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Research article

Sexual orientation, coming out and suicidal ideation in young French LGBP people

Orientation sexuelle coming-out *et idéation suicidaire chez les jeunes LGBP français*

Paul Martins[a,*], Baptiste Lignier[b], Thibault Chiarabini[c], Bénédicte Gohier[a,d], Catherine Potard[a]

[a] *Pays de la Loire Psychology Laboratory (LPPL), Psychology Department, Angers University, Angers, France*
[b] *Psy-DREPI Laboratory, Psychology Department, University of Burgundy, Dijon, France*
[c] *Infectious and Tropical Diseases, Hospital Saint-Antoine, GHU AP–HP. Sorbonne University, Paris, France*
[d] *Department of Psychiatry and Addictology, University Hospital, Angers, France*

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ABSTRACT

Young individuals identifying as lesbian, gay, bisexual, or pansexual (LGBP) are particularly vulnerable to suicidal ideation (SI). This study examines the relationships between sexual orientation, gender, coming out, and suicidal ideation among young French LGBP adults. The sample included 459 participants aged 18 to 35, 50.1% ($n = 230$) of them identifying as LGBP. Data were collected through an online survey using the French version of the Suicidal Ideation Attributes Scale (SIDAS-FR). Findings revealed significantly higher levels of suicidal ideation among LGBP individuals compared to heterosexual people, with bisexual individuals reporting the highest levels. Women of sexual minorities, particularly those who are bisexual and pansexual, were identified as the most vulnerable subgroup for SI. Men of sexual minorities also reported increased SI compared to heterosexual men. Coming out emerged as a protective factor, with participants who had disclosed their sexual orientation to both parents reporting a lower level of SI. The study highlights the need for targeted interventions to support LGBP individuals, focusing on reducing stigma, promoting family acceptance, and strengthening community-based mental health resources.

Mots clés :
Idéation suicidaire
Jeunes LGBP
Orientation sexuelle
Genre
Coming-out
Santé mentale

RÉSUMÉ

Les jeunes individus s'identifiant comme lesbiennes, gays, bisexuels ou pansexuels (LGBP) sont particulièrement vulnérables à l'idéation suicidaire (SI). Cette étude examine les relations entre l'orientation sexuelle, le genre, le *coming-out* et l'idéation suicidaire chez les jeunes adultes français LGBP. L'échantillon comprenait 459 participants âgés de 18 à 35 ans, dont 50,1 % ($n = 230$) s'identifiant comme LGBP. Les données ont été collectées à l'aide d'un questionnaire en ligne utilisant la version française de l'échelle *Suicidal Ideation Attributes Scale* (SIDAS-FR). Les résultats ont révélé des niveaux d'idéation suicidaire significativement plus élevés chez les individus LGBP comparés aux personnes hétérosexuelles, les individus bisexuels rapportant les niveaux les plus élevés. Les femmes issues de minorités sexuelles, en particulier les femmes bisexuelles et pansexuelles, ont été identifiées comme le sous-groupe le plus vulnérable à l'idéation suicidaire. Les hommes issus de minorités sexuelles ont également rapporté une augmentation de l'idéation suicidaire par rapport aux hommes hétérosexuels. Le *coming-out* est apparu comme un facteur protecteur, les participants ayant révélé leur orientation sexuelle à leurs deux parents rapportant un niveau d'idéation suicidaire plus faible. Cette étude met en lumière la nécessité d'interventions ciblées pour soutenir les individus LGBP, en mettant l'accent sur la réduction des stigmates, la promotion de l'acceptation familiale et le renforcement des ressources communautaires en santé mentale.

* Corresponding author: Laboratoire de psychologie des Pays de la Loire, Maison de la recherche Germaine Tillion, université d'Angers, 5 bis, boulevard Lavoisier, 49045 Angers cedex 1, France.
E-mail addresses: paul.marts@icloud.com (P. Martins), baptiste.lignier@u-bourgogne.fr (B. Lignier), thibault.chiarabini@aphp.fr (T. Chiarabini), benedicte.gohier@univ-angers.fr (B. Gohier), catherine.potard@univ-angers.fr (C. Potard).

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1. Introduction

The mental health of young lesbian, gay, bisexual, and pansexual (LGBP) people is a major concern, characterized by significantly higher rates of suicidal ideation (SI) and suicide attempts (SA) than their heterosexual peers [1–3]. This population is particularly vulnerable due to increased exposure to social victimization, harassment, parental rejection, and family exclusion [4,5].

Significant disparities also emerge within this population. Regarding sexual orientation, bisexual (i.e., sexual and/or romantic attraction to two, several or all genders) and pansexual (i.e., sexual and/or romantic attraction to anyone, regardless of sex or gender identity) individuals are at an increased risk of SI, which is often associated with social isolation and exclusion by both heterosexual and gay/lesbian populations [5–7]. Regarding gender, women report higher levels of SI and SA, while men have higher rates of death by suicide [8,9]. However, the interaction between gender and sexual orientation remains complex, with some studies suggesting that gay and bisexual men are at greater risk [1,10], while others identify bisexual women as the most vulnerable group [2] and lesbian individuals as more vulnerable than gay men [6].

In addition to these differences, coming out (CO), understood as the disclosure of a non-heterosexual person's sexual orientation to others, in this case their parents, emerges as a key factor that influences suicidal behaviors. When CO is supported by one's social environment, it can act as a protective factor [4]. In contrast, hiding one's sexual orientation, associated with increased stress and depressive symptoms, promotes SI [11,12]. These dynamics are strongly influenced by the cultural context, as evidenced by the impact of stigma in societies that are less open to sexual diversity [13].

In France, although young LGBP individuals face similar challenges, there is limited data on the relationships between sexual orientation, gender, CO, and SI. The present study aims to fill this gap by exploring SI among young French LGBP adults. It particularly examines the combined influence of sexual orientation, gender, and CO on these ideations. Hypotheses predict lower SI among heterosexual individuals but higher levels in LGBP individuals, especially bisexual and pansexual individuals. Women are expected to have higher SI than men, consistent with broader gender differences in mental health. Bisexual and pansexual women have identified as being most at risk, while gay and bisexual men, although commonly affected, report a lower level of SI. Finally, young people who have come out to their parents are expected to have a lower level of SI than those who have not.

2. Method

2.1. Participants

All participants in the study ($n = 459$) were French, with a mean age of 22 years (SD = 4.7), ranging from 18 to 35 years. Almost half of the participants identified as heterosexual ($n = 229$, 49.9%), while 101 identified as gay/lesbian (22%), 72 as bisexual (15.7%), and 57 as pansexual (12.4%). For methodological reasons related to the small size of the subgroups, certain gender identities were combined into the category "Gender and questioning minorities". This category includes transgender men ($n = 6$), transgender women ($n = 1$), non-binary individuals ($n = 9$), and participants who chose not to answer ($n = 6$). While these identities were included in the descriptive statistics table to ensure their representation and respect for diversity, the small sample size did not allow for the creation of a distinct group for subsequent analyses. In addition, women in the sample were significantly younger than men (Mage: 21.3 vs. 24.7 years; $W = 10.5$, $P < 0.001$). The geographical distribution shows that 33.6% ($n = 154$) of the participants lived in a large city, 37.5% ($n = 172$) in a medium-sized city, and 28.9% ($n = 133$) in a small town or rural area. Finally, as far as educational level is concerned, 55.5% ($n = 255$) of participants have a qualification equivalent to a high school diploma or less, 22.2% ($n = 102$) have completed college degrees, and 22.2% ($n = 102$) have an advanced degree. Additional sociodemographic information on the sample is provided in Tables 1 and 2.

2.2. Procedure

This study was approved by the Research Ethics Committee of the University of Angers (Approval No. COMUE-CER-2023-07). The inclusion criteria for participant recruitment required individuals to be aged between 18 to 35 years, and to be French. The study involved a self-administrated anonymous online questionnaire, created using Lime Survey. The survey was accessible over a period of 14 months, from July 2023 to September 2024. A total of 486 individuals accessed the participation link, but only 459 completed responses were retained for analysis. Participants were invited to sign up through multiple channels, including social media, universities, LGBT+ associations and medical centers such as family planning clinics and CeGIDD (Free Information, Testing, and Diagnosis Centers). Flyers with a QR code leading to the online survey were also distributed at the afore-mentioned locations. Participation was entirely voluntary and free of charge. By scanning the QR code, participants could learn more about the study and its objectives and read the informed consent form. Once this consent was given, they could proceed with the survey. As the study focused on sexuality and mental health, prevention messages and contact details of relevant associations were provided at the end for participants who showed signs of concern in these areas.

2.3. Measures

2.3.1. Coming out related variables

Self-identified LGBP participants were asked to answer questions about CO. The item asked participants whether they had come out to their parent(s) and, if so, whether they had done so with their mother (or parent 1), father (or parent 2), or both.

2.3.2. Suicidal ideation attributes scale – French version (SIDAS-FR)

The SIDAS scale, validated for online use in English [14], in Chinese [15], and in French [16], is a rapid screening tool that assesses the presence and severity of SI. It consists of five items, each rated on a Likert scale ranging from 0 (never) to 10 (an extreme amount), addressing dimensions such as the frequency of suicidal thoughts ("In the past month, how often have you had suicidal thoughts?"), their controllability ("In the past month, how much control have you had over these thoughts?"), proximity to a suicidal act ("In the past month, how close have you come to making a suicide attempt?"), distress associated with these thoughts ("In the past month, how much have you been tormented by suicidal thoughts?"), and the impact on daily life ("In the past month, how much have suicidal thoughts interfered with your ability to carry out daily activities such as work, household tasks, or social activities?"). The sum of the scores for each item is added to give a total SI score. The SIDAS-Fr demonstrates good internal consistency ($\alpha = 83$).

2.4. Statistical analysis

To compare SI scores between different groups based on sexual orientation and CO status, various statistical tests were employed. Welch's *t*-tests were used to compare SI scores between two independent groups [17], specifically the "heterosexual" group and the

Table 1
Sociodemographic and socio-sexual information for the total sample.

Variables	Total sample (n = 459) n (%)	SIDAS mean (SD)
Age, M (interval)	22.1 (18–35)	
Declared gender		
Cisgender man	134 (29.2%)	4.31 (8.09)
Cisgender woman	303 (66.0%)	5.08 (8.76)
Gender and questioning minorities	22 (4.8%)	10.5 (9.89)
Declared sexual orientation		
Heterosexual	229 (49.9%)	3.68 (7.54)
Gays/Lesbians	101 (22.0%)	4.19 (7.09)
Bisexual people	72 (15.7%)	9.56 (11.1)
Pansexual people	57 (12.4%)	6.89 (10.2)
Relationship status		
Single	266 (58.0%)	5.07 (8.57)
Couple	173 (37.7%)	5.74 (9.23)
Married/Civil union	20 (4.4%)	0.3 (0.98)
Living area		
Big city (> 200,000 habitants)	154 (33.6%)	4.61 (8.36)
Medium-sized city	172 (37.5%)	5.44 (9.21)
Small town (< 10,000 habitants)	39 (8.5%)	4.67 (7.78)
Countryside/rural area	94 (20.5%)	5.53 (8.75)
Education		
High school or less	255 (55.6%)	5.76 (9.17)
Some college or college graduate	102 (22.2%)	5.42 (9.69)
Graduate or professional degree	102 (22.2%)	3.20 (5.76)

Table 2
Socio-sexual characteristics of the sample.

	Sexual orientation n (%)				
	Heterosexual	Gay/lesbian	Bisexual	Pansexual	Total
Gender					
Cisgender man	32 (14%)	83 (82.2%)	10 (13.9%)	9 (15.8%)	134
Cisgender woman	197 (86%)	15 (14.9%)	54 (75.0%)	37 (64.9%)	303
Other	0	3 (3.0%)	8 (11.42%)	11 (19.4%)	22

"LGBP" group. To further assess differences in SI scores between LGBP subgroups (gay/lesbian, bisexual, and pansexual individuals), Welch's ANOVAs followed by Games-Howell post hoc tests were performed to account for unequal variances and sample sizes. In addition, a generalized linear model (GLM) was used to calculate interaction effects between sexual orientation and gender. A significance threshold of $P < 0.05$ was used for all analyses.

3. Results

3.1. Comparison of SI scores between individuals who identify as heterosexual and those who identify as LGBP

A Welch's t-test was used to compare the mean scores on the SIDAS scale between the "heterosexual" group and the "LGBP" group. The results indicate that the mean score for the "heterosexual" group (M = 3.68, SD = 7.54) was significantly lower than the "LGBP" group (M = 6.54, SD = 9.52), with $t = -3.56$, $p < .001$.

Focused on the "LGBP" group, results showed a statistically significant difference between the "heterosexual", "gay/lesbian", "bisexual", and "pansexual" groups ($F = 6.95$, df1 = 3, df2 = 151, $P < .001$). More precisely, the "bisexual" group (M = 9.56, SD = 11.07) reported higher SI scores than the "heterosexual" group (M = 3.68, SD = 7.54) (difference M = −5.87, $P < 0.001$) and the "gay/lesbian" group ($M = 4.19$, SD = 7.09) (difference M = 5.37, $P = 0.002$) (Table 3).

3.2. Relationship between gender, sexual orientation and SI

Sociodemographic variables (age, gender, education level, geographic area), sexual orientation and SI scores were entered simultaneously into each GLM as predictor variables (Table 4) of the suicidal ideation score. Regarding gender, men have significantly higher odds of suicidal ideation compared to women (OR = 5.95, 95% CI [5.57, 6.35], $P < 0.001$). In addition, the interaction between gender identity and sexual orientation shows significant effects in all comparisons: heterosexual versus gay/lesbian (OR = 0.34, 95% CI [0.25, 0.45], $P < 0.001$), heterosexual versus bisexual (OR = 0.60, 95% CI [0.44, 0.80], $P < 0.001$), and heterosexual versus pansexual (OR = 0.22, 95% CI [0.14, 0.34], $P < 0.001$).

More precisely, heterosexual women exhibit significantly lower SI scores compared to lesbians (OR = 0.41, z = −8.34, $P < 0.001$), bisexual women (OR = 0.36, z = 15.52, $P < 0.001$), and pansexual women (OR = 0.39, z = 12.86, $P < 0.001$). They also have lower scores compared to heterosexual men (OR = 0.56, z = −7.00, $P < 0.001$), gay men (OR = 0.68, z = −5.04, $P < 0.001$) and bisexual men (OR = 0.33, z = −8.61, $P < 0.001$).

However, lesbians show an increased SI scores compared to gay men (OR = 1.66, z = 4.38, $P < 0.001$) and pansexual men (OR = 2.37, z = 3.87, $P = 0.003$). Bisexual women (OR = 2.74, z = 4.86, $P < 0.001$) and pansexual women (OR = 2.50, z = 4.38, $P < 0.001$) also exhibit higher SI scores compared to pansexual men.

Conversely, heterosexual men appear to be relatively protected from SI, with significantly lower SI scores compared to bisexual women (OR = 0.64, z = −5.21, $P < 0.001$), pansexual women (OR = 0.70, z = −3.73, $P = 0.005$), and bisexual men (OR = 0.60, z = −3.63, $P = 0.008$). Additionally, gay men exhibit lower SI scores than bisexual women (OR = 0.52, z = −8.27, $P < 0.001$), pansexual women (OR = 0.57, z = −6.52, $P < 0.001$) and bisexual men (OR = 0.49, z = −5.50, $P < 0.001$). Finally, the results show that bisexual men exhibit higher SI scores than pansexual men (OR = 2.93, z = 4.62, $P < 0.001$).

Table 3
Comparison of suicidal ideation mean scores according to sexual orientation.

	Heterosexual	Gay/Lesbian	Bisexual	Pansexual	Welch ANOVA	*P*	Post hoc test
Suicidal ideation	3.68 (7.54)	4.19 (7.09)	9.56 (11.07)	6.89 (10.19)	6.95	< 0.001	He < Bi[b] Ho < Bi[a]

He: heterosexuals; Bi: bisexual people; Ho: gays/lesbians.
[a] $P < 0.01$.
[b] $P < 0.001$.

Table 4
Generalized linear model investigating suicidal ideations score according to sexual orientation, gender and sociodemographic variables.

Predictors	Suicidal ideations				
	$R^2 = 0.44$				
	β	SE	OR	z	*P*
Sexual orientation					
Gay/lesbian – heterosexual	0.35	0.07	1.41	4.68	< 0.001
Bisexual – heterosexual	0.78	0.08	2.18	10.04	< 0.001
Pansexual – heterosexual	0.19	0.11	1.21	1.71	0.088
Sociodemographic					
Gender	1.78	0.03	5.95	53.13	< 0.001
Age	−0.07	0.01	0.93	−8.59	< 0.001
Geographical area	−0.04	0.02	0.96	−1.94	0.052
Education level	−0.03	0.03	0.97	−1.29	196
Sexual orientation × gender					
Gender × heterosexual – gay/lesbian	−1.09	0.14	0.34	−7.67	< 0.001
Gender × heterosexual – bisexual	−0.52	0.15	0.60	−3.38	< 0.001
Gender × heterosexual – pansexual	−1.50	0.23	0.22	−6.67	< 0.001

3.3. Relationship between coming out to parents and SI in LGBP young adults

Finally, to test whether suicidal ideation is higher in contexts where LGBP people have come out to their parents ($n = 122$, $M = 4.83$, $SD = 7.46$) or not ($n = 62$, $M = 8.55$, $SD = 11.5$), a Welch's *t*-test was performed. The results show a significant difference between the two means with $t = 2.32$, $df = 88.0$, $P = 0.023$. More specifically, the groups "CO to neither parent" ($n = 62$), "CO to one parent" ($n = 30$), and "CO to both parents" ($n = 92$) were compared. The results indicate a statistically significant difference between the groups ($F = 4.18$, $df1 = 2$, $df2 = 69.7$, $P = 0.019$), showing that suicidal ideation scores are higher for the group "CO to neither parent" ($M = 8.55$, $SD = 11.48$) than for the group "CO to both parents" ($M = 4.39$, $P = 0.022$) (Table 5).

4. Discussion

This study confirms that young French LGBP individuals exhibit significantly higher levels of SI than their heterosexual peers. These findings are consistent with international studies showing an increased prevalence of SI in sexual minority populations, often related to orientation-related stressors, such as discrimination, verbal harassment, low social support (from peers and family), internalized homophobia, and sometimes violence [18,19].

Among LGBP subgroups, the results of this study indicate that bisexual individuals report significantly higher rates of SI than their gay/lesbian and heterosexual counterparts. This increased vulnerability may be due to a combination of psychosocial, identity-related, and relationship factors. Bisexuals suffer from specific forms of stigmatization such as biphobia (rejection and discrimination based on prejudice against bisexuality), monosexism (the idea that sexual orientation only concerns one gender) and social invisibility contributing to social isolation [6,20,21]. Although pansexual individuals are generally associated with SI levels comparable to or even higher than those of bisexual individuals [6,22], this study did not identify a significant difference. This absence may be explained by a sample size too small to detect statistical significance, as well as a lack of data on coming out, which may play a role in SI.

The findings also revealed significant interactions between gender, sexual orientation, and SI, highlighting complex patterns of vulnerability across different demographic groups. Results indicated that men are significantly more likely to experience SI than women. While this result contrasts with the typically higher SI scores reported among women in general populations [6,8], it may be explained by the over-representation of cisgender heterosexual women ($n = 197$) relative to cisgender heterosexual men ($n = 32$) in this study's sample. This demographic imbalance leads to a higher proportion of men from sexual minority groups, who are at greater risk for SI due to the unique challenges they face.

Furthermore, the findings of this study suggest a potential relationship between gender and sexual orientation, with women of a sexual minority appearing as the most at-risk group, particularly compared to heterosexuals, gay, and pansexual men, in line with previous literature [2,6,21]. However, the level of SI among women of a sexual minority and bisexual men does not appear to differ significantly within this study. Similarly, when heterosexual individuals are excluded from the analysis, gay men appear to be the least at-risk group among the sexual minorities, when both gender and sexual orientation are considered. This result can be explained by the cumulative effect of multiple forms of discrimination, where women may face stigma related to both their sexual orientation and their gender [21]. In the case of bisexual men, this may stem from stigma both outside of and within the LGBTQIA+ community, as previously mentioned. It should also be noted that the distribution of sexual orientation varied markedly by gender in the sample of this study, with significantly more gay men than lesbian women, and bisexual or pansexual identities being more common among women. This imbalance may influence the interpretation of interaction effects between gender and sexual orientation.

Finally, the results support the hypothesis that participants who have not come out reported significantly higher levels of SI than those who have come out to both parents. These findings are consistent with previous research highlighting the profound

Table 5
Comparison of suicidal ideation score regarding parents informed of coming out.

	None	One parent	Two parents	Welch ANOVA	*P*	Post hoc test
Suicidal ideation	8.55 (11.48)	6.87 (8.95)	4.16 (6.83)	4.18	< 0.019	Two < none[a]

N = 184 with gays/lesbians (*n* = 101), bisexual people (*n* = 71), pansexual people (*n* = 12).
[a] $P < 0.05$.

impact of coming out and its context on the mental health of sexual minorities. Not having come out is strongly associated with higher levels of depressive symptoms, which, in turn, are significant predictors of suicidal ideation [12]. However, a meta-analysis study shows that non-disclosure of minority sexual orientation is associated with only a small increase in mental health problems [23]. It is equally important to highlight the qualitative dimension of the coming-out process by examining the parental reactions as perceived by young LGBP individuals. Instead of viewing these reactions as binary (acceptance versus rejection), they should be understood as existing along a continuum that includes a range of responses from complete rejection to ambivalent and full support or acceptance [24]. While coming out can act as a catalyst for improved mental health in supportive environments [11,12], it can also lead to increased distress in contexts characterized by stigma, family rejection, or social exclusion. Low parental acceptance and strong parental rejection in this context have both been associated with increased risks of anxio-depressive symptoms, internalized stigma, suicidal thoughts and attempts, substance use, and risky sexual behavior [25–30].

The analyses also show that age is a factor in suicidal ideation. Although it was not one of the hypotheses of this study, recent data from a Santé Publique France study conducted in 2021 [31] show a worrying increase in suicidal thoughts and suicide attempts among young French adults, particularly in the 18–24 age group.

Several limitations must be acknowledged. Although the sample is diverse, it is not fully representative of the French LGBP population. The recruitment strategy, relying on LGBT+ associations and health centers, may have introduced a selection bias, potentially attracting individuals with heightened psychological vulnerability or those more aware of mental health issues. While this approach helped reach a population that is often underrepresented or difficult to access, it may limit the generalizability of the results to the broader LGBP population. Moreover, pansexual individuals (for the coming-out variable) and gender minorities (non-binary individuals, transgender people, etc.) are underrepresented, limiting the generalizability of the findings for these subgroups. This study is cross-sectional, and we are therefore unable to determine causal relationships. Parental reactions were examined in a simplified manner, without detailed evaluation of the quality or nature of the responses (acceptance, ambivalence, rejection). Additionally, certain external factors, such as access to LGBTQIA+ support networks and experiences of discrimination beyond the family sphere, were not included in the analysis, despite their potential influence on SI. Moreover, the study did not include standardized measures of participants' broader psychopathology, such as depression or anxiety. This methodological choice was made to keep the focus on suicidal ideation specifically. However, the inclusion of such measures could have enriched the interpretation of the results by identifying potential comorbid symptoms influencing suicidal ideation. Also, the use of the SIDAS-FR scale limits the assessment of suicidal ideation to the past 30 days, without capturing lifetime suicidal behaviors such as suicide attempts. As a result, the study does not provide data on the broader history of suicidality, which could have offered a more comprehensive understanding of participants' mental health risks. The study did not assess the participants' professional status, which could have shed further light on the potential role of professional integration in the development of SI. Finally, the exclusive use of self-administered questionnaires and the absence of qualitative data also limit the depth of interpretation. Incorporating interviews or open-ended responses in future studies could offer richer insight into the contextual and emotional nuances of coming out and mental health.

These limitations highlight directions for future research, including the use of more representative samples, longitudinal methodologies, and a more detailed exploration of contextual and relational factors.

5. Conclusion

The study emphasizes the disproportionate risk among bisexual individuals, who may experience more stigmatization, and among women of sexual minorities, whose mental health appears particularly affected by intersecting forms of discrimination. Furthermore, the data highlight the critical role of coming out with lower suicidal ideation observed in individuals who had disclosed their sexual orientation to parents. However, the complexity of parental reactions – ranging from outright rejection to ambivalent acceptance – necessitates a more qualitative understanding of how these responses shape mental health outcomes. These results also highlight the importance of developing assessment tools that incorporate specific indicators, such as sexual orientation, gender and the coming-out process, in order to improve the identification of risk factors in the assessment of suicidal crises. Such an approach would not only make it possible to identify high-risk situations, but also to guide interventions towards appropriate and inclusive solutions. Longitudinal studies should be conducted to examine the trajectories of SI among LGBTQIA+ young people. This would provide a better understanding of the cumulative impact of factors such as stigma, social support and long-term parental reactions. Specific mental health services, such as LGBT+ affirmative therapies for young people from sexual minorities, and support programs for parents, focusing on acceptance and support, should be developed to minimize the risk of rejection and enhance the well-being of LGBP young adults. It is also essential to integrate raising-awareness and education programs on sexual orientation and gender identity in schools and workplaces, to reduce stigma and promote inclusive environments.

Disclosure of interest

The authors declare that they have no competing interest.

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