Flanagan & Shaw, 2017; Riggs & Treharne, 2017). In application, this opens-up the therapeutic space for collaborative discussions on broader, socially-orientated phenomena and affords the space for clients to articulate their understandings of *what* produces their experiences of distress and *how* they make sense of the stressors they identify.

Suicidality has historically been conceptualised as a form of deviance from normality (Szasz, 1986; Silverman & Berman, 2014). The notion of a 'deviant group' was discussed by participants as the social positioning of queer and takatāpui people as marginalised from the hegemonic society on the basis of their nonconformity to institutional social norms. This was understood to permit the hegemonic society to subject these individuals to social discrimination, thus severing connectedness, acceptance, and belongingness. As noted by Sommers-Flanagan and Shaw (2017), "a social constructionist model allows for a more neutral conversation to develop…wherein disclosure of suicide ideation is regarded as a valuable communication" (p. 99). Rather than attending to individualist suicide risk and assuming that marginalised identities equate to difficulties, the application of a social constructionist approach affords the space for a clinician-client co-appraisal of risks, including discussions on socially located stressors (e.g., heteronormativity, cisgenderism, racism).

Areas for Improvement and Strengths to Build Upon

Limitations

This research project is not without limitations. Regarding the quantitative study, a single item pertaining to *feeling hopeless* from the Kessler 10 Psychological Distress Scale (K10) was used as a proxy measure of hopelessness. The construct of hopelessness extends beyond the emotion of feeling hopeless, also constituting cognitive and motivational components, such as pessimistic beliefs regarding one's future (Beck et al., 1974). As such, the measure I used did not account for the full dimensionality of hopelessness, indicating that the analyses, wherein the single item of hopeless was used as an independent variable, were likely biased by measurement error (i.e., over or under estimation of hopelessness). A further limitation with

this study was the temporal differences between measures, ranging from lifetime prevalence (e.g., Deliberate Self-Harm Inventory) to the last 30 days (e.g., K10). Given that the Three-Step Theory of suicide is intended to explain how suicidal ideation and suicide attempts are elicited, the variables within each of the three steps are required to occur simultaneously. For example, in step three, an individual must simultaneously experience severe suicidal ideation and the capacity for suicide in order to trigger a suicide attempt (Klonsky et al., 2021). Within my quantitative study, while participants who had experienced discrimination, suicidal ideation, and attempted suicide could be identified, I was unable to determine whether these experiences occurred within the same timeframe. As such, this study cannot explain any cause-and-effect associations between variables.

Regarding the qualitative study, a shortcoming was my limited acknowledgement towards the intersection of disability. Several participants discussed their positioning as a disabled person during the interviews, describing how this intersection contributed to the forms of discrimination they experienced and subsequent understandings of suicide. As disability became a more prominent topic discussed within some interviews, I contemplated retrospectively collecting information on the nature of participants' disabilities but decided that this would be inappropriate. Namely, 1) I had not explicitly indicated within my ethics application that I would collect information pertaining to participants' disabilities; 2) I felt that a retrospective enquiry (e.g., email correspondence) would not provide participants with the space to unpack the intersection of disabled and queer (Fish, 2008); and 3) though the experiences of disability and ableism are important aspects of intersectionality, these were not subjects that I actively sought to explore within this research.

Another shortcoming of my qualitative study is that I only interviewed participants once, rather than undertaking longitudinal or subsequent interviews with participants after a duration of time. While my approach aligns with a social constructionist epistemology, wherein social knowledge is culturally and historically bound to the context of the time (Burr, 2015), the themes presented in this thesis represent cross-sectional understandings of suicide among queer and takatāpui people, circa 2019. Though I could not have anticipated the introduction of COVID-19 at the end of 2019, it is important to recognise that the global pandemic continues to have a devastating effect on Aotearoa, particularly for disabled people (Russell et al., 2022) and queer and takatāpui people (Radford-Poupard, 2021). As such, COVID-19 represents significant changes to the social climate of Aotearoa at both the micro- and macro-structures,

which is likely to have influenced the constructed meanings for suicidality among people who intersect with disability, queerness, and Māori. Such a global shift in our social structures undoubtably warrants exploration within future research.

Strengths

Several strengths exist within this research project. Based on my knowledge of the published literature to date, my quantitative study is the first in Aotearoa to examine the applicability of the Three-Step Theory of suicide with queer and takatāpui people, and likely the second to do so within the context of current international publications (see Wolford-Clevenger et al., 2021). Additionally, my qualitative study represents the second time that the Theory of Decompensation has been utilised as a framework to understand suicidality from the perspectives of queer and takatāpui people (see Schimanski & Treharne, 2019). As such, the findings within this thesis reinforce the benefits of these theories as explorative approaches to both explain why, and understand how, suicidal distress is experienced by people with diverse sexualities and genders.

A further strength of this research was the various ways in which *insider positions* were integrated into each stage of the research process. My connections and friendships with members of queer and takatāpui communities helped facilitate participant recruitment across both studies, such that I was able to draw in support from social networks that may not have been as easily accessed by researchers positioned outside of these communities. During the formation of the qualitative study, I actively consulted with queer and takatāpui organisations, seeking their guidance on how to language this research (e.g., identity terms) and advice on topics that were pertinent to suicidality within our communities, thus enhancing the quality and community relevance of this research. All the participants who I interviewed for this qualitative study had lived experiences of suicidality which ensured that the perspectives and ideas shared were experientially grounded. Further, the overall scope of both studies can be positioned as insider-based, whereby the strengths of this research project are represented by a kaupapa that was informed and conducted **by** queer and takatāpui people **for** the benefit of queer and takatāpui people.

Future Research: Where to Next?

As I have highlighted throughout this thesis, much attention is still required to bolster our understanding of suicidality among queer and takatāpui people in Aotearoa. Research has continuously reiterated the higher likelihoods of suicidal ideation, self-harm, and suicide attempts among queer and takatāpui people, when compared with cisgender-heterosexual people, which provides us with an insight into these ongoing difficulties across time (Fergusson et al., 1999; Skegg et al., 2003; Fergusson et al., 2005; Lucassen et al., 2011; Clarke et al., 2014; Lucassen et al., 2015; Chiang et al., 2017; Spittlehouse et al., 2020; Tan et al., 2021). Additionally, correlates of suicidality have been found within cross-sectional studies conducted in Aotearoa including, level of support at school (Denny et al., 2016), emotional dysregulation (Fraser et al., 2017), social support, belongingness, enacted stigma (Tan et al., 2020b), psychological distress, social discrimination (Treharne et al., 2020), and gender identity change efforts (Veale et al., 2021). However, such research provides limited contribution to explanatory frameworks that capture *how* these correlates elicit suicidality (e.g., ideation-to-action), and *how* suicidality is understood, among queer and takatāpui people. Within my two studies, I have provided preliminary evidence for the applicability of two theories that show promise in explaining and understanding the *processes* that are situated behind the pathways to suicidality.

For future research to maintain momentum within the field of suicidology, I offer three research proposals that build upon the findings presented in this thesis. The first of these directly relates to study two, wherein it would be advantageous to analyse and interpret the qualitative data on topics that I was unable to include in this thesis. These topics included discussions on defining social norms; the relationship between intersectionality and social discrimination; functions of self-harm; the role of whānau in suicide prevention; and the influence of queer and takatāpui people represented in media. Having familiarised myself with all 20 interview transcripts, I believe that analysing the full integrity of this data would provide a foundation for developing an adapted version of the ToD (Riggs & Treharne, 2017) that specifically conceptualises suicidality among queer and takatāpui people from their own perspectives. Such a decompensation framework may provide a more socially holistic understanding of suicidality that is embedded within the constructs of ideology, intersectionality, and privilege.

The second research proposal is a replication of study one, but addressing the limitations outlined in the section above. Firstly, a more robust measure of hopelessness is required to adequately test step-one in the 3ST of suicide. Klonsky et al. (2021) suggest the use of the Beck Hopelessness Scale, full-version or short-version (Beck et al., 1974), both of which have been utilised within prior examinations of the 3ST of suicide. Secondly, since participants in study two seemingly located hope within the social climate of queer and takatāpui communities, another endeavour of future research should be to examine the applicability of social/collective hopelessness to the processes of the 3ST. This form of hopelessness is captured within the Social Hopelessness Questionnaire (Heisel & Flett, 2022). Thirdly, temporally aligning the measures (e.g., 'past month' vs 'lifetime') in such a manner that they assess whether each of the conditions in the three steps have occurred poses a major difficulty (Klonsky et al., 2021). For example, step-one stipulates that the *simultaneous* experience of pain and hopelessness elicits suicidal ideation. Additionally, in step-three, the capacity for suicide (e.g., NSSI) needs to have *preceded* one's suicide attempt. Klonsky et al. (2021) advise against the use of longitudinal research designs and advocate that "conditions measured at baseline should not be assumed to be relevant to future outcomes except to the extent that those conditions persist or re-occur" (p. 5).

The third research proposal is the development of an entirely novel model of suicidality among queer and takatāpui people in Aotearoa. Rather than relying upon adaptations of pre-existing theories of suicide (e.g., the 3ST of suicide, the Interpersonal Theory of Suicide), minority stress (e.g., Minority Stress Model, Gender Minority Stress Theory), and decompensation (e.g., the ToD), it may be more advantageous to start anew. Fenaughty and Harré (2003) used grounded theory to conceptualise their novel Seesaw Model of Suicide from the narratives of gay and bisexual men in Aotearoa. This systematic process to data collection and analysis allows for theories to be developed from an inductive approach (i.e., data-driven), elicits depth and richness from qualitative data, and can facilitate the generation of novel concepts regarding suicide (Hussein et al., 2014).

Reflecting on the Journey

The social climate of Aotearoa has changed since I started my research journey in 2018. The first national survey on transgender and nonbinary people's wellbeing, *Counting Ourselves*, was launched in 2018; the BDMRR Act was reformed in 2021, easing the process for amending

one's registered gender; conversion practices were banned in 2022; and the first openly gay All Black came-out to the nation in 2023. Sadly, for every step forward, there exist pathways that we are yet to travel down. The *Darlington Statement* of 2017 called for unnecessary medical procedures on children with an intersex variation to be criminalised; asylum sought on the basis of sexual orientation and gender identity persecution remains legally unrecognised; and people marched in 2023 to protest against the current barriers to gender affirming healthcare. Now at the end of my research journey in 2023, I can say that there is still much to be learned about suicidality, but I believe that this thesis will help contribute towards suicide prevention among queer and takatāpui people. In the following sections, I reflect on prominent experiences that arose throughout the research process being *an insider looking inwards*, questioning *what is concise*, and remembering *the loss of a participant*.

An Insider Looking Inwards

Throughout my research journey, I flipped between feeling as though my positioning was *too inside* and *not inside* enough. I am Māori, yet I did not always feel 'Māori enough' because of the disconnection between me and my Māori whānau. I identify as queer, takatāpui, and gay, and proudly proclaimed so at the age of 16. Yet, I police myself in unfamiliar spaces out of concern that I will be confronted with prejudicial views. My personal experiences with suicidality have driven my pursuits to contribute to the field of suicidology (Schimanski et al., 2017; Schimanski & Treharne, 2019) and complete clinical psychology training. Yet, I have intentionally omitted this disclosure from both of these spaces, fearing that my past experiences of instability would be used to negatively frame me in the present. One may read this and think that I have 'internalised' negative judgements towards my own intersecting identities, but that person would be mistaken. These negativities are located externally to me, and what I have presented in this paragraph are my reactions to this social environment. With this context in mind, the following paragraphs will outline how I was challenged by my insider position throughout my research journey.

An initial difficulty arose while I was considering how to frame this research in terms of the language I would and would not use. I have qualms when 'rainbow' is used to refer to queer and takatāpui communities. *For me*, 'rainbow' evokes a childish and patronising framing of people with diverse sexualities, genders, and sex characteristics, reducing us to a delicate group of individuals who require paternalistic supports to ensure our safety. This is not to say that I do not understand the important role of 'rainbow' in society. I am aware that 'rainbow' is a

neutral, yet descriptive, term that is designed to recognise the diversity of identities that exist and represent pride towards people who align with these identities. I went back and forth on whether I would use 'rainbow' as a way of describing my two studies (e.g., advertisements, writing this thesis). Confronted by my insider position, it was my right to reject 'rainbow' as a term to describe myself, but it was also my responsibility to ensure that *all* queer and takatāpui people had an equitable opportunity to participate in these studies and to have their language represented. As such, I set aside my own perspectives on languaging and adapted the terms I used according to each person. For example, in email correspondence, and during interviews, I followed suit, adopting the language used by the participants to respond, including 'rainbow'.

I found the process of analysing participants' interview data confronting towards my insider position and role as a researcher. A minority of the people who I interviewed held dismissive views towards the relevancy of considering Māori when discussing connections between discrimination and suicidality. These participants seemed to position all people with diverse sexualities and genders on an 'equal playing field' and shared perspectives that aligned with an 'all the same' agenda. On the one hand, it struck a nerve as I listened to participants undermine the intersectionality of queer people who are Māori, and I found it challenging to maintain active engagement with their data. On the other hand, as a researcher, I endeavoured to remain mindful of my own beliefs as to not erase these participants' understandings from my analytic approach, just because our perspectives were at odds with one another. In another vein, I found it challenging to pull myself out of the trap of taking participants' perspectives for granted. As I listened through participants' audio recordings, there were moments when we would have shared understandings of suicide, discrimination, and resilience. During these moments, I found myself stepping away from my role as a researcher and instead relating to their talk as a peer, thinking of their perspectives as a 'given' within society. Regular meetings with my research supervisors were beneficial for ensuring that I was able to park my insider knowledge and start to view the data for its meaningfulness, rather than taking it for granted.

What is Concise?

If I had described my approach to research at the beginning of my journey, 'being concise' would not have featured. I find comfort in the complex, elaborate, and big concepts within psychology; preferring to over explain, overwrite, and over think my research ideas, rather than consolidate these to concise points. When writing this thesis, my drafts were often aglow with feedback from my supervisors stating, "this point could be made in one sentence", "repetition",

and “can this be simplified?” While making my writing more concise was relatively easy, my biggest challenge was making the scope of this research project an appropriate size for a Doctor of Clinical Psychology thesis.

After settling on a mixed methods design, comprised of two studies, I developed an interview schedule that I thought covered both a breadth and depth of topics relevant to my research questions. What I thought was manageable, grew and grew within the interview space, wherein each of the 20 participants articulated a rich tapestry of ideas. The revelation that I had an overabundance of data was revealed once I became overwhelmed with managing my vast quantity of code labels. NVivo software helped me to contain and organise this qualitative data, but it became evident as I was developing my themes that the 65,000 word limit was not going to cut the mustard. When faced with the prospect of reducing the number of themes I present in this thesis, I was reluctant to part, feeling as though I was undermining the contributions of participants. As I reflect on this now, I realise that it would have been more of an insult if I had presented numerous shallow themes and robbed participants of their deep and meaningful talk. I still have a love-hate relationship with the idea of being concise, but I have learned to embrace its utility within academia.

The Loss of a Participant

I had recently finished drafting the qualitative findings, when I was informed that a person who participated in this study had taken their own life. This was deeply upsetting to hear, and I felt sorrow that they had passed because of suicide. It had been a few years since I had interviewed the individual, so I decided to read through their interview transcript and reflect. I remembered their enthusiasm towards partaking in the study, as well as their sense of humour which came through even as static text on pages. Over the coming days I contemplated the appropriateness of mentioning their passing within this thesis and whether I should omit their quotes from this thesis. After consulting with my research supervisors, we came to a consensus that I needed to mention their passing and that to omit their data would be ethically and principally inappropriate to exclude the contribution they had given to this research. I decided to end these reflections with the final quote they gave during their interview:

"This is for anyone who's going to read it, or wherever it goes; always be open, always be kind, and always be patient because no one really knows what they're going through, and if we've been through that scenario, we always forget about it. So be patient with everyone and listen, just listen and be fair. Anger doesn't get you anywhere, you might as well be stuck to a stall because it doesn't get you anywhere. Be kind, and be prepared to be disagreed with, but train yourself into how you're going to address it and how you're going to feel about it because life's not easy and it starts with you".

Concluding Thoughts

Now at the end of this thesis, I have an even greater appreciation for the complexities, nuances, and controversies that hang from the coat-tails of suicide in Aotearoa. Suicidal distress represents a visceral experience of the self, plaguing existential questions of one's existence, and imposing harm upon oneself. Within my research journey, suicidality has not been an easy subject to sit with, and at times, has been a guest in my home as I contemplated my next chapter or a theory of suicide that I had not considered before. But my discomfort came from a distant place of privilege and does not mirror the distress of those who are experiencing suicidality. Of importance to finishing this thesis was the ongoing thought that this thesis was about the queer and takatāpui people who participated in this research, and ensuring that I did justice to the experiences, perspectives, and data that they shared with me.

This research shows that theoretical frameworks regarding suicide and minority stress are valuable assets in helping us to understand and explain suicidality among queer and takatāpui people in Aotearoa. Klonsky and May's Three-Step Theory of suicide provides a structure for explaining the processes of suicidality and the conditions under which suicidal ideation may transpire into attempting suicide. Riggs and Treharne's Theory of Decompensation provides a social framework for exploring suicidality from the perspectives of queer and takatāpui people, recognising ideologies, intersectionality, and privilege as important constructs to integrate into our understandings of what it means to be socially marginalised. In application, both of these

theories facilitated queer and takatāpui people to express the need for researchers and clinicians to acknowledge the impacts of social discrimination, hopelessness, self-harm, institutional social norms, colonisation, accumulated stress, and the social positioning of communities as marginalised, on pathways of suicidality. Counter to suicide, resistance and protection were understood to foster within social support, privilege, whanaungatanga, Māoritanga, and intersectionality. It is my hope that people embrace this thesis to further our discussions, research, and policies on suicide prevention in Aotearoa.

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Appendices

Appendix A

Table 12

Studies on suicidality risk among people with diverse sexualities and genders in Aotearoa

Reference	Sample	Study Design	Measures of Sexuality and Gender	Measures of Suicidality	Findings*
Fergusson et al. (1999)	• *n* = 979 heterosexual • *n* = 28 gay, lesbian, bisexual (GLB)	A cohort study on a longitudinal birth sample at age 21 (Christchurch Health and Development Study).	• Sex assigned at birth. • Selected sexual orientation and preference from 3 possible options: heterosexual/opposite-sex partners; homosexual/same-sex partners; or bisexual/partners of either sex. • Sexual behaviour: "Have you ever had a sexual relationship with a partner of the same-sex?"	Interviews conducted at ages 15, 16, 18 and 21 enquiring about prior experiences of suicidal ideation and suicide attempt(s).	GLB participants showed significantly higher likelihoods for suicidal ideation (5.4 [2.4-12.2]) and having attempted suicide (6.2 [2.7-14.3]).
Skegg et al. (2003)	• *n* = 770 opposite-sex attraction • *n* = 155 minor same-sex attraction • *n* = 17 major same-sex attraction	A cohort study on a longitudinal birth sample at age 26 (Dunedin Multidisciplinary Health and Development Study).	• Sex assigned at birth. • Selected sexual attraction based on past attraction ("What best describes who you have ever felt sexually attracted to?") and present attraction ("What best describes who you these days feel sexually attracted to?") from 6 possible options: 5 responses scaled from exclusively same-sex attracted to exclusively opposite-sex attracted, and another response for "never attracted to anyone at all".	A semi-structured interview regarding lifetime self-harm (with or without suicide intent), suicidal ideation within the past year, lifetime suicide attempts, and self-harm that resulted in physical injury within the past year.	Significantly higher likelihoods for suicidal ideation (3.1 [1.5-6.6]), deliberate self-harm (5.5 [2.8-11.0]), attempted suicide (3.2 [1.4-7.2]) and self-harm related physical injury (6.4 [3.2-13.0]) among males with any experience of same-sex attraction. Significantly higher likelihoods for suicidal ideation (2.9 [1.6-5.3]) and deliberate self-harm (1.9 [1.1-3.2]) among females with any experience of same-sex attraction.

Fergusson et al. (2005)	• *n* = 852 exclusively heterosexual • *n* = 88 predominantly heterosexual • *n* = 27 predominantly homosexual	Accumulated cohort studies on a longitudinal birth sample at ages 21 and 25 (Christchurch Health and Development Study).	• Sex assigned at birth. **Aged 21**: • Selected sexual orientation and preference from 3 possible options: heterosexual/opposite-sex partners; homosexual/same-sex partners; or bisexual/partners of either sex. • Sexual behaviour: "Have you ever had a sexual relationship with a partner of the same-sex?" **Aged 25**: • Selected sexual orientation from 5 possible options scaling from exclusively same-sex attracted ("100% homosexual") to exclusively opposite-sex attracted ("100% heterosexual"). • Selected sexual attraction measured by the intensity of attraction and sexual preference from 5 possible options (e.g., "I am strongly attracted to people of the same sex as me and most of my sexual experiences will be with people of the same sex as me"). • Sexual behaviour: "Have you ever had any kind of sexual experience with a partner of the same-sex?" • Sexual behaviour: "Have you ever had a sexual relationship with a partner of the same-sex?"	An interview conducted at the age of 25 enquiring about suicidal ideation and suicide attempts experienced from 21 to 25 years of age.	The rates of suicidal ideation (71.4%) and suicide attempts (28.6%) among predominantly homosexual males were significantly higher compared with exclusively heterosexual males (10.9%, 1.6%) and predominantly heterosexual males (28.6%, 0.0%). For female participants, those categorised as predominantly homosexual showed significantly higher rates of suicidal ideation (30.0%) and suicide attempts (10.0%) compared with those categorised as predominantly heterosexual (20.9%, 4.5%) or exclusively heterosexual (9.7%, 1.5%). Among both male and female participants, the rates of suicidal ideation and suicide attempts showed a significant trend of increasing with increasing homosexual orientation.
Lucassen et al. (2011)	• *n* = 7370 opposite-sex attraction • *n* = 73 same-sex attraction • *n* = 270 both-sexes attraction • *n* = 143 not sure • *n* = 146 neither	A cross-sectional population-based survey on a nationally representative sample of secondary school students in 2007 (Youth'07 Survey).	• Selected sex as either male or female. • Sexual attraction ("which are you sexually attracted to?") from 5 possible options: opposite-sex; same-sex; both sexes; not sure; and neither.	Responded with yes or no to the following questions: "during the last 12 months, have you ever deliberately hurt yourself or done anything you knew might have harmed you or even killed you?"; "during the last 12 months have you	Significantly higher likelihoods for having attempted suicide among participants with same-sex attraction (4.8 [2.4-9.6]), both-sex attraction (7.0 [5.2-9.4]), those unsure (2.4 [1.1-5.1]), and no attraction to either sex (1.1 [0.6-1.9]). Males with same-sex attraction (4.5 [2.3-8.7]), or both-

				seriously thought about killing yourself?"; and "during the last 12 months have you tried to kill yourself?"	sex attraction (5.8 [3.9-8.8]) showed significantly higher likelihoods for suicidal ideation. Females with both-sex attraction (4.4 [3.2-6.0]) or unsure (1.6 [0.8-2.9]) showed significantly higher likelihoods for suicidal ideation. Significantly higher likelihoods for having deliberately self-harmed among participants with same-sex attraction (2.8 [1.8-4.4]), both-sex attraction (5.8 [4.4-7.6]), and those unsure (1.8 [1.1-2.7]).
Clark et al. (2014)	• *n* = 7731 cisgender • *n* = 96 transgender • *n* = 202 not sure • *n* = 137 question not understood	A cross-sectional population-based survey on a nationally representative sample of secondary school students in 2012 (Youth'12 Survey).	• Gender modality was measured using responses to, "Do you think you are transgender?" with 4 possible options: yes, no, I'm not sure, and I don't understand the question. • Selected sex as either male or female. • Sexual orientation: "Which are you sexually attracted to?" from 5 possible options: opposite-sex; same-sex; both sexes; not sure; and neither.	Responses of yes or no to the following questions: "during the last 12 months, have you ever deliberately hurt yourself or done anything you knew might have harmed you or even killed you?"; and "during the last 12 months have you tried to kill yourself?".	Significantly higher likelihoods for having self-harmed (2.7 [1.7-4.3]) and attempted suicide (5.0 [2.9-8.8]) among transgender participants. Significantly higher likelihoods for having self-harmed (2.2 [1.6-2.9]) and attempted suicide (1.8 [1.0-3.1]) among participants who were unsure if they were transgender.
Lucassen et al. (2015)	**Exclusively opposite-sex attraction youth (EOSAY)**: • *n* (2012) = 7336 • *n* (2007) = 7370 • *n* (2001) = 8308 **Sexual minority youth (SMY)**: • *n* (2012) = 485 • *n* (2007) = 486 • *n* (2001) = 552	Cross-sectional population-based surveys on nationally representative samples of secondary school students in 2001, 2007 and 2012 (Youth2000 Surveys).	• Selected sex as either male or female. • Sexual orientation: "Which are you sexually attracted to?" from 5 possible options: opposite-sex; same-sex; both sexes; not sure; and neither.	Response of yes or no to, "during the last 12 months have you tried to kill yourself?".	Male SMY showed significantly higher likelihoods for having attempted suicide in 2001 (2.9 [1.8-4.7]), 2007 (7.7 [5.0-11.8]) and 2012 (5.6 [3.3-9.8]). Female SMY showed significantly higher likelihoods for having attempted suicide in 2001 (1.9 [1.3-2.9]), 2007 (4.0 [2.7-5.8]) and 2012 (3.7 [2.5-5.4]).

Chiang et al. (2017)	• *n* = 14706 sexual/gender (SG) majority • *n* = 1306 sexual/gender (SG) minority	Cross-sectional population-based surveys on nationally representative samples of secondary school students in 2007 and 2012 (Youth2000 Surveys).	• Selected sex as either male or female. • Sexual orientation: "Which are you sexually attracted to?" from 5 possible options: opposite-sex; same-sex; both sexes; not sure; and neither. • Gender modality was measured using responses to, "do you think you are transgender?" with 4 possible options: yes, no, I'm not sure, and I don't understand the question.	Responses of yes or no to "during the last 12 months have you tried to kill yourself?".	Male SG minority youth showed significantly higher likelihoods for having attempted suicide when categorised according to ethnicity groups: Pākehā (8.3 [5.6-12.1]), Māori (2.0 [0.7-6.0]), Pasifika (2.7 [1.2-6.1]), Chinese/East Asian (3.5 [0.9-12.9]), Indian/other Asian (7.5 [1.8-30.8]) and other ethnicities (10.2 [2.7-38.9]). Female SG minority youth showed significantly higher likelihoods for having attempted suicide when categorised according to ethnicity groups: Pākehā (4.6 [3.4-6.1]), Māori (2.0 [1.0-3.8]), Pasifika (1.1 [0.6-2.0]), Chinese/East Asian (1.7 [0.5-5.5]), Indian/other Asian (1.8 [0.6-5.2]) and other ethnicities (3.3 [1.4-7.7]).
Veale et al. (2019)	• *n* = 530 non-binary people • *n* = 342 trans men • *n* = 306 trans women	A national cross-sectional survey on trans and nonbinary peoples in 2018 (Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand).	• Gender identities: "What gender or what genders do you currently identify with? *Mark all that apply*." 27 possible options, including an option to specify gender(s) not listed. • Intersex status: "Do you have an intersex variation?" 3 possible options: yes; not; and don't know. • Sex assigned at birth selected as either male or female. • Gender pronouns: "What gender pronouns do you ask people to use to refer to you? *Mark all that apply*." 8 possible options, including "no pronouns. I ask people only to use my name", "I don't ask people to use	• Self-harm: "during the last 12 months, have you deliberately hurt yourself or sone anything you knew might have harmed you (but not kill you)?" 5 options ranging from "not at all" to "more than 5 times". • Lifetime suicidality: "Have you ever seriously thought about killing yourself?" and "have you ever seriously tried to kill yourself?" Response	Among the total sample of trans and non-binary peoples (*n* = 1,178), 495 participants (42%) reported having deliberately self-harmed in the last 12 months. For recent suicidality, 660 participants (56%) reported having contemplated ending their own life in the last 12 months and 141 participants (12%) had attempted to end their own life in the last 12 months. The lifetime prevalence of attempting suicide at least once was 37% of participants (*n* = 436).

			specific pronouns" and an option to specify pronouns not listed. • Sexual attraction was measured using responses to the question, "who are you sexually attracted to? *Mark all that apply*." 7 possible options, including responses for "none of the above" and to specify sexual attraction(s) not listed.	options of "yes" or "no" for both questions. • Recent suicidality: "In the last 12 months, have you seriously thought about killing yourself?" and "in the last 12 months, have you tried to kill yourself?" 3 options available for both questions: "not at all", "once or twice" and "three or more times". • Attempted suicide injury: "Did this ever result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?" Response of "yes" or "no".	
Treharne et al. (2020)	**Aotearoa sample**: • n = 148 transgender • n = 180 cisgender **Australian sample**: • n = 244 transgender • n = 128 cisgender	An international cross-sectional survey with transgender and cisgender samples from Aotearoa or Australian in 2017.	• Gender identity: "What term best describes your gender?" 4 possible options: agender; female; male; and non-binary; and an open-text box for additional responses. • Intersex status: "Do you have an intersex variation?" 3 possible options: yes; no; and unsure; and an open-text box for additional responses. • Sexuality: "What term best describes your sexuality?" 9 possible options and an open-text box for additional responses.	• The Suicidal Ideation Attributes Scale (van Spijker et al., 2014). A measure of suicidal ideation in the past month, pertaining 5 items each on an 11-point scale. • The Deliberate Self-Harm Inventory (Gratz, 2001). A measure of lifetime self-harm, pertaining 17 items each responded with either "yes" or "no" to a novel self-harm behaviour (e.g., "have you ever intentionally burned yourself with a cigarette?").	All measures of suicidality and self-harm were significantly higher for transgender participants when compared with cisgender participants (combined Aotearoa and Australian samples). Namely, recent (χ^2 = 42.9) and lifetime (χ^2 = 24.5) suicidal ideation; recent (χ^2 = 24.7) and lifetime (χ^2 = 45.4) attempted suicide; and recent (χ^2 = 45.0) and lifetime (χ^2 = 65.0) self-harm. There were no significant bivariate differences on the measures of suicidality and self-harm between the Aotearoa (n = 328) and Australian (n = 372) samples.

				• Lifetime and recent suicidal ideation: "Have you ever thought about ending your life?" Response options of "yes" or "no". "How often have you thought about attempting suicide in the last year?" 5 response options ranging from "never" to "daily". • Lifetime and recent suicide attempts: "How many times have you attempted suicide in the last year?" and "how many times have you attempted suicide in total over your lifetime?" Open-ended responses.	
Spittlehouse et al. (2020)	• *n* = 853 heterosexual • *n* = 131 mostly heterosexual • *n* = 36 bisexual • *n* = 20 gay/lesbian	Accumulated cohort studies on a longitudinal birth sample at ages 21, 25, 30 and 35 (Christchurch Health and Development Study).	**Aged 18 to 35**: • Sexual behaviour: "Have you ever had a sexual relationship with a partner of the same-sex?" **Aged 21 only**: • Selected sexual orientation and preference from 3 possible options: heterosexual/opposite-sex partners; homosexual/same-sex partners; or bisexual/partners of either sex. **Aged 25 to 35**: • Sexual behaviour: "Have you ever had any kind of sexual experience with a partner of the same-sex?" • Selected sexual orientation from 5 possible options scaling from exclusively same-sex attracted ("100% homosexual") to exclusively opposite-sex attracted ("100% heterosexual").	Interviews at ages 21, 25, 30 and 35 enquiring about suicidal ideation experienced since the last interview.	Significantly higher likelihoods for suicidal ideation among participants classified as bisexual (5.5 [3.0-10.1]), gay/lesbian (4.6 [2.1-10.3]), or mostly heterosexual (1.8 [1.1-3.0]). The bisexual group showed the highest odds ratio for suicidal ideation compared with all other groups.

			• Selected sexual attraction measured by the intensity of attraction and sexual preference from 5 possible options (e.g., "I am strongly attracted to people of the same sex as me and most of my sexual experiences will be with people of the same sex as me"). • Sexual fantasy (think/daydream of sex) selected from 3 possible options: males only; females only; or both.		
Tan et al. (2021)	• *n* = 93 diverse gender and sexual identities • *n* = 2810 cisgender and heterosexual	National cross-sectional population-based surveys on individuals aged 15 years and older in 2016 and 2018 (New Zealand Mental Health Monitor).	• Gender identity: "What gender do you identify with?" 4 possible options: female; male; gender diverse; and don't know. • Sexuality: "Which of the following options best describes how you think of yourself?" 4 possible options: heterosexual or straight; gay or lesbian/takatāpui; bisexual/takatāpui; and other.	Thoughts of self-harm/suicidal ideation: "Over the last two weeks, how often have you been bothered by thoughts that you would be better off dead, or thoughts about hurting yourself?" 4 response options ranged from "not at all" to "nearly every day".	The frequency of suicidal ideation/thoughts of self-harm was significantly higher among the diverse genders and sexuality sample (21.6%) compared with the cisgender and heterosexual sample (5.2%; *t* = 4.9), with a reported risk ratio of 3.1 (*CI* = 2.0-5.0).
Le Brun et al. (2004) Rossen et al. (2009)	**Youth'01**: • *n* = 8296 opposite-sex • *n* = 345 same/both sexes • *n* = 356 not sure/neither **Youth'07**: • *n* = 7370 opposite-sex • *n* = 343 same/both sexes • *n* = 289 not sure/neither **Youth'12**:	Cross-sectional population-based surveys on nationally representative samples of secondary school students in 2001, 2007, 2012, and 2019 (Youth2000 Surveys).	**Youth'01, Youth'07, Youth'12 and Youth'19**: • Selected sex as either male or female. • Sexual orientation: "Which are you sexually attracted to?" from 5 possible options: opposite-sex; same-sex; both sexes; not sure; and neither. **Youth'07 and Youth'12**: • Gender modality was measured using responses to, "do you think you are transgender?" with 4 possible options: yes, no, I'm not sure, and I don't understand the question. **Youth'19**: • Gender screening: "how do you describe yourself?" with 3 possible	**Youth'01, Youth'07, Youth'12 and Youth'19**: • Suicide attempt: "during the last 12 months have you tried to kill yourself?" • Suicidal ideation: "during the last 12 months have you seriously thought about killing yourself?" **Youth'07 and Youth'12**: • Self-harm: "during the last 12 months, have you ever deliberately hurt yourself or done anything you knew might have harmed you or even killed you?" **Youth'19**:	**Youth'01**: Students who reported their attraction preference as same-sex, both-sexes, not sure, or neither were categorised as 'non-heterosexual' (*n* = 701). Of these students, 210 (30.4% [26.5-34.1]) experienced suicidal thoughts and 106 (15.3% [12.3-18.2]) attempted suicide during the past 12 months. **Youth'07**: Students who reported same-sex or both-sexes attraction (*n* = 343) had significantly higher rates of self-harm (53.4% [47.1-59.7]), suicidal ideation (38.6% [33.0-

Lucassen et al. (2014) Fenaughty et al. (2021)	• *n* = 7336 opposite-sex • *n* = 303 same/both sexes • *n* = 350 not sure/neither **Youth'19**: • *n* = 6339 opposite-sex • *n* = 703 same/both sexes • *n* = 530 not sure/neither	options: boy/man, girl/woman, and I identify in another way. • Sex assigned at birth with 3 possible options: male, female, and indeterminate. • Gender modality was measured using responses to, "are you (or might you be) transgender or gender-diverse?" with 4 possible options: yes, no, I'm not sure, and I don't understand the question. • Selected gender identity(s) with 13 possible options, including 10 terms (e.g., agender, trans girl/woman, trans boy/man), I'm not sure, I don't understand the question, and an open-text box for additional responses. • Selected sexual identity(s) with 9 possible options, including 6 terms (e.g., straight, bisexual, takatāpui), not sure, I don't understand the question, and an open-text box for additional responses.	• Self-harm: "during the last 12 months have you deliberately hurt yourself or done anything you knew might harm you (but not kill you)?"	44.2]), and suicide attempt(s) (20% [15.8-24.3]) compared with students reporting other attraction preferences (i.e., opposite-sex, or not sure/neither). **Youth'12**: Students who reported same-sex or both-sexes attraction (*n* = 302) had significantly higher rates of self-harm (59.4% [53.7-65.1]), suicidal ideation (47.7% [41.2-54.2]), and suicide attempt(s) (18.3% [13.8-22.9]) compared with students reporting other attraction preferences (i.e., opposite-sex, or not sure/neither). **Youth'19**: Students who reported same-sex or both-sexes attraction (*n* = 703) had significantly higher rates of self-harm (50.1% [45.8-54.5]), suicidal ideation (46.9% [42.6-51.3]), and suicide attempt(s) (13% [10.1-15.8]) compared with students reporting other attraction preferences (i.e., opposite-sex, or not sure/neither).

Notes. * Unless stated otherwise, all findings are reported as odds ratios with 95% confidence intervals (*OR* [95%*CI*]) with cisgender and/or heterosexual participants as the reference group for comparisons (*OR* = 1.0).

Appendix B

Associate Professor Damien W. Riggs

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CRICOS Provider No. 00114A

INFORMATION SHEET
for survey participants

Title: The impact of social norms and social connectedness upon suicidality: A comparative study

Researchers:

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School of Social and Policy Studies
Flinders University

Dr Sonja Ellis
Australian Institute of Professional Counsellors

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University of Otago

Description of the study:

The research aims to better understand suicide and self harm in Australia and New Zealand. It has been found that certain groups may be especially at risk of suicide or self harm, but also that certain groups may be protected from such risks, with social connectedness potentially playing a key role in mitigating risk. This project is supported by the School of Social and Policy Studies at Flinders University.

Purpose of the study:

This project aims to identify

1. similarities and differences with regard to suicidality between transgender and non-transgender populations
2. the potential role that social norms and social connectedness play in increasing or preventing suicide
3. similarities and differences between the Australian and New Zealand contexts with regard to suicidality and its predictors

What will I be asked to do?

As a participant, you are invited to voluntarily complete a 30 minute online survey. You are, of course, free to withdraw from involvement at any time before completing the survey.

What benefit will I gain from being involved in this study?

The sharing of your experiences will assist in awareness raising about potential causes of suicidality amongst specific cohorts, and thus contribute to public health campaigns that seek to reduce rates of suicide and self-harm in both Australia and New Zealand.

Will I be identifiable by being involved in this study?

Your responses to this survey will be anonymous and confidential and any reports or publications produced from the findings will be written in ways that ensure your privacy. Contact details entered at the conclusion of the survey will be stored separately.

Are there any risks or discomforts if I am involved?

Given the topic of the survey, it is possible that some people may find certain aspects of the survey distressing. Example questions include: "Have you ever intentionally (i.e., on purpose) cut your wrist, arms, or other area(s) of your body (without intending to kill yourself)?", "Have you ever intentionally (i.e., on purpose) burned yourself with a cigarette?" and "Have you ever intentionally (i.e., on purpose) dripped acid onto your skin?". Given the potential for distress, it is suggested that any person likely to experience significant distress when reading these types of questions should not complete the survey. For those people who are unsure about how distressing the survey might be, it is suggested that you complete the survey when a support person (i.e., friend or family member) is available to speak about any distress you experience. At the end of this information sheet, and also at the beginning and end of the survey, you will find a list of resources that offer free support to people experiencing distress, and you are encouraged to access one of these if you require additional support.

How do I agree to participate?

Participation is voluntary. Consent is indicated by agreeing to proceed with the survey.

How will I receive feedback?

On project completion outcomes will be disseminated by the researchers via social media, in addition to being emailed to participants who enter their contact details.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7430). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix C

NEW ZEALAND CONTACT DETAILS FOR SUPPORT WITH REGARD TO SUICIDE AND SELF HARM

Lifeline Aotearoa
0800 54 33 54 or www.lifeline.org.nz

Lifeline Aotearoa provides 24-hour telephone counselling and support service for those who may be thinking about suicide, or for those who are concerned about friends or whānau. This helpline is staffed by highly experienced helpline counsellors with training in suicide prevention and intervention.

Samaritans
0800 726 666 or www.samaritans.org.nz

The New Zealand Samaritans is a confidential listening and support telephone service operating 24 hours a day for people who may be feeling depressed, lonely, or even be contemplating suicide.

Depression Helpline
0800 111 757 or www.depression.org.nz

The New Zealand Depression Helpline is a 24/7 helpline operated by trained counsellors who can talk about how you are feeling and discuss sources of help. Their website includes information about support for Māori communities, Pasifika communities, deaf communities, and people living rurally.

Youthline
0800 376 633, talk@youthline.co.nz or free text 234

Youthline provides 24-hour telephone support and face-to-face counselling for young people in New Zealand. They also run a free text message support service.

OUTLine
0800 688 5463 or www.outline.org.nz

OUTLine provides telephone support for people with diverse gender identities and/or sexualities. Their website has a range of resources including info about coming out.

Gender Minorities Aotearoa

www.genderminorities.com
Gender Minorities Aotearoa is an online organisation that hosts resources for trans or non-binary people including lists of recommended doctors across New Zealand.

4

Appendix D

Assumption Testing Post-Hoc

Study one was an evaluation of an adapted version of Klonsky and May's (2015) Three Step-Theory (3ST) of suicide using a cross-sectional survey design, with variables defined by risk factors relevant to queer and takatāpui people. Given that the dataset used was not intended for the hypotheses explored within this research, I decided that post-hoc analyses would be advantageous for future research aiming to evaluate the applicability of the 3ST of suicide to queer and takatāpui samples. Several statistical analyses were used to test this study's 12 hypotheses, including Pearson's correlation coefficient, Spearman's rank correlation, hierarchical multiple regression, one-way ANOVA, two-sample unpaired *t*-test, and binary logistic regression. As such, the assumptions of multiple linear regression and Pearson's correlation were tested since these assumptions underpin most of the other analyses that were performed (Williams et al., 2013; Tabachnick & Fidell, 2018). These assumptions were examined on all the main study variables.

Power Analysis

Power analyses were conducted using Faul's G*Power software, Version 3.1.9.6. A power analysis for the hierarchical multiple regression model was performed using the following parameters: $f^2 = 0.916$, $\alpha = .05$, $N = 250$, and $\omega = 3$, which calculated a power level ($1 - \beta$) of 1.0, suggesting that statistical power was high for this regression analysis. With exception to two correlations conducted for hypothesis 10, all other correlational analyses yielded significant results. As such, power analyses were performed on the two non-significant correlation coefficients ($r_s = .133$, $r = .158$) to determine the sample sizes required to yield significant results. For the Pearson's correlation coefficient of .158, it was estimated that a sample size of at least 312 was required to detect a significant result ($\alpha = .05$) at the power level of 0.80. For the Spearman's correlation coefficient of .133, it was estimated that that a sample size of at least 441 was required to detect a significant result ($\alpha = .05$) at the power level of 0.80.

Data Assumptions

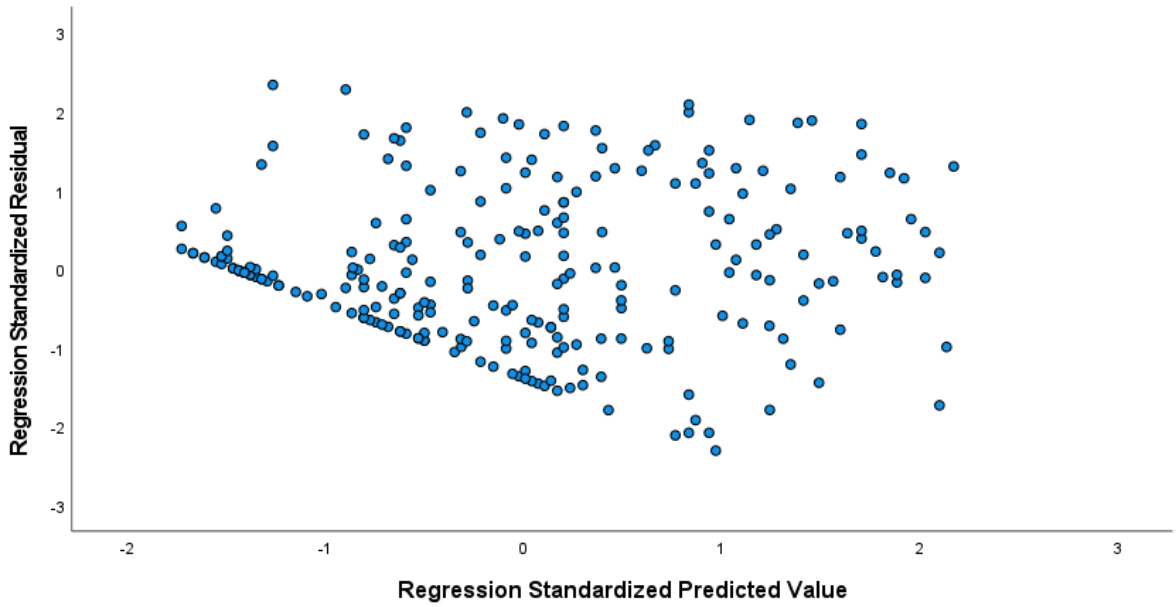
As evident from the correlation matrix (Table 6, p. 82), the magnitudes of the Pearson's bivariate correlations ranged from -.242 to .675. Since none of these correlation coefficients exceeded the magnitude of .80, it can be interpreted that the assumption of multicollinearity

was not violated (Tabachnick & Fidell, 2018). Additionally, the variance inflation factor (VIF) values for the multiple linear regression model (Table 7, p. 83) ranged from 1.0 to 1.08, thus, multicollinearity was unlikely to have influenced this analysis since none of the VIF values exceed 10 (Complete Dissertation, 2021).

The assumptions of independence and homoscedasticity for multiple linear regression were examined using a scatterplot (Figure 9), depicting the standardised residuals (y-axis) and the standardised predicted values (x-axis). As evident in Figure 9, the residuals plotted against the predicted values were not entirely distributed at equal widths across the graph, showing a diagonal trend in the bottom-left of the graph, suggestive of non-random scattering. Therefore, the assumptions of independence and homoscedasticity may have been violated since the residuals did not fall within a rectangular distribution (Tabachnick & Fidell, 2018).

Figure 9

Scatterplot depicting regression standardised residual and predicted values. Dependent variable of suicidal ideation



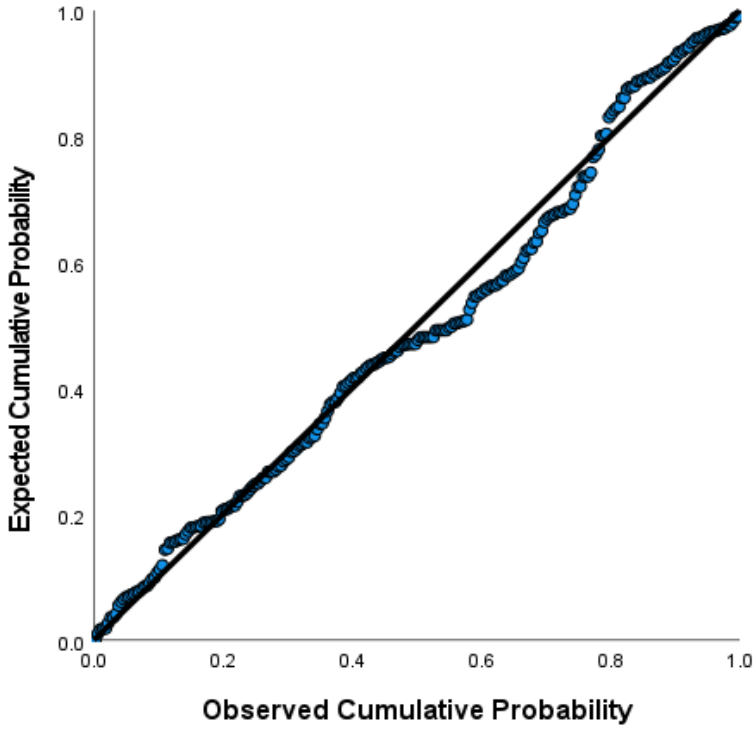
Notes. Multiple regression analysis for hypotheses 3, 4, and 5. Predictor variables: hopelessness, discrimination, and the interaction term. Outcome variable: suicidal ideation.

An analysis for skewness showed that the variables ranged from -.664 to .744, suggesting that the symmetry of the distributions were relatively centred around the means (Tabachnick & Fidell, 2018). Testing for kurtosis, the variables ranged from -.901 to .288, indicating that the distributions were relatively neither too peaked nor too flat (Tabachnick & Fidell, 2018). The

assumption of normality for multiple linear regression was explored using a normal probability plot of the standardised residuals (Figure 10). As evident in Figure 10, the residuals roughly fell along the diagonal line, with some slight deviations evident towards the centre and upper portions of the line. This suggests that the standardised residuals are likely to be normally distributed (Tabachnick & Fidell, 2018).

Figure 10

Normal P-P plot of regression standardised residuals. Dependent variable of suicidal ideation



Notes. Multiple regression analysis for hypotheses 3, 4, and 5. Predictor variables: hopelessness, discrimination, and the interaction term. Outcome variable: suicidal ideation.

Appendix E

Safety Protocol

As recognised within contemporary literature, talking about suicide, and assessing for suicide does not increase individuals' risk for suicidality (Dazzi et al., 2014; Harris & Goh, 2017), and may have some benefits regarding the reduction of suicidal ideation (Blades et al., 2018). Further, a study by Smith et al. (2010) showed that none of the participants had self-harmed or attempted suicide 3-months following participation in suicide research.

To ensure the safety of myself during interview sessions, I will provide my research supervision team with details about scheduled interviews, including the interview locations and start time. I will also notify my supervision team when interviews have finished. This communication will be undertaken via text messages to Associate Professor de Terte (registered clinical psychologist, co-supervisor), and a group email sent to Associate Professor de Terte, Associate Professor Treharne (co-supervisor), Associate Professor Tuffin (primary supervisor), and Associate Professor Tassell-Matamua (cultural advisor).

I will actively check in with participants throughout the interview and ask them how they are feeling and if they are okay to proceed with the interview. If a participant become defensive during the interview, then I will pause the interview and ask the participant if any of the questions are upsetting to them. If the participant's response affirms, then I will remind them that they do not have to answer any of the questions and do not need to provide a justification. I will then ask the participant if they feel comfortable continuing the interview.

If a participant appears to be *mildly distressed* during interviews, then I will pause the interview, ask participants how they are currently feeling, and if they feel capable of continuing with the interview. *Mildly distressed* is defined as the participant appearing:

- Tense,
- Tearful,
- Upset,
- Stutters while they speak,
- Fidgeting (e.g., shaky legs),
- Closed-off body language (e.g., hunched over, crossed arms),

- Sarcastic and/or inappropriate comments (dependent on the context),
- Holding their breath (short duration), and/or
- Remaining silent when asked a question.

If participants' distress escalates to an extent where they appear *severely distressed*, then I will terminate the interview immediately. I will ask the participant how they are currently feeling, and then tell the participant to remain calm and seated. I will contact Ass/Prof de Terte via phone call in order to engage in a safety consultation on how to appropriately approach the current situation. If necessary, I will ask the participant if they have whānau, friend(s) or support person(s) who would be able to pick them up from the interview location to support them, and ask if they consent for the individual(s) to be informed that the participant has experienced some distress. I will not leave the presence of the participant throughout this process as a means of monitoring their distress levels and ensure that they do not unsafely leave the interview location in a distressed state. Within this context, *severely distressed* is defined as the participant:

- Excessively crying,
- Unable to communicate,
- Physically and/or emotionally aggressive,
- Violent or threatening language,
- Having a panic attack, and/or
- Walking out of the interview session.

An emergency procedure will be employed if participants disclose any active intent of ending their own life. This includes if participants express suicidal ideation or begin to self-harm during the interview. I will cease the interview immediately and contact Ass/Prof de Terte via phone call to inform him of the situation and receive safety consultation. I will ask the participant if they have any whānau, friend(s) or support person(s) who they would like the researcher to contact to inform them that they are experiencing distress. I will remain in the presence of the participant. *If deemed appropriate for the situation and the participant consents*: I will subsequently phone the local DHB mental health crisis service (e.g., CATT, Te Haika, CRS) depending on the interview location. If the crisis service is unavailable, then I will contact the police via phone call to 111.

If participants experience any levels of distress during interviews, I will employ *grounding techniques* as a means of ensuring that this distress does not escalate. Grounding techniques are a set of tools used to assist individuals to remain within the present moment during episodes of distress, anxiety, or other overwhelming emotions. Staying in the present moment allows people to feel safe and in-control by focusing on the physical world around, thus reorientating their current focus to external experiences. *Grounding techniques* include:

- Focusing on breathing,
- Asking participants to notice each inhale and exhale,
- Asking participants to feel their feet on the floor,
- Taking participants for a short walk,
- Offering participants drinks,
- Asking participants to locate certain objects in the room, and
- Asking participants to describe their sensory systems (e.g., "what can you hear/taste/smell/see/feel?").

I will make follow-up phone calls to any participant who expressed any level of distress during interviews as a means of supporting them to access appropriate services if required. The researcher will then subsequently debrief with Ass/Prof de Terte.

Appendix F

National and Local Mental Health and Support Organisations

The following list provides contact details for a range of mental health and support organisations. Included are organisations specifically tailored to assisting those experiencing suicidal thoughts and suicide behaviours, as well as community supports for individuals with diverse gender identities and sexualities.

If you feel that you need help, please reach out and talk to someone.

If you feel that either yourself, or someone you know, is in immediate danger, please call emergency services on 111.

OUTLineNZ Free phone: 0800 688 5463, Website: www.outline.org.nz
An organisation that provides support for people with diverse gender/sexual identities. Their website provides numerous resources on related to wellbeing.

Gender Minorities Aotearoa Facebook: www.facebook.com/genderminorities/
An online community that advocates for the rights, health and wellbeing of all sex and gender minority people in Aotearoa.

InsideOUT Phone: 027 331 4507, Email: hello@insideout.org.nz
A national organisation that offers support for people with diverse gender/sexual identities.

Tapatoru Email: info@tapatoru.org.nz, Website: www.tapatoru.org.nz
A Wellington-based organisation that provides support for the Māori trans* people and their whānau.

Tiwhanawhana Website: www.tiwhanawhana.com
A takatāpui community group based in Wellington that provides support for people with diverse gender/sexual identities.

UniQ Massey Email: UniQ@MAWSA.org.nz
A queer representative group that provides support for queer students and friends at Massey University, Wellington. Provides inclusive events.

UniQ Victoria Facebook: www.facebook.com/uniq.victoria.9
A queer representative group that provides support for queer students at Victoria University, as well as anyone who is queer or questioning. Inclusive events.

1737 Free phone or text: 1737
A national support service that provides direct contact with a trained counsellor 24-hours a day, 7-days a week.

Depression Helpline Free phone: 0800 111 757, Free text: 4202
A service tailored to supporting people experiencing depression and/or anxiety. They offer counselling, tools and information for depression and anxiety issues.

Lifeline Aotearoa Free phone: 0800 543 354, Free text: 1737

A national helpline that provides 24/7 confidential support for people contemplating suicide from qualified counsellors and trained volunteers.

Suicide Crisis Helpline Free phone: 0508 828 865 (TAUTOKO)

A national service that provides direct access to telephone counsellors who are experienced with advanced suicide prevention strategies.

Wellington Crisis Assessment Team Free phone: 0800 745 477

A Wellington-region assessment and short-term treatment services for people experiencing a serious mental health crisis with urgent safety issues.

Youthline Wellington Free phone: 0800 37 66 33, Free text: 234

An organisation that provides direct access to trained telephone and face-to-face counselling for young people, 24-hours a day, 7-days a week.

Appendix G

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TE KURA PŪRENGA TANGATA

Tēna koe

Ko Taranaki tōku maunga;
Ko Waitara tōku awa;
Ko Ngāti Rāhiri tōku hapū;
Ko Te Ātiawa, Ngāi Tahu ōku iwi;
Ko Irie Schimanski ahau.

Kia ora, my name is Irie and I self-identify as a cisgender gay man. I am doing a Doctor of Clinical Psychology at Massey University, Wellington, under the supervision of Associate Professor Keith Tuffin (Massey University, Wellington), Associate Professor Gareth Treharne (University of Otago), Dr Natasha Tassell-Matamua (Te Ātiawa, Ngāti Makea kei Rarotonga; Massey University, Palmerston North) and Dr Ian de Terte (Massey University, Wellington).

I am interested in learning about how takatāpui* and LGBTQIA+ people think about suicide and support after having recovered from experiencing suicidal thoughts.

***Takatāpui** is defined as Māori who self-identify as lesbian, gay, bisexual, transgender, or any other diverse sexuality or gender.

Please, read through the following information if you are interested in taking part in the research project

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 18/68.

Information Sheet

Perspectives from takatāpui and LGBTQIA+ people who have recovered from suicidality

What is the purpose of the research?

The research aims to look at how suicidal thoughts, suicide behaviours, discrimination and supports are understood by takatāpui and queer people. I am interested in talking to people who self-identify as queer, takatāpui, non-binary, LGBTQIA+, questioning, or any other diverse gender/sexuality, and have previously experienced suicidal thoughts, self-harmed or attempted suicide. Because the research involves discussions about subjects which may be distressing, if you have self-harmed or attempted suicide within the last 12-months you will be unable to participate in the research.

How would I participate in the research?

Participation will involve taking part in a one-on-one interview with myself. Whānau, a friend, or a support person is able to attend the interview if this would make you more comfortable. The interview is expected to take 60-90 minutes and will be audio recorded. **If you wish to participate, please contact me by emailing: Irie.Schimanski.1@uni.massey.ac.nz**. This will give you the chance to ask any questions and learn more about the interview process. After this we can set up a time and place to do the interview.

Staying safe as a participant

Participation is voluntary, and you should talk to whānau, friends and support persons about the research. During the interview, if you become upset or feel you are unable to continue, then the interview will stop. If you or I have any concerns about your wellbeing or safety during the interview, then I will ask how you are feeling, and we will contact one of my supervisors for support if it is appropriate.

At the end of the interview, I will ask how you are feeling, and you will have the chance to discuss any feelings or thoughts you have. If you feel distressed and wish to talk to a professional about your experiences, I can assist you to access local counselling or support services within your region.

Can I participate if I am not 'out' about my sexuality or gender identity?

Yes. All of your personal information will remain confidential and no material that could identify you will be used in any reports written from this research.

Where will the interview take place?

The interview can take place at a location of your choosing. The place needs to be somewhere private enough so that discussions will not be overheard by strangers and the interview will be recorded clearly. A suitable location could be the Massey University Psychology Clinic in Wellington, a community centre, including a public library or community hall, or at your own home. I am able to travel to where you live for the interview. Please choose a location where you will be comfortable and able to talk without distractions.

What happens after the interview?

I will type out the interview verbatim into a script format, and you will be sent a copy of the interview script to review. You will have 3-weeks to add text/comments or remove any parts that you please. If the script is not returned within 3-weeks, then the original

interview script will be used. Findings from the research will be shared with you via email, telephone or post. If you wish, I will be available to discuss the findings with you.

How will I be compensated?

You will receive a $30 supermarket voucher as koha for your time and effort.

What are my rights if I participate?

Please read this information before agreeing to participate. If you have any questions about your rights or something is not clear, I am happy to go through this with you before your interview.

- You can withdraw at any time before the research is written up. To do this, just contact me and your interview recording, as well as any information about yourself will not be used in the research. Withdrawing will have no negative impact on you, and you do not have to explain why you are withdrawing.
- You do not have to answer an interview question. If any question makes you feel uncomfortable, then you can decline to answer and do not have to provide a reason why. The audio recorder can be paused at any stage during the interview if you wish to take a break.
- Your information and interview will remain private. All of your personal information and interview recording will be kept securely at Massey University. Your interview will be written up as a transcript and a pseudonym will be used to identify you. Only my supervisors and I will have access to your information, including your identity.

Who should I contact if I have any questions or concerns?

You can email me if you have any questions or concerns about the research at any stage. If you wish to speak to someone other than myself, you can also contact Associate Professor Keith Tuffin, who is my primary research supervisor.

Irie Schimanski
Doctor of Clinical Psychology Student
Irie.Schimanski.1@uni.massey.ac.nz

Associate Professor Keith Tuffin
Associate Professor
School of Psychology
K.tuffin@massey.ac.nz
(04) 801 5799 ext. 63605

If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.

National helplines and support services

Suicide Crisis Helpline:	Free call 0508 828 865 (0508 tautoko)
Lifeline:	Free call 0800 543 354
Depression Helpline:	Free call 0800 111 757 or text 4202
1737 (trained counsellors):	Free call or text 1737
Youthline:	Free call 0800 37 66 33
The Low Down:	Text 5626 or visit www.thelowdown.co.nz
OUTLine NZ:	Free call 0800 688 5463

Emergency Support

If you feel yourself, or someone you know, is in immediate danger, please call emergency services on 111

Appendix H

Key questions

- Subsequent questions are relevant to the key question and will be utilised in order to gain a greater depth to each subject matter.
    - *Prompting questions and examples will be utilised to elicit further discussion **if** participants do not understand the questions, **and/or** find it conceptually difficult to answer the questions.*

The phrase 'LGBT+ people' may be replaced with specific identities that have been self-disclosed by the participant (e.g., takatāpui, queer, LGBTQIA+ terms).

Interview Schedule

Thank you for agreeing to participate in the research, I really appreciate you giving your time to take part in this interview.

Engage in small talk:

- Are you feeling comfortable?
- How have you been lately?
- Where are you from?

As you saw in the interview schedule that I sent you, I'm going to be asking you some questions about discrimination, self-harm and suicide. I just want to remind you that you do not have to answer any questions that you are uncomfortable with, and you can tell me at any time if you want to stop the interview for any reason at all. Please let me know if you feel upset or distressed at any point and we'll take a break.

- Are there any questions on the interview schedule that you have concerns about?

Before we begin, would you like us to say a karakia to open up the space for our kōrero?

- Do you have a particular one that you would like us to use?
- Or, would you prefer that I say one that I really like?

I'm going to start recording now, is this okay?

START RECORDING

Just to get us started, I'm going to go through some demographic questions so I can get a better sense of who you are and how you self-identify.

- What is your name?
- How old are you?
- What sex were you assigned at birth?
- Are you intersex or do you have a diagnosis of a diverse sex variation?
- What terms do you use to describe your gender identity?
- What gender do you have listed on your current identity documents?
- What terms do you use to describe your sexuality?
- What terms do you use to describe your ethnicity?
    - *If Māori*: Can you please tell me the iwi and hapū you belong to?

Thank you for providing that information. Now I'm going to ask you some questions about social norms and discrimination. **Are you feeling okay to continue?**

What is your understanding of "social norms"?
Within our society, there are common views around ethnicity, gender and sexuality which people use to decide what is "normal" and what may be unusual. These are called "social norms". If we take gender as an example, within society it is considered "normal" for an individual to self-identify as the gender they were assigned at birth, and another dominant view is that gender exists as a binary; male and female. ***Does this make sense?***

Thinking about the dominant social norms around ethnicity, gender and sexuality, do you think these social norms cause LGBT+ people to experience discrimination?

- In what ways do LGBT+ people experience discrimination?
    - *What does this discrimination look like?*
- Do you think discrimination is particularly difficult for some LGBT+ people compared with others?
    - *For example, do you think the discrimination experienced by a Pākehā gay man, would be the same for a Māori gay man?*
- Within research on suicide, marginalised ethnic, gender and sexual identities are often referred to as "risk factors". What are your thoughts on these groups being referred to as risk factors?

Why do you think people self-harm?

- Do you think self-harm contributes to people going on to attempt suicide later on?
    - *In what ways does self-harm contribute to suicide attempts?*
- What do you think are the differences between a suicide attempt and self-harm?
    - *How would someone recognise the difference between a person who had attempted suicide or if they had instead self-harmed?*
- Some people understand self-harm as a way of coping with distress. What are your thoughts on this?
    - *Do you think self-harm is a healthy way of dealing with stress?*
    - *Drug and alcohol abuse has been increasing within LGBT+ communities recently. Why do you think this is happening?*

Thinking specifically about LGBT+ people, what do you think are the main factors which contribute to these people starting to have suicidal thoughts?

- Do you think discrimination contributes to suicidal thoughts and suicide among LGBT+ people?
    - *How do you think discrimination makes someone feel so that they start to have suicidal thoughts? For example, do you think discrimination is a type of pain?*
- What do you think takes someone from having suicidal thoughts to attempting suicide?

How do you think suicide is understood within LGBT+ communities as a whole?

- Now thinking about yourself. In what ways does being ******insert the participant's ethnic, gender and sexual identities******* shape your understanding of suicide?
    - *Why do/don't you think your self-identity influences your beliefs on suicide?*
    - What about if I use culture and religion instead of ethnicity?
- Do you think your beliefs around suicide are different from people with different self-identities?
    - *For example, a group of people who are cisgender and heterosexual.*

What do you think would help prevent suicide among LGBT+ people?

- Do you think social supports help LGBT+ people resist against discrimination?
- What kinds of social supports are most useful for LGBT+ people?
    - *What kinds of supports could LGBT+ organisations offer which would be helpful for preventing suicide?*
- What do you think the role of whānau is regarding support and suicide prevention?
- How does being *****insert the participant's ethnic identity***** contribute to LGBT+ peoples' resiliency against suicide?
    - *Resiliency is one's capacity to recover from or adjust easily to stress that they experience in their lives. This can be day-to-day stressful situations or can be a traumatic event.*
- Do you think how the media portrays suicide influences whether or not someone will go on to attempt suicide?
    - *For example, some participants have said that showing or talking about suicide in movies and television can cause people to start to contemplate committing suicide.*
- How does the positive representation of LGBT+ people within media contribute to resiliency?

Is there anything that we've talked about that you'd like to add to?

STOP RECORDING

How are feeling after those questions?

- The interview may have caused you to have some thoughts and feelings, these are normal given what we've discussed.
- Is there anything I can get for you?

Here is a list of local and national support services many of whom are specifically for people with LGBTQIA+ identities. If you feel like you need any extra support or are concerned about your wellbeing, I can help you make contact with any of these support services.

- Would you like me to help you contact any of these?
- Even if you decide after this interview that you want me to help you make contact, you can send me an email and we can work through the process together.

To finish this off, I have two quick questions for you to answer:

- What is one act of self-care that you are going to do after you/I leave?

- Who's one person in your life that you can contact if you need support?

If the participant self-discloses active suicidal thoughts

Cease the interview immediately.

- Thank you for letting me know this. How are you feeling at the moment?
- Do you have these thoughts when you are not in an interview like this? Or, did these thoughts come about because of this interview?
- Are you currently attending any form of therapy or counselling services?
- Is there anyone that I can call for you to make sure that you have support?
    - Do you mind If I give them a call now?

Phone Ian for support and do not leave the participant alone.

- Take note of what question/questions elicited the participant's distress.
- Take note of any physical signs of distress the participant is displaying.
- Take note of as many details as possible for the use of emergency/support services.

If the participant self-discloses that they have self-harmed or attempted suicide within the last 12-months

Cease the interview immediately.

- Thank you for letting me know this. How are you feeling at the moment?
- Unfortunately, the university has only given me permission to interview people who haven't self-harmed or attempted suicide recently. I'm sorry to say but I will not be able to interview you today.
    - *Based on the participant's reaction*: How do you feel about what I just said?
- Before you leave, I have two quick questions for you:
    - What is one act of self-care that you are going to do after you/I leave?
    - Who's one person in your life that you can contact if you need support?

Maintaining my safety during interviews

- Sit by the door if possible.
- Maintain a passive and calm voice throughout the interview.
- Do not stand up if the participant appears to be angry during the interview.
- Gage each participant as an individual and do not rely too heavily on scripted safety responses because this can arise in missed information.

Appendix I

Interview Questions

Perspectives from takatāpui and LGBTQIA+ people who have recovered form suicidality
I will ask the following questions to you during a one-on-one interview between the two of us.

Demographic questions:

- What is your name?
- How old are you?
- What sex were you assigned at birth?
- Are you intersex or do you have a diagnosis of a diverse sex variation?
- What terms do you use to describe your gender identity?
- What gender do you have listed on your current identity documents?
- What terms do you use to describe your sexuality?
- What terms do you use to describe your ethnicity?
    - *If Māori*: Can you please tell me the iwi and hapū you belong to?

What is your understanding of "social norms"?

Thinking about the dominant social norms around ethnicity, gender and sexuality, do you think these social norms cause LGBT+ people to experience discrimination?

- In what ways do LGBT+ people experience discrimination?
- Do you think discrimination is particularly difficult for some LGBT+ people compared with others?
- Within research on suicide, marginalised ethnic, gender and sexual identities are often referred to as 'risk factors.' What are your thoughts on these groups being referred to as risk factors?

Why do you think people self-harm?

- Do you think self-harm contributes to people going on to attempt suicide later on?
- What do you think are the differences between a suicide attempt and self-harm?
- Some people understand self-harm as a way of coping with distress. What are your thoughts on this?

Thinking specifically about LGBT+ people, what do you think are the main factors which contribute to someone starting to have suicidal thoughts?

- What do you think takes someone from having suicidal thoughts to attempting suicide?
- Do you think discrimination contributes to suicidal thoughts and suicide among LGBT+ people?

How do you think suicide is understood within LGBT+ communities as a whole?

- Now thinking about yourself. In what ways does your ethnic, gender and sexual identities shape your understanding of suicide?
- Do you think your beliefs around suicide are different from people with different self-identities?

What do you think would help prevent suicide among LGBT+ people?

- Do you think social supports help LGBT+ people resist against discrimination?
- What kinds of social supports are most useful for LGBT+ people?
- What kinds of supports could LGBT+ organisations offer which would be helpful for preventing suicide?
- What do you think the role of whānau is regarding support and suicide prevention?
- How does ethnic identity contribute to LGBT+ peoples' resiliency against suicide?
- Do you think how the media portrays suicide influences whether or not someone will go on to attempt suicide?
- How does the positive representation of LGBT+ people within media contribute to resiliency?

Is there anything that we've talked about that you'd like to add to?

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 18/68.

Appendix J

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AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

PARTICIPANT CONSENT FORM

Perspectives from takatāpui and LGBTQIA+ people who have recovered from suicidality

I have read the Information Sheet and I understand what is involved.

I have had the details of the research explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time during the research.

I have been given sufficient time to consider whether to participate in this research and I understand participation is voluntary and that I may withdraw from the research at any time without any consequences to myself.

I understand that the interview will be used for the purposes of doctorate research and may be used to produce subsequent manuscripts for publication in academic journals.

1. I agree to the interview being audio recorded;
2. I agree to participate in this study under the conditions set out in the Information Sheet;
3. I agree to have the interview recording and script stored at Massey University for up to 10-years;
4. I wish to have my interview script returned to me so I can review and edit it: **YES** ☐ or **NO** ☐
    a. I understand that I have 3-weeks to edit and return my interview script, otherwise the initial interview script will be used in its original integrity.

Declaration by Participant:

I _____ hereby consent to take part in this study.
(Print full name)

Signature: _____ **Date**: _____

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 18/68.

Appendix K

PERSPECTIVES FROM TAKATĀPUI AND LGBTQIA+ PEOPLE WHO HAVE RECOVERED FROM SUICIDALITY

Kia ora! Do you self-identify as queer, takatāpui, non-binary, intersex, questioning, LGBTQIA+, MVPFAFF or another diverse gender/sexuality?

Have you personally experienced suicidal thoughts or attempted suicide?

Are you aged 18-years or older?

I am interested in interviewing adults with diverse gender identities and sexualities who have lived with suicidal thoughts, suicide behaviours and whakamomori.

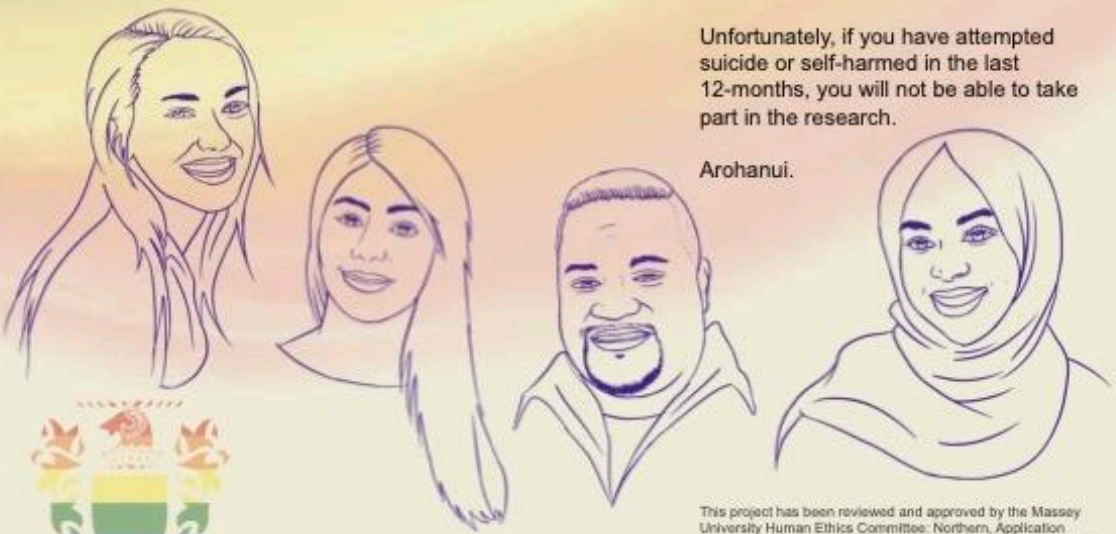
The purpose of the one-on-one interview is to hear what you think about suicide and your ideas around what supports takatāpui and LGBTQIA+ communities need for suicide prevention.

The interview is expected to last around 90 minutes and you will receive a **$30 supermarket voucher as koha** for expenses you may encounter.
If you are interested in taking part in the study or have any questions at all, please email Irie Schimanski at **Irie.Schimanski.1@uni.massey.ac.nz**

As a precaution for safety, please talk to whānau, friends and supports before deciding to participate.

Unfortunately, if you have attempted suicide or self-harmed in the last 12-months, you will not be able to take part in the research.

Arohanui.



This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 18/68. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.

Appendix L


PERSPECTIVES FROM MĀORI LGBTQIA+ AND TAKATĀPUI PEOPLE WHO HAVE RECOVERED FROM SUICIDALITY
Kia ora! Are you Māori and LGBTQIA+/Takatāpui?
Have you personally experienced suicidal thoughts or attempted suicide?
Are you aged 18-years or older?
I am interested in interviewing Māori adults with diverse gender identities and sexualities who have recovered from suicidal thoughts, suicide behaviours, whakamomori.
The purpose of the one-on-one interview is to capture Māori understandings of suicide, as well as your ideas around what supports takatāpui communities need for suicide prevention.
The interview is expected to last around 90 minutes and you will receive a $30 supermarket voucher as koha for expenses you may encounter.
If you are interested in taking part in the study or have any questions at all, please contact Irie Schimanski.
email | irie.schimanski@yahoo.com
text | 0278189717
As a precaution for safety, please talk to whānau, friends and supports before deciding to participate. You are more than welcome to bring along a whānau member or friend as a support person.
Unfortunately, if you have attempted suicide or self-harmed in the last 12-months, you will not be able to take part in the research. Aroha nui.
This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 18/68. If you have any concerns about the conduct of this research, please contact Associate Professor David Tappin (Committee Chair), Massey University Human Ethics Committee: Northern, email humanethicsnorth@massey.ac.nz.

Appendix M

Research Case Study

Holding Space for Queerness: The therapeutic use of self as a means of growing the therapeutic alliance

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This case study represents the mahi of Irie Schimanski during his doctoral research from 2018 to 2019 and reflections as an Intern Psychologist in 2020. Clinical supervision was received during the assessment and therapy for the tangata whaiora described within this case study by Katie Ryan, Caleb Carati, and Michele Pedersen. All names and identifiable information within this case study have been anonymised and changed to protect the privacy of the tangata whaiora.

Abstract

The current case study outlines my reflections on the application of my doctoral research to my mahi as an Intern Psychologist at Te Whare Marie and Wellington South Community Mental Health Team. I begin by sharing my own identity as a takatāpui, Māori and Pākehā man using my pepeha. A summary of my doctoral research is provided highlighting the two theories that I utilised: The Three-Step Theory of suicide and the Theory of Decompensation. Research on the therapeutic use of self in therapy is integrated into this case study to provide an understanding on how experiences, worldview and mutuality informed my mahi with two tangata whaiora. My reflections outline experiences on how my research and personal intersectionality informed my processes of developing therapeutic alliances within kaupapa Māori and mainstream mental health services. These reflections include a positioning statement in relation to my internship placements, and connectivity with tangata whaiora through mutuality, worldview and shared experiences.

Key words: Therapeutic alliance, tangata whaiora, takatāpui, queer, identity, self, suicide

Pepeha

Tēnā koutou katoa.
I te taha o tōku matua
Ko Taranaki tōku maunga
Ko Waitara tōku awa
Ko Ōwae tōku marae
Ko Te Ātiawa me Ngāi Tahu ōku iwi
Ko Ngāti Rāhiri tōku hapū
I te taha o tōku whaea
He Pākehā ia, nō Scotland me Poland
Engari I whanau ia I roto Taranaki
Nō reira ko Waitara te tūrangawaewae o mātou whānau
Nō reira, tēnā koutou, tēnā koutou, tēnā koutou katoa.

My identity intersects dimensions of Māori and Pākehā whakapapa, takatāpui/queer and cisgenderism. I was fortunate to have been born and raised within my iwi whenua of Waitara, Taranaki. The awa of Waitara flows past my whānau whare from the peaks of maunga Taranaki to the base of Manukoriki pā (‘*the singing of the birds’*) before connecting with Te Moana-nui-a-Kiwa (*Pacific Ocean*). The banks of this awa were my childhood playground under the watch of maunga Taranaki.

Both my research and internship placements have been imbued with dimensions of te ao Māori and those whom identify as takatāpui and queer. Being a takatāpui/queer man has formed an integral part of my identity and I have devoted many years advocating for the rights of queer and takatāpui communities. My experiences during internship have significantly contributed to my development as a mental health worker and contributed to my understanding of *the self* as means of forming therapeutic alliances with tangata whaiora. I will be reflecting on this knowledge by describing my mahi with two tangata whaiora who self-identified as members of the queer community.

Doctoral Research Summary

Within contemporary society, the term *queer* has undergone a reclamation movement. Precedingly representing a pejorative towards homosexuality, queer has since been used to denote identities that do not adhere to heterosexual and/or gender binary norms (Riggs & Treharne, 2017a; Schimanski & Treharne, 2019). Within my research, the term queer is utilised as a pan-descriptive term to denote individuals who claim membership to categories of lesbian, gay, bisexual, or transgender, as well as other marginalised genders and/or sexualities (LGBTQIA+). Similar to queer, the term *takatāpui* has seen resurgence within modern Aotearoa. Traditionally meaning, "intimate companion of the same sex" (p. 2), takatāpui now denotes Māori who identify with diverse sexualities and genders (Kerekere, 2016). As a homage to the incorporation of te ao Māori, takatāpui parallels the term queer within my research to recognise participants who intersect as both Māori and queer identities.

Research Rationale and Aim

The Minority Stress Model (Meyer, 2003) currently stands as a significantly accepted framework for explaining psychological distress among individuals with marginalised gender and sexual identities. This model postulates that suicidal behaviours develop as stress reactions to experienced and perceived discrimination (Baams et al., 2015). While the interconnectivity between suicidality and discrimination among queer and takatāpui people has been well validated by the Minority Stress Model (see McAndrew & Warne, 2010; McLaren, 2016), this model presents with two central caveats. Firstly, the model fails to account for queer peoples' perspectives on what factors potentiate and mitigate suicidality. Secondly, the conceptualisation of stressors (e.g., internalised homophobia) within the model frames coping with discrimination as the responsibility of queer and takatāpui people, and disregards stress as a reaction to external social factors acting upon the individual (Riggs & Treharne, 2017b). This framework places liability for suicidality upon marginalised people, and neglects that stress arises from wider social norms regarding sexuality and gender. The limitations with the Minority Stress Model provide a foundational rationale for exploring the applicability of the Three-Step Theory of suicide and the Theory of Decompensation among takatāpui and queer people.

The Three-Step Theory of suicide is grounded within the suicide ideation-to-action framework (Klonsky & May, 2015), which represents the development of suicidal ideation and suicide attempts as distinct processes. This theory represents a redevelopment of the Interpersonal Theory of Suicide (Joiner, 2005), and utilises three central hypotheses ('steps') to explain how people come to experience suicidality. Firstly, the interaction between pain (psychological, emotional, and/or physical) and hopelessness precipitates the development of suicidal ideation. Secondly, among people experiencing suicidal ideation, connectedness is understood to buffer the severity of suicidal ideation. The construct of connectedness is intentionally undefined as it can represent any degree of connection with a person, activity and/or occupation, which protects against the risk of developing severe suicidal ideation. Thirdly, dispositional, acquired, and practical capacities for suicide bridges the pathway from suicidal ideation to attempting suicide. "Acquired capacity refers to an individual's habituation to pain, fear, and death through exposure to life experiences" (p. 118), which includes non-suicidal self-injury, suicide among friends and family, and physical abuse (Klonsky & May, 2015).

The Three-Step Theory offers remedy to one of the caveats with the Minority Stress Model. Rather than conceptualising 'stress' as an internal liability which is solely the responsibility of the people experiencing this stress, the Three-Step Theory acknowledges broader social processes that potentiate suicidal ideation to evolve into attempting suicide. The progression to attempted suicide is not perceived as simply a reaction to experienced pain (e.g., discrimination), but instead, individuals are recognised as dynamic entities who do not operate in a vacuum. To exemplify, the second hypothesis acknowledges socialisation as an influencing factor by iterating that lack of connectivity to salient aspects of one's environment may exacerbate the severity of suicidal thoughts to an extent that suicidal desire emerges (Klonsky & May, 2015). Furthermore, the third hypothesis iterates that a capacity for attempting suicide is through a habituation process that can occur via situations beyond an individual's control (e.g., being subjected to physical abuse). The Three-Step Theory appraises suicide as a series of processes that incorporates the influence of one's environment and does not direct liability for suicide towards the individual experiencing stress.

The Theory of Decompensation proposes that experiences of stress among people with marginalised sexualities and/or genders are influenced by three constructs 1) ideology, 2) intersectionality, and 3) privilege (Riggs & Treharne, 2017b). Stress is conceptualised as the result of institutional social norms regarding the categorisation of identities (ideologies),

whereby experiences of stress vary as a function of the multiple facets of identity that one intersects (intersectionality). Consequently, enacted social norms can both elicit stress (e.g., discrimination), and mitigate stress by socially placing people within dominant social positions (privilege) or marginalised positions (Riggs & Treharne, 2017b). As a solution to one of the caveats with the Minority Stress Theory, the decompensation framework utilises ideology, intersectionality, and privilege as a means of conceptualising how stress is experienced by takatāpui and queer people. When the Theory of Decompensation is applied to qualitative methods, suicidality is able to be explored from the understandings of takatāpui and queer people, particularly regarding how suicidality is influenced by dominant social norms regarding gender and sexuality.

The diverse social climate of Aotearoa provides research with a means of understanding the associations between suicidality and takatāpui people. Aligning with the constructs of the Theory of Decompensation, the intersectionality between marginalised sexual, gender and ethnic identities seemingly forms a unique phenomenon regarding resilience against suicidality among takatāpui people. A cross-sectional survey from a nationally representative sample of Aotearoa adolescents showed that compared with cisgender-heterosexual adolescents, adolescents with marginalised sexualities and/or genders had a greater likelihood for prior suicide attempts (Chiang et al., 2017). Among these marginalised adolescents, those who identified as Pākehā reported higher rates of attempted suicide compared with Māori adolescents. These results suggest a potential buffering effect from intersecting with a Māori identity among takatāpui people. A historical account of non-heterosexual partnerships within traditional Māori society, prior to colonisation, indicates that takatāpui people were accepted and embraced within te ao Māori and the social structures (Aspin & Hutchings, 2007).

My research utilised a mixed methods design across two studies. Study one examined the applicability of the Three-Step Theory of (Klonsky & May, 2015) among takatāpui and queer people as a means of explaining the development of suicidal ideation and the processes that underpin pathways to attempting suicide. Study two focused on interviewing takatāpui and queer people with experiences of suicidality to explore their understandings of suicide, using the constructs within the Theory of Decompensation (Riggs & Treharne, 2017b) to inform the interview schedule. Namely, ideologies, intersectionality, and privilege. Interviews were analysed and interpreted using a theory-driven approach to reflexive thematic analysis (Braun & Clarke, 2006) underpinned by social constructionism to develop the themes.

Engagement with Research Participants

I am an intrinsic member of takatāpui/queer communities, both within my personal life and research capacity. Academia has historically undertaken research on marginalised groups rather than with them. As such, I incorporated the perspectives of organisations who support takatāpui and queer people (e.g., InsideOUT) in order to ensure that the project was appropriate for potential participants. The principle of participation was reflected in myself as someone of Māori whakapapa (Te Ātiawa, Ngāi Tahu). It was acknowledged that Māori often hold a belief that kanohi ki te kanohi is the best approach regarding the transference of knowledge. Thus, a mutual connection between myself and participants was formed through whanaungatanga, mihimihi (e.g., exchanging pepeha), karakia and sharing kai.

The study afforded participants a space to voice their understandings and beliefs on suicide, free from scrutiny and discrimination. Participants were encouraged to consult whānau or supports prior to agreeing to participate. They had the option of having the interview occur in a suitable venue of their choosing. Participants had the option of having whānau or support person(s) present during the interview and were made aware of available local and national support services prior to interview commencement.

Results will be presented to participants in a consumable form, free from academic jargon. I will offer participants, as well as groups involved in the consultation process, the opportunity to meet face-to-face in order to kōrero about the research findings. This also affords a space for participants and groups to enquire more about how the findings inform clinical practices and suicide prevention within Aotearoa.

The Therapeutic Use of Self

The *therapeutic use of self* can be conceptualised as the therapist's conscious "use of [their] personality, insights, perceptions, and judgements as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). Using an interpretive phenomenological analysis, Sleater and Scheiner (2020) analysed the experiences of therapists to construct a model outlining three factors encapsulating the use of self: connection, awareness and wellness. Connection recognises the therapist's use of overt self-disclosure (e.g., sharing personal information), covert self-disclosure (e.g., personality, countertransference), and worldview (e.g., belief

systems and experiences). Regarding awareness, the use of self is presented as mutuality and vulnerability, whereby the therapist expresses emotional vulnerability while upholding boundaries as a means of presenting self as non-defensive. Finally, wellness signifies the use of self-compassion to avoid burn out and maintain a work-life balance.

Positioning Statement

The language within clinical psychology forms a relational dyad within the therapeutic space. Positions of *therapist* and *tangata whaiora* acknowledges that people can internalise differing lived experiences, identities, and personalities. Beyond the acknowledgement of differences, I perceive that the therapeutic use of self bridges this dyad through mutuality and whanaungatanga. Within my own intersection as a takatāpui Māori and Pākehā queer man, I held anxiety regarding how I would be received within the kaupapa Māori service of Te Whare Marie. As someone who has been disconnected from their Māori whānau, I felt that my Māoritanga would not stand up to the mana of Te Whare Marie. *Would I be able to uphold tikanga Māori? Would my knowledge of te reo Māori be sufficient to understand the kōrero within the whare? Would I do or say something to cause offence to the tangata whaiora I work with?*

I have always found a sense of self and solace in queer communities. Among fellow takatāpui and queer people, I feel within a space where I am able to express my authentic self and elevate my confidence. Having experienced discrimination from the hegemonic society, I have always felt a need to hide my queerness in order to protect my wellbeing. When transitioning into the mainstream space of Wellington South Community Mental Health Team (WSCMHT), I felt anxious about my ability to remain true to who I am while also preparing myself for beliefs that may invalidate my identity. Rejection is a strong feeling that causes rupture to connectedness/whanaungatanga.

Reflecting on my time at both Te Whare Marie and WSCMHT, I am thankful that my anxious thoughts were disproven. I felt embraced and that my identities and sense of self were validated and valued within both internship placements. During kōrero with my supervisor, Dr Carati, at WSCMHT, my attention was drawn to the concept of the therapeutic use of self and its utility within the therapy space. My supervisor encouraged me to utilise my lived experiences and

knowledge of communities (ideologies) to facilitate my therapeutic alliance with tangata whaiora.

Connecting with Tangata Whaiora

The foundation of my doctoral research is understanding suicide and discrimination alongside those with lived experiences of suicidality rather than taking this knowledge from them. During my internship, I strived to carry forward this ethos both within my clinical practice (e.g., assessments) and during the formation of therapeutic alliances. I looked to the tangata whaiora I worked with as the experts on their journeys to recovery.

While working at Te Whare Marie, I was fortunate to work with *Alex*, a 15-year-old who identified as a non-binary/transgender female and was asexual. Initially, it was difficult to build a therapeutic alliance with Alex as rapport was fraught with defensiveness and disconnection. On reflection, I recognise that Alex was slow to warm to the process of self-disclosure. A turning point during therapy was when Alex disclosed that their gender identity did not align with the gender they had been assigned at birth, which they reportedly had not told to anyone else. From my own experience, I understood the difficulty of coming out and opening yourself up to vulnerability. Using this shared experience, I reflected to Alex the idea that our self-identification is a means of sharing our lived realities, which opened a space for mutuality and connectedness. From forth, our kōrero incorporated reflecting on societal discourses that oppress takatāpui and queer identities, which were contributing to Alex's fear of social judgement (i.e., cisgenderism). Using covert self-disclosure (i.e., indirectly), I was able to draw upon my own experiences of discrimination and judgement and use these as examples on how to reframe the negative beliefs of others as reflections of their character, rather than a reflection of Alex's self-worth.

During my time at WSCMHT, I undertook an ADHD assessment with *Mark*, a 47-year-old who identified as a transgender man. Early on within the assessment process, I got a sense that Mark was withholding information regarding the psychosocial stressors he had experienced. Reflecting on my engagement process with my supervisor, I thought that my approach with Mark had been too focused on gathering information on ADHD symptomatology rather than coming alongside him. As such, I had allowed the *clinical* component of assessment to overshadow the *humanistic* component, such as developing rapport and an alliance with Mark.

This was in contrast with the ethos of my doctoral research. Changing my approach, I focused more on exploring the systems that Mark lived within and his emotional experiences. During a session, emotional vulnerability became a prominent theme within the therapy space as Mark disclosed the organisations that had been antagonising the advocacy mahi that his partner and himself were undertaking. I remember internalising the sadness within Mark's kōrero and becoming tearful, which Mark responded to by stating that he could sense our shared queerness, and this had made him feel safe to open up. Drawing upon my empathetic awareness, I said to Mark, "this is a queer space", and thanked him for his bravery.

Conclusion

I believe that the therapeutic relationships formed with the two aforementioned tangata whaiora reflect how shared queerness can facilitate the principles of the therapeutic use of self. Through my doctoral research, I have come to understand that an alliance is not borne from merely engaging with an individual, but instead grown from whanaungatanga/connectedness. Coming alongside a tangata whaiora through mutuality, shared experiences and self-awareness reflects the pinnacle skills that I have developed as an intern psychologist during my placements at Te Whare Marie and WSCMHT. I know that there is much more knowledge and skills that I need to place within my kete, and I look forward to seeing what the future holds for me.

Mā te kimi ka kite. Mā te kite ka mōhio. Mā te mōhio ka marama.
Seek and discover. Discover and know. Know and become enlightened.

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