ORIGINAL ARTICLE

"It's Not the 'Being Trans,' It's Everything Around That": Trans Community Perspectives for Suicide Prevention

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Trans people are at significantly elevated risk of suicide death, suicide attempts, and suicidal ideation than their cisgender peers. Suicide prevention efforts are needed that address the most important issues to the trans community. In this qualitative study conducted in the United States in 2021, we aimed to broadly explore trans community member perspectives on suicidality and suicide prevention needs. We conducted four virtual focus groups—including one exclusively for trans people of color. We also solicited additional online responses to the same focus group questions. A total of 56 trans individuals with a history of suicidality participated. We utilized reflexive thematic analysis to develop themes to inform suicide prevention efforts for the trans community. The themes were multicontextual, representing needs across healthcare, legal and political arenas, workplaces, community groups, and interpersonal relationships. The central organizing theme identified as crucial for suicide prevention was "Having (Real) Rights and Respect." Supporting themes were "Being in Control of Our Own Bodies," "Being Safe as Ourselves," and "Feeling Support and Acceptance," which also included a subtheme of "Embracing Diversity within the Trans Community." We provide suggestions and directions for suicide prevention, which build on these themes.

KEYWORDS trans, transgender, suicide prevention, qualitative, healthcare
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Suicide death, suicidal actions, and suicidal thoughts are critical public health concerns throughout the US and globally (SAMHSA 2021; WHO 2021). One segment of the population consistently identified with heightened risk of suicidality is LGBTQIA+ individuals (The Trevor Project 2022), with strikingly high indication of suicide risk among trans individuals (Herman et al. 2019; Marshall et al. 2016; McNeil et al. 2017). Trans people are individuals whose gender identity does not correspond with the sex they were assigned at birth and can include a wide variety of binary and nonbinary gender identities. According to Herman and colleagues (2022), 1.6 million people in the US, or an estimated 0.6% of the population over the age of 12, identify as trans. Trans people may decide to transition in one or more ways if they have the opportunity and safety to do so. For example, trans individuals may seek social transition (e.g., altering their name, pronouns, appearance), legal transition (e.g., legal name change, gender marker change), and/or medical transition (e.g., gender-affirming healthcare such as hormone therapy, surgeries) to affirm self and identity (Coleman et al. 2022). While disclosure of trans identity (i.e., coming out) is important for many trans people, coming out and undergoing transition can also be accompanied by experiences of discrimination, stigma, loss of social networks, and violence (James et al. 2016).

Overwhelming evidence demonstrates significantly elevated risk of suicidality among trans people (Herman et al. 2019; Kidd et al. 2023; Marshall et al. 2016; McNeil et al. 2017). A US national study of high school youth found that trans students were at six-fold greater risk for a suicide attempt than their cisgender peers (Johns et al. 2019). Meanwhile, estimates suggest an 18-fold higher rate of past-year suicide attempts among trans adults in the 2015 US Transgender Survey compared to the US general population (Herman et al. 2019). In the more recent 2022 US Transgender Survey, 44% of trans adults reported recent suicidal ideation and 7% reported a recent suicide attempt (Kidd et al. 2023).

Our study builds on a body of existing evidence about risk and protective factors among trans people. Notable risk factors for suicidality among trans people often center around discrimination and rejection (Hunt et al. 2020; McNeil et al. 2017). Further, recent studies have included both trans and sexual minority participants in in-depth qualitative explorations. Clark and colleagues' (2022) work included eight trans and nonbinary participants in a study of sexual and gender minority people who had near-fatal suicide attempts and found that aspects of identity invalidation, structural stigma, and normalization of suicide contributed to participants' experiences of acquiring the capability for suicide. Kaniuka and colleagues' (2024) study on sexual and gender minority suicide risk and protection, which included 13 trans and gender nonconforming participants, described how precipitating vulnerabilities and stressors led to feelings of being hopeless and trapped. Together, these studies lend credence to the relevance of minority stress theory (Brooks 1981; Hendricks and Testa 2012; Rich et al. 2020) in explaining the heightened risk of suicidality in the trans community. Minority stress is characterized by stress resulting from stigmatized social status, and in the case of trans people, resulting from transphobia and gender non-affirmation (Hendricks and Testa 2012).

Further, consistent with minority stress theory, other quantitative and qualitative studies with trans participants have also identified some protective factors for suicidality, namely social support, transitioning, and resilience (McCann et al. 2021;

McNeil et al. 2017; Moody et al. 2015). The qualitative study of written responses to open-ended online questions from 133 trans adults—with and without histories of suicidality—in Canada conducted by Moody and colleagues (2015) identified protective experiences for trans individuals such as self-acceptance, coping skills, and individual reasons for living. Thus, the existing literature suggests that individual, social, and structural factors are relevant for understanding suicide risk and prevention in the trans community.

Despite knowledge about social and structural factors related to suicide risk, suicide prevention efforts often view suicide as a mental health problem related to psychiatric illness and internalizing psychological factors (Bryan 2022; Franklin et al. 2017). This psychocentric (Rimke and Brock 2012) lens contributes to an emphasis on crisis lines, screening tools, and mental health treatments as commonly relied-on suicide prevention efforts. The tendency to view trans suicide risk through a solely mental illness lens may be even more likely given the medicalization of trans identities wherein being trans is associated with a disorder within the *Diagnostic and Statistical Manual*. Accordingly, the potential influences of systems, environments, and social structures on suicide risk in the trans community (White Hughto et al. 2015) are often ignored or de-emphasized as pathways for suicide prevention.

While mental health treatments are indeed one important resource for people experiencing suicidality, the dominance of these prevention strategies have not had the desired population-level impact on preventing suicides or reducing suicidality (Bryan 2022) and the research base for specific mental health prevention strategies is relatively limited (Platt and Niederkrotenthaler 2020). Two reviews and meta-analyses have found that, across multiple studies, single-level, and even single-encounter, mental health interventions had an impact on reducing suicide completion and attempts among prior attempters (Doupnik et al. 2020; Hofstra et al. 2020). However, despite developments in the mental health space, we continue to see a gradual rise in risk of suicide death in the United States (CDC 2021). Therefore, there is a compelling need to also look outside of mental health services for additional suicide prevention opportunities. Two reviews have pointed to the potential promise of multi-level suicide prevention interventions, which take into account multiple aspects of community, social life, and healthcare (Hofstra et al. 2020; Platt and Niederkrotenthaler 2020).

In the current study, we aimed to build on the strengths of the existing literature and theoretical developments related to trans suicide risk and prevention to gather a comprehensive understanding of avenues for trans suicide prevention. We desired to take a community-oriented approach to understand how the trans community thinks about their risk of suicide and what they see as the community's suicide prevention needs. We approached the study with research questions about risk and protective factors related to suicidality for trans individuals and suicide prevention needs, and during the analytic process (detailed later) focused in on prevention needs specifically while relying on the interconnected discussions of risk and prevention to frame the findings and implications.

METHODS

We used a qualitative, inductive approach to develop a comprehensive and community-driven understanding of suicide prevention needs from the perspectives of trans individuals who have experienced suicidality. Because of our desire to be community-driven, we selected focus group methodology as our main approach to center discussions among community members (Flick 2006). We wanted to inform recommendations for policy and practice, with particular emphasis in our interpretation on implications for healthcare settings. The study was approved by the University of Utah Institutional Review Board.

Recruitment

We initially set out to conduct three focus groups of trans community members who have experienced suicidality in Utah. We recruited participants by disseminating digital fliers to LGBTQIA+ and trans community organizations and healthcare services throughout the state. To be eligible, individuals needed to identify as trans, report a history of experiencing suicidal thoughts or behaviors, be 18 years of age or older, and reside in the state. We purposefully did not place boundaries on the criteria to be considered trans for inclusion in this study. Rather, in line with the philosophical positioning of the study, we included any individuals who consider themselves to be trans. Similarly, we did not place specific bounds on what qualified as meaningful suicidality and considered eligible any individual who reported lifetime or past year suicidal thoughts or behaviors (question wording: "*Do you have a history of experiencing suicidal thoughts or behaviors (includes serious thoughts about ending your life and/or suicide attempts)?*").

Although we took steps to recruit a racially and ethnically diverse participant pool, we received very few responses from trans individuals who identified as members of minoritized racial or ethnic groups. We expected this may be related to relatively limited racial and ethnic diversity in Utah. To address this gap, we planned a fourth focus group exclusively for trans people of color and broadened recruitment to people living anywhere in the US However, notably, six of the seven enrolled participants in this fourth group also resided in Utah (the seventh resided in Texas).

During recruitment, the team shared an IRB-approved consent cover letter and invited questions in advance of the focus group. Then, prior to the start of the focus group, the facilitator reviewed the document verbally and visually (using the screen-sharing feature on Zoom) and allowed additional time for questions prior to each participant providing verbal consent. Online participants reviewed a consent cover letter and had the opportunity to reach out to the study team with questions.

Data collection

We collected data for this study between June and October 2021.

Screening and descriptive data questionnaire

During recruitment, we invited interested individuals to complete an online form in REDCap (Research Electronic Data Capture) to determine if they were eligible for the study and to provide descriptive data. We used the gathered descriptive data to facilitate maximum variation sampling (Patton 2002; Schreier 2018). Specifically, we aimed

to invite a diverse panel for each focus group with variability in ages, gender identities, transition experiences, recency of suicidality, and backgrounds. Our descriptive questionnaire is detailed in Supplement A.

Focus groups

Focus group methodology was selected as the primary approach in this study to align with our goal to understand community-level perspectives and needs. Focus groups allow for group discussion and conversation as a source of knowledge, in addition to individual contributions (Flick 2006). We followed guidelines outlined in Flick (2006) and the accumulated knowledge and experience of the facilitation team. We conducted four focus groups virtually over Zoom (Zoom Video Communications, Inc., San Jose, CA) with 7–9 participants per group. Experienced staff from our university's NIH-funded Clinical and Translational Science Awards Program led recruitment, coordinated with participants, facilitated the focus group sessions, and took notes throughout the session. One investigator from the research team was present throughout each session to provide an overview of the research and answer any participant questions about the study.

During recruitment and at focus groups, we provided participants with a list of available suicide and mental health crisis resources (e.g., TransLifeline, The Trevor Project, National Suicide Prevention Lifeline). A clinical psychologist was present for each session to provide additional mental health resources or crisis support to participants, if needed or desired.

We recognize the frequent problem of fraudulent research participants in online studies (Pullen Sansfaçon et al. 2024; Ridge et al. 2023) and took steps to prevent fraudulent data. We first reviewed the screening and descriptive questionnaire findings for suspicious responses. Further, a study investigator was present for each focus group, and contributed to assessing the legitimacy of participants. We excluded two potential participants who we determined to be fraudulent before starting one focus group. Participants offered meaningful, unique, consistent, and relevant contributions to the discussion, and the study team is confident they were not fraudulent. Participants were not expressly required to have their cameras on for the focus group, but all participants chose to.

The questions guiding the focus group sessions are listed in Table 1, including the alternative wording for the fourth group. Questions were developed, refined, and finalized by our research team, which included mental health professionals, trans healthcare providers, suicide and mental health researchers, and graduate students. Our team approached this study with a desire to support the autonomy and self-determination of the trans community, and to honor their perspectives as paramount for understanding their suicide risk and prevention needs. One member of our research team is also trans and evaluated the questions from their perspective, considering how they and their fellow community members may respond. The questions probed about community-level risk for suicide and also about personal protective and stress factors related to their broader mental health to gather a blend of positive and negative personal and community-level considerations for both suicide prevention and broader mental health needs among trans individuals with a history of suicidality. Participants received the questions in advance so they could consider their answers outside the

Table 1. Questions asked to participants [including additions made for the focus group for trans people of color]

Question Number	Question Wording
1	From your perspective, what do you think are reasons that trans people [—and BIPOC trans people in particular—] may be at risk for mental health problems and suicide?
2	What have been protective factors in your own life (what has helped your mental health)? What have been stress factors (what has hurt your mental health)?
3	Thinking broadly about things related to society, local communities, and health-care, what ideas do you have about suicide prevention for the [BIPOC] trans community?

Note. We also asked participants about their priorities for research related to suicide risks and prevention; however, the responses to that question were not included in this analysis. BIPOC: Black, Indigenous, and people of color. We used the term BIPOC for recruitment and framing questions in this group because that was a commonly used term in our community at the time of the study. However, we have altered the terminology in this manuscript since this language is less common at the time of submission.

group setting. Study team members transcribed the audio-recorded Zoom sessions and downloaded the chat transcripts. After each focus group, participants received a written summary of the discussion, and were invited to make any additions or clarifications via email, as a form of member checking (Schwandt 2007). One participant provided a response, adding further clarity to a point they had made. Participants were also invited to send private chat messages to the facilitation team at any point during the focus groups, which one participant chose to do to disagree with another participant. Focus group participants each received a $75 gift card.

Online submissions

Because community member interest in the study exceeded our focus group capacity, we further extended the study to the remaining eligible individuals who had completed the screening and descriptive data questionnaire. After initial screening, we sent 40 eligible individuals email invitations to answer the questions from Table 1 through an online submission in REDCap. Twenty-two participants completed an online submission and received a $20 gift card.

Participants

Study participants included 34 focus group participants and 22 online respondents (total $N = 56$). Participants self-described their gender identities and expressions in a variety of ways (see Table 2). They also answered a close-ended question about their gender, with 46.4% identifying primarily as man/male/masc, 28.6% as primarily woman/female/femme, and 25.0% as primarily nonbinary. No participants selected the fourth response option to decline to be categorized. Participants ranged in age from 18 to 67 years ($M = 30.3$, $SD = 12.2$). Nine (16.1%) participants identified as a member of one or more minoritized racial or ethnic groups. See Table 3 for complete participant descriptive information.

In open-ended questions, we asked participants to briefly describe the ways they had transitioned, as well as any ways they plan to transition in the future. Par-

Table 2. Participants' self-described genders

Participant Number	Open-ended Self-description
1	Trans masc/non-binary
2	Transgender male
3	Female
4	Trans man
5	Female
6	Non-binary/masc
7	Maleish
8	Transmasculine/Non-binary
9	Non binary, agender, genderfluid
10	Female
11	Transmasc nonbinary
12	Man
13	Male
14	Transmasc non-binary
15	Non binary
16	Female
17	Male
18	I am an AFAB (Assigned Female at Birth) transmasculine individual. I mostly present as male but do experiment with my presentation often
19	Trans male
20	Genderqueer, non-binary
21	MTF
22	Trans femme
23	Transgender woman
24	Female
25	Straight male
26	Trans man
27	Transgender Male
28	[N]on-binary transmasculine genderfluid
29	Trans-masc non-binary
30	Nonbinary/Agender, trans masculine
31	Non binary/agender/trans
32	I'm a non-binary trans man.
33	Transgender Agender
34	Transgender woman (MTF)
35	Agender

Participant Number	Open-ended Self-description
36	Male
37	Trans man
38	Transwoman
39	Transmasculine
40	Female
41	Non-binary/Agender
42	Transgender man
43	Nonbinary
44	Transgender woman
45	Post Op MtF
46	I am trans feminine.
47	Man, Trans-man
48	Ftm
49	Transfeminine
50	Transgender Man
51	Non binary/trans
52	Transgender woman
53	Transgender male
54	Non binary
55	Female (mtf)
56	Non-binary/transmasc

ticipants provided wide ranging responses, some having transitioned in only one way (e.g., socially, with their name and/or pronouns) and some in several ways (e.g., socially; medically, through treatments and/or procedures; and/or legally, through name and/or gender marker changes). Most participants had several plans or hopes to transition further in the future, while fewer (16.1%) expressed that they had no future plans (e.g., responding with: "Happy now"; "I am there now. Complete."; and "pretty much done").

A majority (60.7%) of participants had experienced suicidality in the last year and the remaining (39.3%) had experienced it in the past but not the last year. Participants also reported diagnosed mental health conditions, with many experiencing depression (94.6%), anxiety (82.1%), and post-traumatic stress disorder (53.6%). The majority also reported currently receiving mental healthcare including therapy or counseling (67.9%) and medication (57.1%).

We asked about other social factors that can influence access to mental health and gender-affirming transition services (e.g., income, employment status, geography; James et al. 2016). Participants reported a range of annual household income brackets, with over 30% reporting below the poverty line. More than half (57.1%) of par-

ticipants reported being currently employed, 17.9% reported being unemployed and looking for work, and 23.2% reported being unemployed but not looking (e.g., student, engaged in unpaid caregiving). Most participants indicated that they lived in a suburban or urban location.

Data analysis

We conducted an experiential qualitative analysis (Braun and Clarke 2022) focused on centering the experiences and meaning that participants ascribed to their experiences (e.g., essentialist or realist framework). We set out to follow Braun and Clarke's phases for reflexive thematic analysis. Through the process, we used an open, exploratory, and iterative approach to identify themes representing patterns of "shared meaning organised around a central concept" (Braun and Clarke 2022, 77).

While Braun and Clarke (2002) do not recommend engaging in evaluations of saturation when using reflexive thematic analysis, our approach aimed to gather a broad view that incorporated diverse community perspectives. We used the focus group data as our primary analytic focus for inductive analyses and then followed-up with analysis of the online survey data looking for confirming and disconfirming evidence. The online survey results were highly consistent with the focus group findings and offered support for the transferability (Schwandt 2007) of the study findings outside of the focus group context.

The four-person core analytic team read and re-read the text data, and met regularly to discuss key concepts, preliminary codes, and developing themes that represented important patterns and concepts in the data focused on suicide risks, protective factors, and ideas for prevention. Through this process, we also identified the salience of contexts within which the participants' experiences of suicidality and suicide prevention occurred. Engaging in an iterative process, we developed several different ways of conceptualizing the data; we returned to the data each time we refined the patterns and concepts to evaluate their fit with the data. We also engaged the larger research team throughout the process to review preliminary results, ask questions, and provide feedback to improve the process (e.g., internal auditing; Lincoln and Guba 1985). In the finalized analysis, we focused on themes of suicide prevention using an interpretative analysis of the data (Braun and Clarke 2022).

We used Dedoose (Version 9.0.18) analytic software and Microsoft Excel worksheets during the process to help organize data extracts. We present verbatim quotes in this report to enhance trustworthiness and transparency in the process and to center the voices of participants. We labeled each quote with a randomly assigned participant number following a letter indicating the focus group (A/B/C, or D for the people of color group; and ending with a "c" if originating from the Zoom chat) or online submission (O). Gender identities used in-text are verbatim as provided by the participant, and their included race or ethnicity came from a categorical descriptive question. Quotes are unedited, except where brackets (to clarify) or ellipses (to abbreviate) are used.

Throughout the process, we engaged in several steps to promote trustworthiness of the qualitative research process and methodological rigor (Lincoln and Guba 1985; Schwandt 2007). First, credibility was supported by sending focus group summaries to participants after the sessions (i.e., member checking) and engaging a trans team

Table 3. Participant descriptive information (N = 56)

Variable	**n (%) / *M* (*SD*)**
Categorized gender[a]	
Non-binary	14 (25.0%)
Woman/Female/Femme	16 (28.6%)
Man/Male/Masc	26 (46.4%)
Decline to be categorized	0 (0%)
Age (years)	30.3 (12.24), range 18–67
Race and ethnicity[b]	
Asian	4 (7.1%)
Black or African American	0 (0%)
Hispanic or Latinx	5 (8.9%)
Middle Eastern or Northern African	0 (0%)
Native American or Alaska Native	2 (3.6%)
Pacific Islander or Native Hawaiian	1 (1.8%)
White	52 (92.9%)
More than one Race or Ethnicity	3 (5.4%)
Suicidality experiences	
In the past year	34 (60.7%)
Previously, but not in the past year	22 (39.3%)
Current mental health treatment[b]	
Therapy/counseling	38 (67.9%)
Medication	32 (57.1%)
Total annual household income	
Less than $10,000	8 (14.3%)
$10,000-24,999	9 (16.1%)
$25,000-39,999	11 (19.6%)
$40,000-49,999	6 (10.7%)
$50,000-74,999	12 (21.4%)
$75,000 or more	9 (16.1%)
Missing	1 (1.8%)
Employment status	
Not employed for pay and looking for work	10 (17.9%)
Not employed for pay and not looking (student, volunteering, engaged in unpaid caregiving, etc.)	13 (23.2%)
Employed for pay (includes self-employment, full-time, part-time)	32 (57.1%)
Missing	1 (1.8%)

Note. [a]See Table 2 for each participant's self-described gender, [b]responses are not mutually exclusive, so percentages do not total 100.

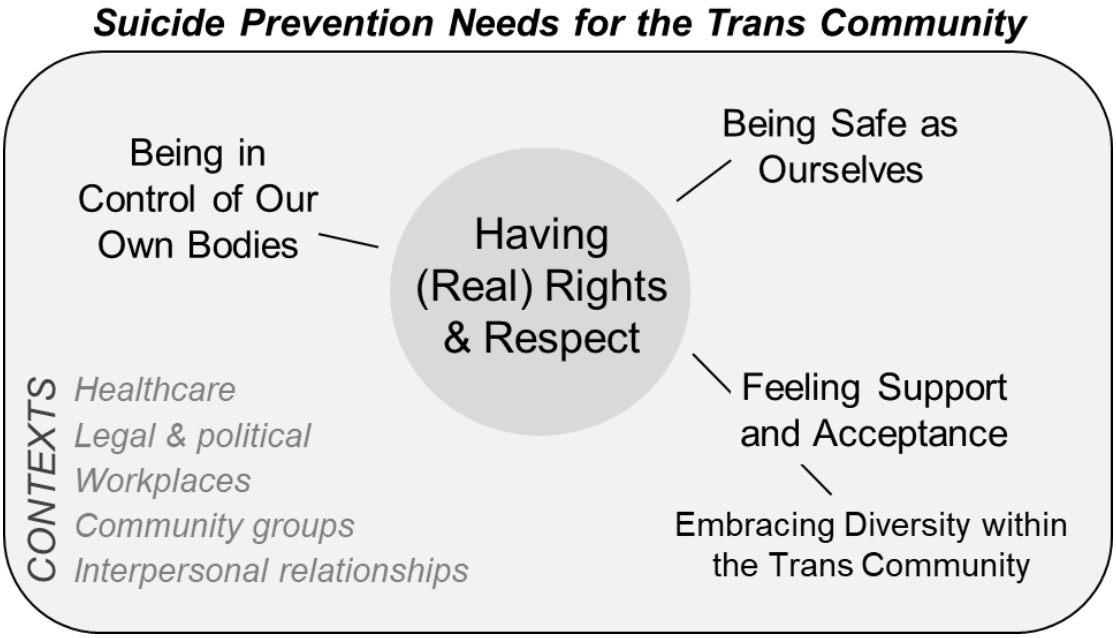

Figure 1. Visual map of results

member throughout the research process. Transferability was supported by examining similarities and differences within and between focus groups as well as between the focus groups and the online survey data. Dependability was supported by documenting each step of the research process, using previously established and successful approaches, and engaging in internal auditing by experienced qualitative researchers and team members with diverse expertise. Finally, confirmability was supported by engaging a multi-person analytic team, internal auditing of the analysis and findings, and providing verbatim quotes throughout the manuscript with transparency about the source of the data (which focus group or online survey).

We also approached the study mindful of representational ethics and the politics of our analysis (Braun and Clarke 2022). We aimed to uphold representational ethics through first ensuring that participants knew the purpose of our study and the lens through which we approach this work by having an investigator deliver an introduction at each focus group. We also encouraged them to respond openly and honestly to our questions, also providing options to do so privately if they preferred (via chat or email) as well as in response to the summary sent to them after the focus group. Finally, we were mindful throughout the analytic process and in disseminating the findings that we do our best to honor the participants' perspectives and avoid inadvertent harm to the community through our representations.

RESULTS

The analysis process produced one central organizing theme, three themes, and one subtheme. We also identified important contexts for suicide prevention that are rel-

evant across the themes. As one white transgender woman[1] articulated, "It's not the 'being trans,' it's everything around that" (A08). The discussed contexts for suicide prevention included healthcare, legal and political arenas, workplaces, community groups (e.g., religious communities, LGBT+ community groups), and interpersonal relationships (e.g., families, friendships). See Figure 1 for a visual map of the results.

Having (Real) Rights and Respect

The central organizing theme we identified focuses on the need for rights and respect in order to reduce risk of suicide for the trans community. Participants spoke about the importance of civil rights, institutional protections, stigma- and discrimination-free access to healthcare and other survival needs, as well as respect from individuals and society. The inclusion of "(Real)" in the theme name highlights participants' assertions that rights and respect must be more than in name only; they need to be fully carried out to have an impact on suicide prevention.

Regarding their civil rights, participants emphasized the impact of the significant negative legislative attention that has been on the trans community in their state and across the United States. A white transgender woman described that the recent attention on anti-trans legislation[2] felt like the trans community had become the latest "queer punching bag" (B06). She directly connected this to her suicidality, stating, "it can feel really hard to feel proud of yourself and feel like a real person when you've become this political talking point and there are these debates about whether or not you exist, what you deserve" (B06). This link between rights, respect, and suicidality was emphasized by a white trans masc/nonbinary participant stating that discriminatory policies made them feel "like I am not worth the air I breathe or other resources I consume because I am a joke to society" (B01).

The ability to have names and gender markers legally changed was seen as another important right that can support suicide prevention for trans community. One white transmasc nonbinary participant explained about the mental health impact of their name change, "I was, just recently was able to get my name legally changed and it's been incredible to be able to have" (B03). However, it was clear that legal rights do not automatically address discrimination and stigma. One biracial (Asian and white) non binary/agender/trans participant reported, "I don't want to change my gender marker. I do not want people to know that I am legally nonbinary to further persecute me" (D01), emphasizing that the everyday realities of discrimination still exist even with legal rights.

Participants also spoke about the need for employment rights in workplaces and yet how even current protections are rarely enacted. A biracial (Asian and white) non binary/agender/trans participant described, "no matter what actual policies exist in a workplace, none of it is actually protecting trans people in the workplace" (D01). Employment discrimination can result in trans people's "Struggle to have or find a job at all or one that accepts/acknowledges your identity" (D03), as described by a bira-

1 Gender descriptors accompanying each quote are in each participant's own words based on a fill-in survey item; race and ethnicity descriptors are based on a categorical survey item.

2 Participants were primarily referring to the rhetoric around numerous bathroom bills and youth sports-related bills being proposed at the time of the study in 2021.

cial (Asian and white) non-binary transmasculine genderfluid participant. One white nonbinary/agender trans masculine participant described frequently having to change jobs due to discrimination and the negative influence of that on their mental health:

> I also lost my job because of being trans last year and have had— I had the same job for 7 years and [now] I've had 4 in one year because I just can't—I keep running into people—I can't get a basic amount of respect. (A01)

Ensuring the basic right to healthcare for trans community members is another critical avenue for suicide prevention. Several participants described their restricted ability to receive healthcare, related to stigma and discrimination. For example, one white man explained:

> The lack of access to healthcare that is not transition related. Even just being able to get support for other things like my ADHD—which has nothing to do with me being trans—but the fact that I'm trans makes it harder to receive care for that. (C03)

Another participant (in a different focus group), a white transgender man, explained this common phenomenon of healthcare discrimination: "some people call it the 'trans broken arm syndrome' where all your symptoms are kind of lumped into your transness and attributed to the transness" (A02) making it more difficult for trans people to receive standard care. Meanwhile, a white transgender woman reported a reverse of this issue, where her trans identity was not taken seriously because of her autism diagnosis: "I have faced problems just being Autistic and they'll try to say that my gender dysphoria is a special interest thing, which it's not" (C06). This ableist framing contributed to invalidation, inadequate healthcare, and suicidality.

Overall, the central organizing theme 'Having (Real) Rights and Respect' reflects the emphasis from participants that suicide prevention needs to be viewed systemically and supported through enacted policies, rather than viewed as an individual problem for trans people to address with strength and resilience. One white nonbinary/agender trans masculine participant explained the importance of systems:

> Putting all of the pressure on the system—not on us—to do better. Because a lot of the times when we're in these conversations, I feel like I'm back in women's self-defense classes again… where you're being told how not to be hate-crimed instead of talking to the people doing the hate crime… it shouldn't be on us to do that. It should be based on… the system. (A01)

Being in Control of Our Own Bodies

Bodily validation, connection, and autonomy were described by participants as critical for suicide prevention. Participants were in agreement that having access to medical transition options was critical to their mental health. Participants described the psychological benefits of "physical transition. I can't stress that enough" (O19; white man trans-man). When asked what has been protective in their own life, one white transmasc nonbinary participant described, "having my surgeries: top surgery and my hysterectomy. Those have both helped a lot" (B03). A white male in the same focus group reflected, "being able to medically transition somewhat and going through the process of starting HRT [Hormone Replacement Therapy] has been super affirming" (B02).

Feeling a lack of control over his physical development, one white man trans-man wrote, "Female puberty was one of the worst things of my life. My body was betraying me and there was nothing I could do" (O19). Such experiences of gender dysphoria, while not experienced by all participants, were described by many as contributing to suicidality when not validated or supported through gender affirming care.

Systemic barriers to receiving gender affirming care, described by participants as "gatekeeping," were frequently pointed to as worsening suicidality. In many cases other people (e.g., parents, therapists, policy) hold the power to decide whether or not trans people—especially when they are younger than 18 years—can access gender affirming healthcare. One white female participant described her personal experience with others deciding when and how she could medically transition:

> Being told by my family and healthcare providers that if I wanted to receive trans related healthcare I would need to wait until I was 18… [I] left my home and paid for it on my own, needlessly putting it off for years. (O10)

Another participant, a white transmasc nonbinary individual, provided an example of how, paradoxically, their suicidality was used as a reason they were denied gender affirming surgery:

> When I went to have top surgery, the surgeon that I had chosen cancelled my surgery a week before I was supposed to have it because they decided I was at risk for suicidality. Which was interesting because it wasn't like [delaying the surgery] helped with depression. Like, it was kinda the opposite of what I would think would help. (B03)

Finally, the financial barriers to accessing gender affirming care were also emphasized by participants as ways that lack of control over their own bodies contributed to suicidality. A white non binary/trans participant explained:

> I'm not currently validated in my bodily experience, my transitioning experience, because transitioning is incredibly expensive and as a college student, I don't have that kind of money. So, I think—'cause when you're in a body that you know was not yours, it feels very disheartening and not validating. And when you feel like you're in the wrong body, obviously, you're going to experience suicidality. (C02)

Thus, for participants, having bodily autonomy was not just about the legal availability of gender affirming care, but also its access and affordability.

Being Safe as Ourselves

The physical and emotional safety of participants was a common thread described by participants as essential for suicide prevention. Physical violence, homelessness, poverty, and emotional abuse were patterns of threats to safety experienced by participants.

Physical violence, abuse, hate crimes, and threats were extremely traumatic experiences contributing to suicidality. A white transgender man described, "I'm a trans man and I've been raped and sexually ass[a]ulted" (A04c). A white trans masc/non-binary participant explained how physical assaults seemed intended to change their identity: "[I] had, like, the queer beaten out of me, but you know, it doesn't go. And so, you know, it kept popping back up and every time, physically beaten out of me,

but it doesn't go" (B01). A Latinx and multi-racial (Native American and white) trans femme participant stated, "I cannot tell you the amount of times—it's white women—pull guns at me" (D02). She also shared how she sees society justify violence against the trans community:

> When people shot at me, the first thing I thought of was, if we die right now, all these people and the way they react to other shootings, they're gonna be like "ah well they failed out of this class" or "well, they weren't that good of an employee because they were late"… people justify violence against us. (D02)

Safe housing and financial safety were described as critical suicide prevention needs. A white transgender man explained the connection: "My parents kicked me out and I was homeless and there was a lot of bad shit on the streets, a lot of bad shit happened for a long time…I had multiple suicide attempts and a lot of self-harm" (A02). Others described how these risks can prevent trans individuals from living as their true self. For example, a white transgender woman (MTF) explained:

> For a lot of people, being trans is literally a threat to your livelihood. I'm still in a situation where, although I'm out with most friends and family, most of my day-to-day life at work I'm still not out and I can't really come out for the foreseeable future. And so, coming out would present a direct threat to eating, paying rent, stuff like that. (A08)

Participants also frequently discussed the impacts of emotional abuse such as bullying, harassment, gaslighting, micro- and macro-aggressions, and misgendering on their suicidality. For example, participants shared transphobic statements made to them, such as a white trans male, "Being told that I must not have morals because I'm trans" (O15), and a white transgender man reporting, "My Mom says I'm a trans man because I have 'daddy issues'" (A04c). These attitudes from important people in their lives contributed to participants' diminished self-worth and led to suicidality.

A common domain of discussion related to emotional violence was religious culture. The salience to participants may be due to the predominance of religion in Utah but was also discussed as connected to early experiences of suicidality by participants raised elsewhere. Participants described the experiences of rejection, being told that they were sinful, "religious shame and threats" (O09; white trans man), experiencing conversion therapy, and the influence that conservative religions can have on harmful policies and offensive societal/personal opinions about the trans community.

Participants also described how many dehumanizing and traumatic experiences resulted in emotional distress manifested as anxiety, PTSD, and substance use, which then further decreased their safety and exacerbated their suicidality. For example, a biracial (Asian and white) non binary/agender/trans participant stated, "When you can't bring your full self into a room, you are constantly having to protect those parts of yourself, and it just really puts you on high alert. It gives you a lot of anxiety" (D01). Another, who is a Latinx and multi-racial (Native American and white) trans femme, stated:

> Having been a victim of different hate crimes, both for race and being queer, it's just hard to feel safe. So not having that many places where I could really take off that high alert definitely affected my anxiety, because it's just like a survival mechanism to always be on such high alert. (D02)

The prior quote also reflects participants' perspectives on the importance of considering intersectionality within the trans community for suicide prevention.

Feeling Support and Acceptance

Participants shared about the many benefits of social support and acceptance for suicide prevention, and conversely about the pain and negative impacts on suicidality when social support lacked or diminished. In particular, participants described the value of having a social network of other trans people. For example, participants shared: "Honestly, being around other trans people of color, or trans people in general, and watching them transition has helped my mental health" (D01; biracial (Asian and white) non binary/agender/trans), and "Online communities probably saved my life" (A08c; white transgender woman (MTF)). While support and acceptance from cisgender individuals was often harder to come by, it was also supportive of suicide prevention for participants. For example, a white transgender woman shared, "One of the most positive things has just been being treated like just a normal person" (B06). Another participant, a Latinx and Native American nonbinary individual, shared xir appreciation for xir family's growth and acceptance over time: "As many growing pains and heart aches I've had with my family, I have to say, they've come around a lot, especially the last few years, with understanding who I was" (D06). These experiences made it easier for participants to feel loved and part of a social fabric, lessening suicidality.

Better education about the trans community—as a mode of increasing awareness, acceptance, and social support—was underscored as a critical need for suicide prevention. Participants shared about the relief they experience when people in their lives demonstrate knowledge and acceptance about gender, trans experiences, and respectful language. One white transmasculine/non-binary participant shared: "I think education is one of the key ways to reduce Suicide risk in the trans community. Many people are discriminatory or prejudiced simply because they are uneducated or misinformed regarding the trans community" (O07). However, participants also discussed how much pressure there is on them to educate others about transness. For example, a white non-binary trans man described how they experience "marginalization fatigue" from repeatedly being "that person who educates others…[which] puts your own mental health into jeopardy because you're constantly having to defend yourself" (C01).

Embracing diversity within the trans community

Discussions of support and acceptance among participants highlighted a need for better inclusion, representation, and wider acceptance of the myriad of identities in the community. Embracing diversity in trans communities (related to aspects such as gender identity, transition decisions, sexual orientation, race and ethnicity, country of origin, appearance, disability) can more comprehensively support broad suicide prevention and community wellbeing. Multiple layers of exclusion were described by participants as current barriers, even within the LGBTQIA+ and trans communities. A white female participant said,

> Even in the LGBT+ community, [being trans] is still really divisive… you still have people who don't even think that trans people should be in the queer community. And then, within even in the trans community, you have, you know, like trans medicalists who are going to be saying, "you

> need X amount of dysphoria to be trans," or "you need surgeries to be trans," and all of this stuff. (B05)

A Latinx transmasc non-binary participant shared about the importance of diverse representation to contribute to better awareness and broader acceptance of the whole community:

> I also think one of the biggest things is lack of visibility. All of the trans representation that we have is very cis-passing, very binary narratives and I don't see a lot of people of color, I don't see a lot of Black people, I don't see a lot of fat people, I don't see a lot of neurodivergence. I don't see me anywhere I go, which is my point. (A03)

Further, participants in the fourth focus group described how the trans community can be exclusionary to people of color. For example, a biracial (Asian and white) non binary/agender/trans participant explained how white trans people in their life claimed ownership over trans identities, which they attributed to cultural differences and power differences. They said, "Something that really affected my mental health was white queer people telling me that there was no way that I could be trans" (D01) and referred to it as having their gender "colonized." They continued:

> That hurt me. Looking up to whiteness, and seeing how I didn't feel represented in it, in its queer transness, prevented me from coming out for so long, prevented me from changing my pronouns, prevented me from starting hormones. I had to fight myself and my internalized racism every fucking step of the way that I chose to step into my queer brown transness. (D01)

Some participants of color also described challenges with feeling on the borders of their communities, and having conflicting experiences related to multiple identities and their intersections. The following quote offers an example of the liminality experienced.

> Being biracial and being nonbinary has left me in this kind of weird in-between space, where I'm not quite trans enough for the trans community in some spaces. I'm not quite white enough or Asian enough in other communities. So that's kind of a feeling of disconnect from certain communities, and something I'm trying to continuously reach out for support. (D07; biracial (Asian and white) transgender male)

Speaking specifically about seeking out mental healthcare for people who have intersectional trans identities, a Latinx agender participant explained, "because we deal with that intersectionality, the mental health resources we go to will either be someone who doesn't understand your struggles as a trans person, or one that doesn't understand your struggles as a person of color" (D04).

DISCUSSION

This study characterized suicide prevention needs directly from the perspectives of trans people with a history of suicidality. Using data collected from focus groups and an open-ended online questionnaire, we identified key themes that can support trans suicide prevention. Although all participants had at least one diagnosed mental health condition, their perspectives about suicide risk and prevention did not center on these

conditions nor on mental healthcare access (although it was mentioned as a community need). Instead, participants emphasized a need for rights and respect to be at the center of suicide prevention efforts for the diverse trans community. They focused attention on the need for social, cultural, and systemic changes over conventional individual-focused suicide prevention approaches, such as efforts to enhance a patient's resilience and coping skills (one of the protective factors identified by Moody et al. 2015). These findings are important to consider in the context of White Hughto et al.'s (2016) work applying a socioecological model to understanding transgender stigma. Similarly, we find here that suicide prevention needs identified by the trans community are related to structural, interpersonal, and individual level needs. Based on our findings, addressing trans stigma at each of these levels, as suggested by White Hughto and colleagues (2016), would be supportive of suicide prevention.

In Table 4, we outline recommendations to support suicide prevention within the healthcare context, a critical context discussed by participants. The recommendations are based on the suggestions and narratives from participants, organized and presented through the lens of the interpretive thematic structure of the results. Healthcare was one of the most heavily discussed contexts in this study. Healthcare settings are crucial, lifesaving spaces where all people should feel safe and cared for. However, participants described frequently experiencing both mistreatment and cultural incompetence in healthcare, as well as limited power and constrained self-determination. Their embodied knowledge of their own needs was often not respected by providers, which contributed to suicidality for participants.

Bodily autonomy was an important theme identified in this study, and typically requires healthcare support. Prior research supports the linkage between gender affirming medical care and lower risk of suicidality (Almazan and Keuroghlian 2021; Baker et al. 2021; Fontanari et al. 2020; Herman et al. 2019; Jackson 2023). These findings suggest that increasing access to bodily autonomy through information and access to gender affirming care options is an important component of suicide prevention.

Participants also explained how their identity and needs as a trans person could intersect with other healthcare needs, often finding that providers were not adequately prepared to provide needed care which limited their rights to healthcare and contributed to suicidality. This occurred in several ways, by (a) focusing only on trans-related needs and/or assuming all their needs were related to trans identity (e.g., trans broken arm syndrome; Wall et al. 2023), (b) dismissing trans needs due to other factors such as age or disability (which has been described previously, e.g., Shapira and Granek 2019), or (c) lack of education or preparedness to address the comprehensive healthcare needs of the full diversity of the trans community. Providers should be trained to have a nuanced understanding of binary and nonbinary trans healthcare needs, as well as how to provide individualized and bias-free care for all trans people to ensure their comprehensive healthcare needs are met. There are growing efforts to incorporate trans education into healthcare, with evidence of efficacy for improving provider attitudes and knowledge (Dubin et al. 2018). Based on our study, we believe that these improved provider attitudes and knowledges will likely serve as a protective factor for patient suicidality. Future studies should look at this link between provider education and trans patient suicide risk directly.

It is also critical to consider the many social determinants of health that can im-

Table 4. What healthcare providers can do to support suicide prevention for the trans community: Suggestions based on participant perspectives, organized by study theme

Theme	Suggestion
Having (Real) Rights and Respect	· Support trans people's legal rights to accessible and appropriate healthcare (including general health, gender affirming care, and mental health services) free of discrimination and stigma. This support could take the form of legal testimony, published statements, or signed letters of support for trans rights legislation. · Prioritize respect for trans people in all interactions. · Consider the current state of trans rights within and beyond healthcare settings; advocate for equity and representation across all contexts (e.g., workplace, education, legal, community).
Being in Control of Our Own Bodies	· Insist that trans individuals lead decision making about their gender affirming care, with clear and transparent information from healthcare providers. · Recognize that gender affirming care is currently not financially accessible to many people in the trans community, take steps to decrease financial barriers (e.g., working with a wide range of insurance providers, offering additional funding options for uninsured patients, sharing opportunities for external grants and other financial resources for patients), and advocate for systemic change around informed consent. · Reject implications that mental health conditions or other disabilities (e.g., autism) thwart individuals' abilities to make informed decisions about their transition journeys. · Engage in educated advocacy (e.g., based on reading work by trans people or listening to trans people's testimonies) alongside the trans community to reduce gatekeeping and increase patient's rights where current policies or procedures do not support bodily autonomy.
Being Safe as Ourselves	· Provide trauma-informed healthcare at all levels of care, recognizing that trans people have often experienced high levels of emotional abuse and physical violence. · Consider the social determinants that may be affecting the health of trans patients, which could include discrimination, safety concerns, familial instability, housing instability, employment disruptions, and financial stress. · Acknowledge that trans people likely have had negative healthcare experiences in the past and work to create a safe and respectful healthcare experience, inclusive of paperwork, administrative phone calls, patient-provider interactions, the clinical environment, and documentation. This includes allowing people to self-identify their gender and pronouns instead of selecting from predetermined options, and taking steps to prevent misgendering across healthcare interactions.

Feeling Support and Acceptance	· Seek out comprehensive and up-to-date education about the trans community. Healthcare education programs and employers should integrate high quality, community-informed training. · Consider concrete ways to signal your commitment to trans patients (e.g., on websites, in office/clinic/units, wearing trans pride flag pins, lanyards, etc.). · Be prepared to provide information for trans-affirming community organizations, support groups, and other resources if warranted or desired by patients. Also consider if family members or other supporters need education or resources to effectively support trans patients. Healthcare systems may need to work to create new trans-affirming resources if they are unavailable in the community.
Embracing Diversity within the Trans Community	· Recognize that trans people are diverse across many aspects of identity including culture, race, gender identity and expression, age, sexual orientation, appearance, body size, and disability status. Trans people have various countries of origin, interests, career paths, educational histories, family structures, religious/spiritual preferences, and life choices. Avoid stereotypical and culturally limited perspectives about the trans community and seek out expansive education and representation. Recognize that not all trans people identify in the gender binary, and not all trans people choose medical transition. · Support trans people who seek to medically transition in ways that do not align with traditional comprehensive, binary paths (e.g., seeking top surgery without taking hormones, taking hormones temporarily but not permanently, seeking non-flat top surgery).

pact trans community members and their risk of suicidality. Basic survival and safety needs are the most fundamental forms of suicide prevention (Britton et al. 2014) and participants described often not having access to the resources needed to survive and live safely. Existing research demonstrates that trans people are three times more likely to be unemployed than the national average and over two times as likely to live below the poverty line (James et al. 2016). One-in-10 trans individuals report being physically attacked, and those attacks are correlated with elevated risk of suicide attempt (James et al. 2016). The constant fear of physical violence and emotional abuse described by participants are known to be chronic minority stressors associated with suicidality (Green et al. 2022; Pellicane and Ciesla 2022). Healthcare providers need to consider the impact of social determinants of health and ways to address them to support the health of trans patients (see Andermann 2016, for a framework for addressing SDOH for health professionals), as well as to acknowledge the potential traumas that trans individuals are more likely to experience by adopting trauma-informed care practices (Guelbert 2023; Levenson et al. 2023).

The healthcare sector is strongly linked with policy, as healthcare can be restricted or mandated by policies. According to participants, supportive and inclusive policies (e.g., national, state, local, institutional) hold potential to be helpful for suicide prevention—but only when they are truly enacted. Participants referenced a

wide range of laws and policies from HR discrimination policies in employment settings, school policies for both students and teachers, bathroom bills, name and gender marker change policies and laws, and laws restricting access to gender affirming care for minors. There was a clear indication of a need for policies that are inclusive of trans people and allow for their self-determination and ability to participate in all aspects of life and community. Other available evidence supports this finding, with Perez-Brumer and colleagues (2015) reporting fewer trans suicide attempts in places with lower state-level structural discrimination. While the development and enactment of new supportive and inclusive policies are clearly warranted, the most pressing need appears to be stopping the wave of negative, restrictive, and discriminatory policies targeting trans people that have been discussed, proposed, and codified in recent years. When we gathered the data for this study in 2021, the number of anti-trans bills had more than doubled proposals from any prior year (Branigin and Kirkpatrick 2022). Participants described how the increased and highly negative political rhetoric around these bills contributed to their suicidality. Since then, we have seen even more legislation that further marginalizes trans people proposed and codified (American Civil Liberties Union 2023). Well educated healthcare providers may be well positioned to advocate alongside the trans community for rights to bodily autonomy, healthcare access, and other trans needs, as appropriate in their community and workplace.

The need for support and acceptance across multiple contexts was highlighted by participants in this study as necessary for suicide prevention, which is consistent with prior qualitative studies (e.g., Clark et al. 2022; Kaniuka et al. 2024; Moody et al. 2015). Further, Diamond and Alley (2022) emphasized how social safety is critical for health and wellness, and often under threat for sexual and gender minority populations. Prior research shows that social protection from suicidality can begin in adolescence; young trans people who feel supported in social transition (e.g., using their chosen name and pronouns) are significantly less likely to report suicidality (Russell et al. 2018; The Trevor Project 2020). Family support can be especially critical for mental wellbeing among trans youth (Durwood et al. 2021), while the lack of family support is associated with homelessness (Siebel et al. 2018) and suicidality (The Trevor Project 2020). Participants discussed the importance of having social support from individuals and communities, and prior research supports the connection between interpersonal/community rejection and suicidality (James et al. 2016). They also emphasized the importance of people in participants' lives being educated about the trans community. There is a clear need for efforts to improve family and social support, which can be informed by the best practice clinical strategies outlined by Malpas and colleagues (2022) such as using multiple modes of support, offering psychoeducation, and emphasizing the meaningful impact of family acceptance.

Participants talked about suicide risk and prevention in the context of formal community organizations and institutions. For example, participants described experiences of rejection in religious communities as well as conversion therapy efforts which are known to be linked to increased suicidality (Campbell et al. 2022; James et al. 2016; Turban et al. 2020). However, studies such as Moody and colleagues (2015) have also pointed to religion and spirituality as protective factors for suicide for trans people. More surprisingly, some participants also described exclusion from LGBTQIA+ communities, and even trans-specific communities. Exclusion experiences were

linked to participants' multiple and intersecting identities: as trans (vs. lesbian, gay, or bisexual), nonbinary (vs. identifying within the gender binary), and/or people of color (vs. white). Prior research has demonstrated unique forms of marginalization related to intersectionality in the LGBTQIA+ community and associated mental health consequences (Kulick et al. 2017). Furthermore, having multiple marginalized identities (including racial minority and disability) is associated with increased risk of suicidality among trans adults (Cramer et al. 2022). Whereas supportive communities and positive representation play a protective and affirming role for trans mental health. Specifically, Sherman and colleagues (2020) found that actively participating in the trans community (e.g., in-person, online, or through engagement with positive media representations) was associated with better mental health and reduced distress. Participants in this study also suggested a causal link from engaging in an online community to reduced distress related to suicidality. Together, these findings highlight the need for positive and affirming communities inclusive of the full diversity of the trans community. Community advocates are already doing this work (Horak 2019)—and participants spoke about their own attempts to advocate in their communities—but broader awareness and recognition of these problems within the community may help advance these efforts.

Strengths and limitations

The primary strength of this study was our focus on the perspectives of the trans community, honoring embodied knowledge and community priorities. This is further reflected by our use of open-ended questions and an inductive analytic process to understand community priorities for suicide prevention. Because of the nature of the study and our focus on recruiting trans people who experienced suicidality, we cannot draw conclusions about protective factors that may support trans people to never experience suicidality in the first place (as explored by Moody et al. 2015). However, we were able to gather data about what has been both helpful and harmful for participants using a broad lens, which supported our development of interpretive themes for suicide prevention. Further, recruiting participants from a politically and religiously conservative state allowed us to explore the experiences and needs of trans community members in a place where trans rights are under social and political siege. We do not know if the results would differ if we had also enrolled participants from politically moderate or liberal states. Additional research is needed to test how restrictive public policy at the state level does or does not contribute to rates of suicidality among trans people.

Focus groups and online data collection each have their own strengths and limitations. Specifically, focus groups allow for group discussion and community engagement, but may risk social pressure and privacy concerns. Whereas online data collection can lack depth of understanding because of the inability to ask follow-up questions and does not incorporate community discussion, but may create more opportunity for candid responses. We hope that by utilizing both in this study, we maximize the benefits of each. Notably, the results across focus groups and between the focus groups and online responses were highly similar.

We aimed to recruit a diverse group of trans community members within Utah. We accomplished this aim on several fronts including having participants representing a wide range of ages, gender identities, income levels, and mental health needs.

However, we experienced some difficulties recruiting participants from a broad range of racial and ethnic backgrounds. Throughout our recruitment and data collection process, it was apparent that trans people of color often feel on the outskirts of trans spaces (this also supported by existing research, e.g., de Vries 2012; James et al. 2016; Ussher et al. 2022). Once we advertised a focus group exclusively for trans people of color, we had an increased response. We suggest that future efforts to gather community input should consider offering spaces specifically for trans people of color—they may feel safer, more welcomed, and more confident they will be heard.

Although participants in this study provided valuable insights about needed directions for suicide prevention, our approach was not designed to identify the specific mechanisms through which recommendations could be accomplished. Future research and community efforts can build on the recommendations provided herein to identify and address key mechanisms of change. Lastly, we did not ask details about participants' histories of suicidality, beyond whether their experiences were in the past year or further in their history. Given the advancement of ideation-to-action frameworks of suicide (e.g., Bayliss et al. 2022), knowing more about the types and timing of suicidal thoughts and actions may have allowed for more nuanced implications about suicide prevention. This could be explored in future research.

CONCLUSION

This study examined perspectives on trans community suicide prevention needs from trans people with a history of suicidality. We identified rights and respect as central suicide prevention needs along with bodily autonomy, safety, and social support and inclusion of the full diversity of the trans community. The findings underscore the need for future research and suicide prevention that focuses on social and systemic change efforts to support suicide prevention strategies that extend beyond mental healthcare.

REFERENCES

Almazan, Anthony N, and Alex S. Keuroghlian. 2021. "Association between Gender-Affirming Surgeries and Mental Health Outcomes." *JAMA Surgery* 156 (7): 611–618. https://doi.org/10.1001/jamasurg.2021.0952.

American Civil Liberties Union. 2023. "Mapping Attacks on LGBTQ Rights in US State Legislatures." *American Civil Liberties Union*. https://www.aclu.org/legislative-attacks-on-lgbtq-rights.

Andermann, Anne. 2016. "Taking Action on the Social Determinants of Health in Clinical Practice: A Framework for Health Professionals." *Canadian Medical Association Journal* 188 (17–18): E474–E483. https://doi.org/10.1503/cmaj.160177.

Baker, Kellan E, Lisa M. Wilson, Ritu Sharma, Vadim Dukhanin, Kristen McArthur, and Karen A. Robinson. 2021. "Hormone Therapy, Mental Health, and Quality of Life among Transgender People: A Systematic Review." *Journal of the Endocrine Society* 5 (4): bvab011. https://doi.org/10.1210/jendso/bvab011.

Bayliss, Luke T, Steven Christensen, Andrea Lamont-Mills, and Carol du Plessis. 2022. "Suicide Capability within the Ideation-to-Action Framework: A Systematic Scoping Review." *PLOS One* 17 (10): e0276070. https://doi.org/10.1371/

journal.pone.0276070.
Branigin, Anne, and N Kirkpatrick. 2022. "Anti-Trans Laws are on the Rise. Here's a Look at Where — and What Kind." *The Washington Post*, October 14. https://www.washingtonpost.com/lifestyle/2022/10/14/anti-trans-bills/.
Braun, Virginia, and Victoria Clarke. 2022. *Thematic Analysis: A Practical Guide*. Thousand Oaks, CA: SAGE.
Britton, Peter C, Kimberly A. Van Orden, Jameson K. Hirsch, and Geoffrey C. Williams. 2014. "Basic Psychological Needs, Suicidal Ideation, and Risk for Suicidal Behavior in Young Adults." *Suicide & Life-threatening Behavior* 44 (4): 362–371. https://doi.org/10.1111/sltb.12074.
Brooks, Virginia R. 1981. *Minority Stress and Lesbian Women*. Lexington, MA: Lexington Books.
Bryan, Craig J. 2021. *Rethinking Suicide: Why Prevention Fails, and How We Can Do better*. New York: Oxford University Press.
Campbell, Travis, and Yana van der Meulen Rodgers. 2023. "Conversion Therapy, Suicidality, and Running Away: An Analysis of Transgender Youth in the US" *Journal of Health Economics* 89: 102750. https://doi.org/10.1016/j.jhealeco.2023.102750.
Clark, Kristy A, Travis Salway, Erin M. McConocha, and John E. Pachankis. 2022. "How Do Sexual and Gender Minority People Acquire the Capability for Suicide? Voices from Survivors of Near-Fatal Suicide Attempts." *SSM - Qualitative Research in Health* 2: 100044. https://doi.org/10.1016/j.ssmqr.2022.100044.
Cramer, Robert J, Andrea R. Kaniuka, Farida N. Yada, Franck Diaz-Garelli, Ryan M. Hill, Jessamyn Bowling, James M. Macchia, and Raymond P. Tucker. 2022. "An Analysis of Suicidal Thoughts and Behaviors among Transgender and Gender Diverse Adults." *Social Psychiatry and Psychiatric Epidemiology* 57: 195–205. https://doi.org/10.1007/s00127-021-02115-8.
de Vries, Kylan M. 2012. "Intersectional Identities and Conceptions of the Self: The Experience of Transgender People." *Symbolic Interaction* 35 (1): 49-67. https://doi.org/10.1002/symb.2.
Diamond, Lisa M, and Jenna Alley. 2022. "Rethinking Minority Stress: A Social Safety Perspective on the Health Effects of Stigma in Sexually-Diverse and Gender-Diverse Populations." *Neuroscience and Biobehavioral Reviews* 138: 104720. https://doi.org/10.1016/j.neubiorev.2022.104720.
Doupnik, Stephanie K, Brittany Rudd, Timothy Schmutte, Diana Worsley, Cadence F. Bowden, Erin McCarthy, Elliott Eggan, Jeffrey A. Bridge, and Steven C. 2020. "Association of Suicide Prevention Interventions with Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-Analysis." *JAMA Psychiatry* 77 (10): 1021–1030. https://doi.org/10.1001/jamapsychiatry.2020.1586.
Dubin, Samuel N, Ian T. Nolan, Carl G. Streed Jr., Richard E. Greene, Asa E. Radix, and Shane D. Morrison. 2018. "Transgender Health Care: Improving Medical Students' and Residents' Training and Awareness." *Advances in Medical Education and Practice* 9: 377–391. https://doi.org/10.2147/AMEP.S147183.
Durwood, Lily, Leila Eisner, Kaitlyn Fladeboe, Chonghui (Gabriella) Ji, Samantha Barney, Katie A. McLaughlin, and Kristina R. Olson, K.R. 2021. "Social Support

and Internalizing Psychopathology in Transgender Youth." *Journal of Youth and Adolescence* 50 (5): 841–854. https://doi.org/10.1007/s10964-020-01391-y.
Flick, Uwe. 2006. *An Introduction to Qualitative Research*. Thousand Oaks, CA: SAGE.
Fontanari, Anna Martha V, Felipe Vilanova, Maiko A. Schneider, Itala Chinazzo, Bianca M. Soll, Karine Schwarz, Maria Ines R. Lobato, and Angelo B. Costa. 2020. "Gender Affirmation is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement." *LGBT Health* 7 (5): 237–247. http://doi.org/10.1089/lgbt.2019.0046.
Franklin, Joseph C, Jessica D. Ribeiro, Kathryn R. Fox, Kate H. Bentley, Evan M. Kleiman, Xieyining Huang, Katherine M. Musacchio, Adam C. Jaroszewski, Bernard P. Chang, and Matthew K. Nock. 2017. "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research." *Psychological Bulletin* 143 (2): 187–232. https://doi.org/10.1037/bul0000084.
Green, Amy E, Myeshia N. Price, and Sam H. Dorison. 2022. "Cumulative Minority Stress and Suicide Risk among LGBTQ Youth." *American Journal of Community Psychology* 69 (1–2): 157–168. https://doi.org/10.1002/ajcp.12553.
Guelbert, Cristopher S. 2023. "Providing Trauma-Informed Care to Patients Who Identify as LGBTQAI." *Nursing* 53 (4): 45–48. https://doi.org/10.1097/01.NURSE.0000920440.68593.aa.
Hendricks, Michael L, and Rylan J. Testa. 2012. "A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model." *Professional Psychology: Research and Practice* 43 (5), 460–467. https://doi.org/10.1037/a0029597.
Hofstra, Emma, Chijs van Nieuwenhuizen, Marjan Bakker, Dilana Özgül, Iman Elfeddali, Sjakko J. de Jong, Christina M. van der Feltz-Cornelis. 2020. "Effectiveness of Suicide Prevention Interventions: A Systematic Review and Meta-Analysis." *General Hospital Psychiatry* 63: 127–140. https://doi.org/10.1016/j.genhosppsych.2019.04.011.
Horak, Molly. 2019. "The Role of the Transgender Community in the LGBT+ Rights Movement." *Lawyer's Committee for Civil Rights Under Law.* https://www.lawyerscommittee.org/the-role-of-the-transgender-community-in-the-lgbt-rights-movement/.
Hunt, Quintin A, Quinlyn J. Morrow, and Jennifer K. McGuire. 2020. "Experiences of Suicide in Transgender Youth: A Qualitative, Community-Based Study." *Archives of Suicide Research* 24 (Suppl 2): S340–S355. https://doi.org/10.1080/13811118.2019.1610677.
Jackson, Daniel. 2023. "Suicide-Related Outcomes Following Gender-Affirming Treatment: A Review." *Cureus* 15 (3): e36425. https://doi.org/10.7759/cureus.36425.
James, Sandy E, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi. 2016. *The Report of the 2015 US Transgender Survey*. Washington, DC: National Center for Transgender Equality.
Johns, Michelle M, Richard Lowry, Jack Andrzejewski, Lisa C. Barrios, Zewditu Demissie, Timothy McManus, Catherine N. Rasberry, Leah Robin, and J. Michael Underwood. 2019. "Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors among

High School Students — 19 States and Large Urban School Districts 2017." *Morbidity and Mortality Weekly Report* 68: 67–71. http://dx.doi.org/10.15585/mmwr.mm6803a3.

Kaniuka, Andréa R, Eleanor M. Nanney, Ryan Robertson, Rhoen Hoff, Mac Smith, Jessamyn Bowling, Erin D. Basinger, Alicia A. Dahl, Robert J. Cramer. 2024. "A Grounded Theory of Sexual and Gender Minority Suicide Risk: The Sexual and Gender Minority Suicide Risk and Protection Model." *Psychology of Sexual Orientation and Gender Diversity.* Advance online. https://dx.doi.org/10.1037/sgd0000699.

Kidd, Jeremy D, Nicky A. Tettamanti, Roma Kaczmarkiewicz, Thomas E. Corbeil, Jordan D. Dworkin, Kasey B. Jackman, Tonda L. Hughes, Walter O. Bockting, and Ilan H. Meyer. 2023. "Prevalence of Substance Use and Mental Health Problems among Transgender and Cisgender US Adults: Results from a National Probability Sample." *Psychiatry Research* 326: 115339. https://doi.org/10.1016/j.psychres.2023.115339.

Kulick, Alex, Laura J. Wernick, Michael R. Woodford, and Kristen Renn. 2017. "Heterosexism, Depression, and Campus Engagement among LGBTQ College Students: Intersectional Differences and Opportunities for Healing." *Journal of Homosexuality* 64 (8): 1125–1141. https://doi.org/10.1080/00918369.2016.1242333.

Levenson, Jill S, Shelley L. Craig, and Ashley Austin. 2023. "Trauma-Informed and Affirmative Mental Health Practices with LGBTQ+ Clients." *Psychological Services* 20 (Suppl 1): 134–144. https://doi.org/10.1037/ser0000540.

Lincoln, Yvonna S, and Egon G. Guba. 1985. *Naturalistic inquiry.* SAGE Publications.

Malpas, Jean, Michael J. Pellicane, and Elizabeth Glaeser. 2022. "Family-Based Interventions with Transgender and Gender Expansive Youth: Systematic Review and Best Practice Recommendations." *Transgender Health* 7 (1): 7–29. https://doi.org/10.1089/trgh.2020.0165.

Marshall, Ellen, Laurence Claes, Walter Pierre Bouman, Gemma L. Witcomb, and Jon Arcelus. 2016. "Non-Suicidal Self-Injury and Suicidality in Trans People: A Systematic Review of the Literature." *International Review of Psychiatry* 28 (1): 58–69. https://doi.org/10.3109/09540261.2015.1073143.

McCann, Edward, Gráinne Donohue, and Michael Brown. 2021. "Experiences and Perceptions of Trans and Gender Non-binary People Regarding Their Psychosocial Support Needs: A Systematic Review of the Qualitative Research Evidence." *International Journal of Environmental Research and Public Health* 18 (7): 3403. https://doi.org/10.3390/ijerph18073403.

McNeil, Jay, Sonja J. Ellis, and Fiona J R Eccles. 2017. "Suicide in Trans Populations: A Systematic Review of Prevalence and Correlates." *Psychology of Sexual Orientation and Gender Diversity* 4 (3): 341–353. https://doi.org/10.1037/sgd0000235.

Moody, Chérie, Nate Fuks, Sandra Peláez, and Nathan Grant Smith. 2015. "'Without This, I Would For Sure Already Be Dead': A Qualitative Inquiry Regarding Suicide Protective Factors among Trans Adults." *Psychology of Sexual Orientation and Gender Diversity* 2 (3): 266–280. https://doi.org/10.1037/sgd0000130.

Patton, Michael Quinn. 2002. *Qualitative Research & Evaluation Methods.* 3rd ed. California: Sage Publications, Inc.

Pellicane, Michael J, and Jeffrey A. Ciesla. 2022. "Associations between Minority

Stress, Depression, and Suicidal Ideation and Attempts in Transgender and Gender Diverse (TGD) Individuals: Systematic Review and Meta-Analysis." *Clinical Psychology Review* 91: 102113. https://doi.org/10.1016/j.cpr.2021.102113.

Perez-Brumer, Amaya, Mark L. Hatzenbuehler, Catherine E. Oldenburg, and Walter Bockting. 2015. "Individual- and Structural-Level Risk Factors for Suicide Attempts among Transgender Adults." *Behavioral Medicine* 41 (3): 164–171. https://doi.org/10.1080/08964289.2015.1028322.

Platt, Stephen, and Thomas Niederkrotenthaler. 2020. "Suicide Prevention Programs: Evidence Base and Best Practice." *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 41 (Suppl 1): S99–S124. https://doi.org/10.1027/0227-5910/a000671.

Pullen Sansfaçon, Annie, Elio Gravel, and Morgane A. Gelly. 2024. "Dealing with Scam in Online Qualitative Research: Strategies and Ethical Considerations." *International Journal of Qualitative Methods* 23. https://doi.org/10.1177/16094069231224610.

Rich, Ashleigh J, Travis Salway, Ayden Scheim, and Tonia Poteat. 2020. "Sexual Minority Stress Theory: Remembering and Honoring the Work of Virginia Brooks." *LGBT Health*, 7 (3): 123-168. https://doi.org/10.1089/lgbt.2019.0223.

Ridge, Damien, Laurna Bullock, Hilary Causer, Tamsin Fisher, Samantha Hider, Tom Kingstone, Lauren Gray, Ruth Riley, Nina Smyth, Victoria Silverwood, Johanna Spiers, and Jane Southam. 2023. "'Imposter Participants' in Online Qualitative Research, a New and Increasing Threat to Data Integrity?" *Health Expectations* 26 (3): 941–944. https://doi.org/10.1111/hex.13724.

Rimke, Heide and Debra Brock. 2012. "The Culture of Therapy: Psychocentrism in Everyday Life." In *Power and Everyday Practices*, edited by Deborah Brock, Aryn Martin, Rebecca Raby and Mark Thomas, 182–202. Toronto: University of Toronto Press.

Russell, Stephen T, Amanda M. Pollitt, Gu Li, and Arnold H. Grossman. 2018. "Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior among Transgender Youth." *The Journal of Adolescent Health* 63 (4): 503–505. https://doi.org/10.1016/j.jadohealth.2018.02.003.

Schreier, M. 2018. "Sampling and Generalization." In *The SAGE Handbook of Qualitative Data Collection*, edited by Uwe Flick, 84–98. Thousand Oaks, CA: SAGE.

Schwandt, Thomas A. 2007. *The SAGE Dictionary of Qualitative Inquiry.* Thousand Oaks, CA: SAGE.

Shapira, Shahar, and Leeat Granek. 2019. "Negotiating Psychiatric Cisgenderism-Ableism in the Transgender- Autism Nexus." *Feminism & Psychology* 29 (4): 494–513. https://doi.org/10.1177/0959353519850843.

Sherman, Athena D.F., Kristen D. Clark, Kelley Robinson, Tara Noorani, and Tonia Poteat. 2020. "Trans* Community Connection, Health, and Wellbeing: A Systematic Review." *LGBT Health* 7 (1): 1–14. https://doi.org/10.1089/lgbt.2019.0014.

Siebel, Bruna L, Bruno de Brito Silva, Anna M.V. Fontanari, Ramiro F. Catelan, Ana M. Bercht, Juliana L. Stucky, Diogo A. DeSousa, Elder Cerqueira-Santos, Henrique C. Nardi, Silvia H. Koller, and Angelo B. Costa. 2018. "The Impact of the Parental Support on Risk Factors in the Process of Gender Affirmation of Transgender and Gender Diverse People." *Frontiers in Psychology* 9: 399. https://

doi.org/10.3389/fpsyg.2018.00399.
Substance Abuse and Mental Health Services Administration (SAMHSA). 2021. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health." (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). *Center for Behavioral Health Statistics and Quality, SAMHSA*. https://www.samhsa.gov/data.
The Trevor Project. 2022. "2022 National Survey on LGBTQ Youth Mental Health." *The Trevor Project*. https://www.thetrevorproject.org/survey-2022.
Turban, Jack L, Noor Beckwith, Sari L. Reisner, and Alex S. Keuroghlian. 2020. "Association between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts among Transgender Adults." *JAMA Psychiatry* 77 (1): 68–76. https://doi.org/10.1001/jamapsychiatry.2019.2285.
Ussher, Jane M, Alexandra Hawkey, Janette Perz, Pranee Liamputtong, Jessica Sekar, Brahmaputra Marjadi, Virginia Schmied, Tinashe Dune, and Eloise Brook. 2021. "Gender Affirmation and Social Exclusion Amongst Trans Women of Color in Australia." *International Journal of Transgender Health*, 23 (1–2): 79–96. https://doi.org/10.1080/26895269.2021.1947432.
Wall, Catherine S.J., Alison J. Patev, Eric G. Benotsch. 2023. "Trans Broken Arm Syndrome: A Mixed-Methods Exploration of Gender-Related Medical Misattribution and Invasive Questioning." *Social Science & Medicine* 320: 115748. https://doi.org/10.1016/j.socscimed.2023.115748.
White Hughto, Jaclyn M, Sari L. Reisner, and John E. Pachankis. 2015. "Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions." *Social Science & Medicine* 147: 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010.
World Health Organization (WHO) (n.d.). "Suicide Worldwide in 2019: Global Health Estimates." *World Health Organization*. https://www.who.int/publications/i/item/9789240026643.

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