



Suicide and gay/lesbian/bisexual youth: implications for clinicians¹

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The research indicating the incidence rates and specific risks for suicide in the gay, lesbian, bisexual, and questioning (GLBQ) adolescent population is reviewed. An ecological model of suicide risk assessment for GLBQ youth is presented based on Bronfenbrenner's model of human development. The model argues for individual, micro, and macro levels of assessment to increase clinical judgement and accuracy in determining high risk GLBQ adolescents. The model also delineates both primary and secondary intervention strategies which could be utilized to prevent GLBQ youth suicide.

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Introduction

Recent estimates indicate that adolescents are at significant risk for self-injurious behaviors including suicide attempts and completions (Berman and Jobes, 1991; Bongar, 1991). More specifically, the National Center for Health Statistics (1990) has indicated that suicide is now the second leading cause of death for persons aged 15–24 years old, and suicide accounts for 11 per cent of all deaths in this age group (Berman and Jobes, 1991). Suicide can be explicated on a continuum from suicidal ideation, indirect suicide, suicidal gestures, and non-fatal attempts to fatal completions (Maris, 1992). In recent years, the Centers for Disease Control and Prevention (CDC) have begun compiling national statistics on adolescent suicide attempts and ideation as part of the comprehensive Youth Risk Behavior Surveillance Project (YRBS). These surveys indicate that 27.3 per cent of high school students self-report suicidal ideation, and about 8 per cent of students surveyed indicate they have attempted suicide in the last year (U.S. Youth Risk Behavior Surveillance, 1997). In other studies, between 30 and 60 per cent of young persons report suicidal ideation, and of this group, 35,000–300,000 young persons annually attempt suicide “unsuccessfully” (Berman and Jobes, 1991; Morrison, 1993).

GLBQ youth suicide ideation and attempts

A growing body of research indicates that suicide is of particular concern in marginalized and victimized adolescent groups including gay, lesbian, bisexual and questioning (GLBQ) youth (Hetrick and Martin, 1988; Garnets and Kimmel, 1991; D'Augelli and Hershberger, 1993; Gibson, 1994). This finding is consistent with Durkheim's sociological theory of suicide (Durkheim, as cited in Berman and Jobes, 1991) which proposed that one of the major reasons people kill themselves is a lack of integration into the dominant culture. To quantify this phenomenon specifically in the GLBQ youth population, anywhere from 18.5 per cent (Gibson, 1994) to 42 per cent (D'Augelli and Hershberger, 1993) of GLBQ youth surveyed report attempting suicide unsuccessfully. Hammelman (1993) reported that one-third of her

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sample of GLB youth had attempted suicide before the age of 17 and nearly 75 per cent of those who had attempted suicide cited sexual orientation as the most significant factor in the decision to end their life. These numbers contrast sharply with overall youth suicide attempts (8%), and indicate that GLBQ youth suicide is a significant health concern.

To address growing concern with regard to GLB youth suicide risk, a limited number of U.S. states have begun compiling statistics on GLBQ youth as part of the Youth Risk Behavior Surveillance surveys administered in both private and public secondary schools. The State of Massachusetts has been a leader in analyzing state data with specific regard to suicide risk in GLBQ youth. In 1995, the Massachusetts Department of Education reported that students who described themselves as GLB and/or students who have had same-sex sexual contact reported being significantly more likely than their heterosexual peers to face threats, attempt suicide, and abuse drugs and alcohol. More specifically, the GLBQ youth were four times more likely to have attempted suicide, five times more likely to have used cocaine, and five times more likely to miss school because of feeling unsafe (Massachusetts Department of Education, 1995). Similar results have been reported in the states of Washington (Seattle YRBS, 1995; Washington Safe Schools Anti Violence Project, 1995), and Vermont (Vermont Department of Health, 1995). While more states need to investigate the relationship between GLB identity and/or same-sex sexual behavior and overall health risk, it is striking how similar the results are across these three disparate states. Also of importance in the results of YRBS data is the co-morbidity of suicide risk with other health risk indices such as drug and alcohol abuse, victimization, and school drop-out rates.

“Successful” GLBQ youth suicide

The research previously cited addresses suicidal ideation and unsuccessful attempts in the GLBQ youth population, however, GLBQ youth also make up a disproportionate number of “successful” youth suicides. It is unclear from epidemiological research how many “successful” adolescent suicides are GLBQ youth, however, a 1989 U.S. Department of Health and Human Services report indicated that gay and lesbian youth may be two to three times more likely to commit suicide than their heterosexual counterparts (Hunt, 1992; Owens, 1998). In addition, one study reviewed found that more than 50 per cent of a gay adolescent male sample reported multiple suicide attempts (Rotherman-Borus *et al.*, 1994). Since it is a well-supported finding that multiple suicide attempters are more at risk for completed suicide in the future (Bongar, 1991), this finding points to increased risk for successful suicides in the GLB adolescent population.

The clinical utility of actuarial data

While this data is somewhat helpful to clinicians, other demographic risk indices such as differential gender and race suicide rates have not sufficiently aided clinicians in increasing their accuracy in predicting who is most at risk for successfully killing themselves (Bongar, 1991; Motto, 1992; Bingham *et al.*, 1994). To be more precise, clinicians are generally familiar with the data indicating that white, male, and dually diagnosed clients are at increased risk for suicide, but that has not been especially useful in determining which specific clients to hospitalize due to imminent risk (Morrison, 1993). Similarly, knowing that being gay or lesbian increases suicide risk doesn't necessarily help determine if a particular client is at risk for suicide. The complicated task of utilizing actuarial data in clinical decision making has been systemically problematic for clinicians, and produced high numbers of “false-positives” in the assessment process (Pokorny, 1992; Morrison, 1993). For GLBQ

youth, that might mean that some adolescents are inappropriately hospitalized when they may not be in imminent danger of harming themselves. In sum, actuarial assessment models have been widely criticized for their lack of utility in high risk, low base-rate phenomenon such as suicide (Maris, 1992).

To address the growing dissatisfaction with actuarial assessment models, some researchers have proposed more holistic assessment methods that retain empirical validity while increasing clinical utility (Foreman, 1990). One example of a holistic assessment model was posited by Stoelb and Chiriboga (1998). These researchers proposed that clinicians need to assess the combined implications of both individual and situational risk factors when examining suicide risk. They argued that situational risk factors such as family functioning, social relationships, and life stressors need to be taken into account when assessing for adolescent suicidal risk (Stoelb and Chiriboga, 1998). In addition, they cited homosexuality as a particular situational risk factor, due in part to the presence of homophobia. While Stoelb and Chiriboga (1998) present an important new model for suicide risk assessment in that they include some risk factors other than those that are traditionally examined, they stop short of including the larger socio-cultural factors that might influence suicide risk in a given individual. For example, in the model Stoelb and Chiriboga (1998) propose, homosexuality is viewed as a situational risk factor that increases the likelihood that an adolescent will attempt suicide, however, they do not delineate specific factors that would make one GLBQ youth more at risk than another.

The benefits of a socio-cultural model

It is proposed that the most clinically useful suicide assessment model for GLBQ youth needs to follow a socio-cultural framework. Bronfenbrenner (1997) argued that in order to understand human development, one must consider the entire ecological system in which growth occurs. Based upon Bronfenbrenner's model of ecological human development, a sociocultural framework for GLBQ youth suicide risk would investigate risk factors at both the micro and the macro levels of involvement. To be more specific, to assess a particular young person's risk for killing themselves adequately, a clinician would need to know about the individual themselves (demographic and situational variables), the immediate environment that surrounds that individual (microsystem), and the social conditions under which the immediate environment operates (macrosystem). The addition of micro and macrosystem analysis is particularly important for marginalized groups such as GLBQ youth, because it includes the societal conditions under which the adolescent is operating. Furthermore, the proposed model is particularly useful in that it incorporates cultural norms and values, and provides clinicians with both primary (assessment and treatment of individuals) and secondary (assessment and treatment of environments) levels of intervention.

A working knowledge of risk factors in all three socio-cultural systems should increase clinicians' abilities to adequately assess and intervene with potentially suicidal GLBQ youth. The remaining three sections explicate the particular risk factors associated with each of the three socio-cultural systems particularly focused for GLBQ youth.

Individual risk factors

General findings

The individual risk factors associated with high rates of attempts and completions in the heterosexual population should be investigated with GLBQ youth as well. To be more

specific, Garland and Ziglar (1993) report that increased risk for “successful” suicide exists in individuals with a psychiatric history, a family history of suicide, substance abuse, and the availability of a lethal method. In addition to these individual risk factors common for all sexual orientations, GLBQ youth are more at risk for suicide if they: (1) acknowledge their sexual orientation at an early age (Remafedi *et al.*, 1991); (2) report a sexual abuse and/or familial abuse history (Gibson, 1994); (3) do not disclose their sexual orientation to anyone (Remafedi *et al.*, 1994); (4) self-present with high levels of gender non-conformity (Remafedi *et al.*, 1991); and (5) report high levels of intrapsychic conflict regarding their sexual orientation (Savin-Williams, 1990).

Coming-out issues

At first glance, it appears contradictory that GLBQ youth that “come out” at an early age and those that do not “come out” to anyone are both at high risk. The commonality between these two groups is the extreme isolation felt by young people in both cases. A youth who is “out” to others and self at an early age is at increased risk for assaults and harassment, and is thus more psychologically isolated. Similarly, a young person who self-identifies as GLB but does not feel safe enough to share this identity with anyone in their environment is also incredibly isolated. It is well established elsewhere that isolation and hopelessness increase depression and suicide risk on an individual level for people of all sexual orientations (Beck *et al.*, 1985).

Gender issues

The statistics correlating age of coming out and suicide risk have particular implications with regard to gender. It has been documented that men come out to self and others at an earlier age than do women (Savin-Williams, 1990). To be more specific, the mean age of first same-sex sexual activity for boys is 13 while for girls it is around the age of 15 (Savin-Williams, 1990). This gender difference may increase the risk for suicide in gay male adolescents as they are more likely to feel isolated at an earlier age than their lesbian counterparts.

“Double-minority” status

GLBQ youth of color also face specific risk factors endemic to their “double minority” status. Savin-Williams and Rodriguez (1993) argued that GLBQ youth of color have difficulties establishing a mature identity because they must integrate their ethnic, racial, and cultural backgrounds with their sexual orientation. In addition to these added intra-psychic stressors, GLBQ youth of color may face both a lack of acceptance from their racial/ethnic community and racism within the GLB community, further isolating and placing them at increased risk for suicide.

Microsystem risk factors

Those systems in the individual's environment that directly interface with the developing organism comprise the microsystem (Bronfenbrenner, 1997). Thus the microsystem could include teachers, parents, counselors, friends, religious communities, neighborhoods, and youth serving agencies. To adequately assess suicide risk for a GLBQ youth, it is proposed that an investigation of the microsystem's support of that youth needs to be taken into account when predicting suicide risk. It is not sufficient to simply address the presence or

lack of homophobia in these systems, it is also imperative that heterosexism be examined. Herek (1992) defined heterosexism as a more inclusive concept than homophobia, because heterosexism includes a wide range of experiences of discrimination and it points out the ubiquity of normalizing and concomitant privileging of the heterosexual community.

What does and does not get talked about in schools

To be more specific, a lack of GLB content in classes and teaching may increase suicide risk for GLB youth. Of particular concern is the lack of GLB information in health education contexts (Owens, 1998). Not only do GLB relationship issues get largely ignored in middle and high school curricula, but safer sex practices for same-sex sexual behavior are rarely introduced. In addition, without the inclusion of adequate role models in the curriculum, GLB youth have little to feel proud about in terms of their identity (Owens, 1998). A similar phenomenon has been investigated with regard to racial and ethnic minority persons (Clark and Clark, 1947). In striking contrast to the lack of positive information regarding GLBQ issues, adolescents report hearing derogatory comments regarding GLBQ persons on a regular basis (Sears, 1991), particularly from their peers. Those who work with adolescents in the schools are familiar with how often derogatory comments such as “fag” and “dyke” are used to enforce adherence to strict sex-role norms within peer groups. This is particularly true for young men who do not conform to societal expectations regarding masculinity (Savin-Williams, 1990). Non-conformity to these norms have deleterious consequences even for those youth who do not identify as GLBQ (Stevenson, 1988).

Homophobia and heterosexism in the microsystem

A ubiquitous tolerance of homophobic and heterosexist attitudes in teachers, peers, religious leaders, and family members may increase suicide risk for GLBQ youth. An overwhelming majority (97%) of GLB youth report hearing homophobic remarks within their immediate school environment (Sears, 1991), and some of these remarks are made in front of school personnel that do nothing to challenge the peers' anti-gay attitudes (D'Augelli, 1992). This type of microsystem tolerance of homophobia may increase GLB youth suicide risk by increasing the isolation and depression a GLB youth feels.

Of particular concern with regard to microsystem inadequacies for GLBQ youth, is the mental health care system which is the predominant system interfacing with a potentially suicidal young person. While the American Psychological Association and other professional organizations have officially recognized GLB persons as a normal variant in human experience for over 20 years (Phillips and Silling, 1997), heterosexist and homophobic attitudes continue to be prevalent in psychologists (Phillips and Silling, 1997) and social workers (Berkman and Zinberg, 1997). To be more specific, in mental health care providers, there is a demonstrated lack of knowledge about GLB issues and life-styles, differential assessment and treatment of clients based on sexual orientation, a lack of awareness of oppression as it relates to GLB clients, and the pathologizing and denigration of GLB persons simply because of their sexual orientation (Garnets *et al.*, 1991). Unfortunately, recent research indicates that training in clinical and counseling psychology is not vastly improving clinicians knowledge and/or attitudes with regard to GLB clients (Phillips and Silling, 1997).

These troubling findings relate to GLBQ youth suicide risk assessment in several important dimensions. First, it is possible that a GLBQ young person has interacted with a mental health care provider in the past, and has had a negative and debilitating experience. Thus, they could be coming into treatment guarded and not willing to disclose either their

orientation or their suicidal ideation, thus placing them more at risk. Secondly, a negative experience with a mental health care provider could further isolate a GLBQ young person and put them over the edge in terms of suicidal risk. Finally, a lack of information regarding GLBQ youth isolation and oppression in mental health care providers may contribute to misdiagnosis and a lack of preventative care for potentially suicidal GLBQ young persons.

Rigid systems

A third microsystem issue involves the rigidity and inability to accept change of the familial and school environments. A growing body of research evidence indicates that families with rigid role structures and an inability to accept change have increased rates of suicide in family members (Richman, 1986). Thus, a family that is unwilling to support, accept, and affirm a child that is questioning their sexual orientation or coming out as GLB may contribute to an increased risk for suicidal ideation and attempts. Since the school environment is also a "system", it is a logical jump to assume that rigidity in school environments may also increase suicide risk. Thus the school that is unable to handle a male student who wishes to wear dresses to school, or a lesbian couple who want to attend the prom, may be increasing suicide risk for all students by enforcing high rigidity and inflexibility.

Accessible social support

Finally, a lack of informed support networks in the GLBQ youth's immediate environment may increase risk for suicide attempts and completions. Access to a GLBQ affirming youth agency such as Project 10 in California, BAGLY in Boston, the Hetrick-Martin Institute in New York City, and Outright in New England can decrease isolation and self-destructive behaviors in GLB youth. To be more specific, outcome efficacy data from Outright in Portland Maine over a two year period indicates that an overwhelming majority of participants felt supported in the coming out process (78%) and 82 per cent felt less isolated (Morrison and Garthwaite, 1999). In addition, 42 per cent of youth participants reported practicing safer sex as a result of education they received at Outright, and 39 per cent of youth participants reported using less drugs and alcohol since attending Outright programs. Drug and alcohol use are often correlated with suicide risk, particularly in adolescent age groups (Berman and Jobes, 1991). In summary, access to programs that affirm all sexual orientations and decrease isolation for GLBQ youth may decrease all forms of self-destructive behavior, including suicide risk.

Macrosystem risk factors

The macrosystem involves those institutions that may influence the microsystem but do not necessarily directly interface with the individual GLBQ youth (Bronfenbrenner, 1997). For example, civil rights law, professional ethical guidelines for psychologists, counselors and teachers, mass media, school, national and state policies, and prevalent cultural values all may indirectly influence suicide risk for GLBQ youth.

Mass media

A good example of macrosystem influence involves the mass media. Either an absence or an increase in media attention to GLB issues may increase stress for both closeted and out GLB youth. If the young person has directly interfaced with the media attention to GLB issues,

this may increase intra-psychic stress which is correlated with suicide risk (Berman and Jobes, 1991). However, even if the young person is not aware of the increased media attention, their risk for suicide may increase. More specifically, when GLB issues are prominent in the press, anti-gay violence often escalates, and threats, harassment and violence may put GLB youth at increased risk for self-injurious behaviors (D'Augelli, 1992).

Non-discrimination policies in schools

A second macrosystem factor in suicide risk assessment for GLBQ youth is the presence or absence of school policies that set expectations for educators to neither tolerate nor participate in homophobic and/or anti-gay rhetoric. In addition, non-discrimination policies that include sexual orientation are an important safeguard for students who may feel unsafe and/or harassed. An important secondary assessment should be the level to which these non-discrimination policies are enforced. For example, in performing a suicide risk assessment for a particular GLBQ youth, if the young person attends school at an institution with (1) a non-discrimination policy which includes sexual orientation; (2) diversity training for staff and teachers on GLB issues; and (3) diversity training for other students which includes GLB issues, that student is less likely to face harassment and homophobia in school and therefore may be less likely to engage in self-injurious behaviors.

Non-discrimination policies in societal systems

Communities, states, and nations can decide to include sexual orientation as a protected group under existing human rights acts with regard to housing, employment, credit and public accommodations. When these amendments to existing human rights laws emerge in state legislatures, they are often subsequently rejected by popular vote. In the state of Maine for example, since 1979, sexual orientation has been defeated as an amended class to the Human Rights Act eight times by the State Legislature, and once by veto of the governor in 1993. In 1997, the state legislature finally passed a bill prohibiting discrimination on the basis of sexual orientation but this bill was overturned by popular vote in 1998. These types of defeats for inclusion of sexual orientation in non-discrimination policies may have an indirect effect on GLBQ youth suicide by increasing hopelessness, isolation, and depression.

Macrosystem pressure to stay in the closet

A third macrosystem factor in suicide risk assessment involves cultural values that promote "hiding" a GLBQ identity. This pressure can come from racial, ethnic, religious, national, and/or community cultural values. When a GLBQ youth is pressured from those in the microsystem (who are influenced by those systems in the macrosystem) to hide his/or her GLBQ identity, they are denied a fundamental right of passage common to all adolescents: the development of a coherent, authentic self. The self-alienation and postponement of identity development for GLBQ youth in macrosystems that promote "hiding" can increase suicide risk by decreasing self-esteem (Savin-Williams, 1990). This phenomenon is compounded for GLBQ youth of color who are asked by our society to assimilate into both "white" and heterosexual cultures (Savin-Williams and Rodriguez, 1993).

Utilizing the model

The utility of this multifaceted model has yet to be demonstrated in empirical research, however, it can be utilized conceptually in clinical work until such empirical evidence is

collected. It is proposed that using the individual, micro- and macrosystem risk variables can increase the accuracy with which clinicians assess suicide risk in GLBQ youth. Ideally, the different levels of the model would be assessed holistically with each risk factor weighed appropriately and combined with moderating variables that might prevent a GLB youth from contemplating or attempting suicide. Given that empirical research demonstrating the relationship among the risk factors is yet to be conducted, the risk factors could be utilized in the meantime in an actuarial format. For example, even in the most simplistic additive model where each risk factor is given an equal weight and risk factors are summed for individual, micro, and macrolevels of the model, clinical utility can be seen in a case study.

Jess is a 16-year-old Caucasian female presenting with suicide ideation. She describes herself as a lesbian, and she presents with very androgynous characteristics. She reports multiple suicidal gestures in the past, and high degrees of depression and hopelessness. She reports knowing she was gay at an early age, and she became estranged from her family as a result. She is living in foster care, and while she has not come out to her foster parents, she has been attending a GLB youth agency for two months. She is a junior in a rural high school in Maine with very high degrees of homophobia and heterosexism both in the students and staff. She has few friends at school, but has made a few connections at the youth agency. The guidance counselor at school is reported to be "cool" and she referred Jess for treatment.

In this hypothetical case study, the multiple levels of risk are clear. The client has multiple individual risk factors that are exacerbated by the lack of support in her micro- and macrosystems. She does have mediating variables in her guidance counselor and the connections she has made at the youth serving agency, however, these systems are not as constant as the school environment, and the estrangement from her parents. Suicide risk for Jess is high, but not imminent. Further assessment needs to be done at the individual level (depression, hopelessness, comorbid alcohol/drug use) the micro level (homophobic/heterosexist experiences at school, within previous mental health care, and in her family) and the macro level (what is the culture/climate under which Jess is operating and what can be done to "treat" the environment as Jess is getting psychotherapy). Thus, a talented and affirming therapist would capitalize on the guidance counselor and agency support, and work on secondary prevention strategies in the school and foster care environment, while simultaneously providing therapeutic interventions to Jess.

Summary

The model described in this paper is designed to provide mental health practitioners with specific data on individual, micro, and macro risk factors for GLBQ youth. It is intended to allow practitioners with intervention strategies to assess, treat, and prevent GLBQ youth suicide. Prevention of GLBQ adolescent suicide thus could entail treating the environments that interface with GLBQ youth in addition to treating the adolescents themselves. Additionally, an adequate assessment of individual, micro, and macro levels for the potential GLBQ youth at risk might help the clinician see the client in context and better be able to assist the client in reframing their environment as opposed to seeing suicide as the only alternative to alleviate their pain.

The model could be tested for utility and accuracy in future research. The multiple risk factors particular to GLBQ youth could also be studied cross-culturally to assess for the importance of macrosystem variables. More specifically, cultures with more affirming

environments for GLBQ adolescents should have decreased rates of GLBQ youth suicide. It is hoped that further research in this area could increase clinicians ability to accurately predict which GLBQ youth are at high risk for suicide, and point to prevention strategies that effectively decrease the disproportionate numbers of GLBQ youth who kill themselves.

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