GAY ADOLESCENTS AND SUICIDE: UNDERSTANDING THE ASSOCIATION

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ABSTRACT

Suicide among gay* adolescents is a major public health concern, but it is still under-emphasized within mainstream healthcare. This article brings together information garnered from past studies, articles, and experiences to create a more in-depth understanding of why gay adolescents are at a higher risk for suicide. By creating a better understanding, this article attempts to push forward the significance of this issue and encourages physicians to take a more active role in suicide prevention. The article initially explores why issues involving homosexuality are seldom discussed and provides evidence for an increased risk in suicide among gay adolescents. By addressing major psychosocial issues faced by gay adolescents, it spends the majority of time facilitating an understanding of the increased risk.

*In this article “gay” refers to homosexual males and females, and bisexuals unless otherwise indicated.

A FAMILIAR BUT UNFAMILIAR CASE

A 16-year-old male with depression has committed suicide. He had been seeing a physician who placed him on an anti-depressant three weeks ago. His family, friends, and physician knew of his depression, but did not know why he was depressed or why he committed suicide. Was he hiding an unbearable secret? Homosexuality was never brought up. His parents could not conceive of the idea and it was not accepted by their religion. His male friends would always talk about girls with him, and occasionally made gay jokes, but he never seemed to mind. His physician assumed he was heterosexual because he had a girlfriend in the past. In actuality, he was confused, scared, and alone. He thought he liked girls, but he had been feeling more attracted to boys. He could not control these feelings despite the fear that his parents would disown him and his friends would turn on him. He had

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no one to talk to and was afraid his physician might be homophobic and reveal his feelings to his mother, who was always sitting right outside the office. Fortunately, this is a fictional case, but how many suicides resemble this?

INTRODUCTION

Approximately one million adolescents attempt suicide per year (Gould et al., 2003). Every 90 minutes one adolescent commits suicide, making it the third leading cause of death among ten- to 19-year-olds (Gould et al., 2003; Kaplan & Sadock, 2003). To explain the high suicide rate, Kaplan and Sadock (2003) state, “Universal features in suicidal adolescents are the inability to synthesize solutions to problems and the lack of coping strategies to deal with immediate stressors. Therefore, a narrow view of the options available to deal with recurrent family discord, rejection, or failure contributes to a decision to commit suicide.” For gay adolescents this reasoning is far more pronounced. The process of realizing that one is gay and having to accept it is not just an immediate stressor and can actually narrow one’s options further by taking away coping resources, such as friends and family (Goldfried, 2001; Heimberg & Safren, 1999; Paul et al., 2002; Nelson, 1997). Gay adolescents who “come out” (disclose their sexuality) may experience great family discord, rejection, and even failure from the disappointment they elicit (Hart & Heimberg, 2001; D’Augelli et al., 1998). It would make sense to conclude that homosexuality is an important risk factor for adolescent suicide. However, many physicians disagree and textbooks fail to adequately emphasize this point. This reflects the need to understand the increased risk of suicide among gay adolescents.

This article explores why issues involving homosexuality are seldom discussed, provides evidence for an increased risk of suicide among gay adolescents, and attempts to facilitate an understanding of why these individuals are at such increased risk. With this understanding, a physician is more likely to adequately approach the issue of sexuality with an adolescent and ultimately play a more significant role in suicide prevention.

When considering possible reasons for patients’ suicidal ideation or attempts, is their sexuality brought up? And if so, is it dismissed based on an assumption? “They are not gay because they have a girl/boyfriend.”
Why is it Seldom Discussed?

Nusbaum and Hamilton (2002) reported a study in which only 35% of primary healthcare physicians reported that they often (75% of the time) or always take a sexual history. Two of their explanations for the low percentage were embarrassment and the belief that it is irrelevant to the chief complaint. Sex is still an uncomfortable and embarrassing subject for many people, even for physicians. As a result, the tendency is to avoid it. When interviewing an adolescent who is depressed or suicidal how often is sexuality questioned? And if it is brought up, is it discussed and in how much detail? How does the adolescent feel about answering such questions, especially if he/she does not know how gay-friendly the physician is. Sexuality may seem irrelevant to the physician who is seeing an adolescent whose chief complaint is depression or suicidal ideation—and therefore ignores the subject.

There is still a stigma attached to being openly gay even in the medical field. During a small conference on gay issues at my former medical university, one of the deans referred to the medical environment as not being the most open-minded and cautioned students to be careful about revealing their sexuality. For some people, not just gays, there is the fear that if one brings up a gay issue or gives a lecture on it, one will be assumed to be gay, especially if one is not married. Unless it is my “gay paranoia,” I would not be surprised if readers of this article assumed I was gay. This was a risk I was hesitant to take. Unfortunately, it is a risk that some physicians are not willing to take out of fear jeopardizing their careers. This fear hinders important gay issues from being discussed in the mainstream. Goldfried (2001) stated that despite the growing literature on gay issues, mainstream psychology has tended to ignore much of the work that has been done in this area. Thus, important issues, such as suicide among gay adolescents, remain invisible not only to mainstream psychology, but to mainstream healthcare.

During a lecture at the same university noted, a public health physician asked, “What are some risk factors for adolescent suicide?” After waiting for everyone else’s response, I finally said, “homosexuality.” The physician was unsure about this answer and turned to the psychiatrist who currently held a fellowship in child and adolescent psychiatry. To my surprise, he stated, “I do not think so.”

An Increased Risk

Being a gay adolescent is a significant risk factor for suicidal thoughts and attempts. More than 15 different studies conducted within the last 20 years have consistently showed significantly higher
rates of suicide attempts, in the range of 20 to 40%, among gay adolescents (Gould et al., 2003; Goldfried, 2001; Heimberg & Safren, 1999; Paul et al., 2002; Russell & Joyner, 2001; D'Augelli et al., 2001; Remafedi, 1999; Lock & Steiner, 1999; Garofalo et al., 1999; Borowsky et al., 2001; Udry & Chantala, 2002). Russell and Joyner (2001) were the first to use nationally representative data to support this association. In a study involving over 6,000 adolescent girls and over 5,000 adolescent boys, they concluded that adolescents with a same-sex orientation were more than twice as likely to attempt suicide.

How many suicides occur without learning whether the person was gay? People commit suicide leaving family and friends asking, "Why?" Could it be because of a secret they could not bear revealing—such as being gay? One study involving 350 gay adolescents between the ages of 14 and 21 reported that 54% made their first suicide attempt before coming out to others, 27% made the attempt during the same year they came out, and 19% made the attempt after coming out (D'Augelli et al., 2001).

Since being a gay adolescent is a risk factor for suicide, it needs to be addressed within the medical community. Physicians can help by raising the issue when appropriate on rounds, in case conferences, or during lectures. Addressing the issue of sexuality with adolescents can be made easier and more effective if the physician understands why it is so unbearable for some adolescents to reveal their sexuality or to live with being gay.

Understanding the Association

Being gay in-and-of-itself is not the cause of the increase in suicide. The increased risk comes from the psychosocial distress associated with being gay. Six studies reported by Remafedi (1999) found that suicide attempts were significantly associated with psychosocial stressors, including gender nonconformity, early awareness of being gay, victimization, lack of support, school dropout, family problems, acquaintances' suicide attempts, homelessness, substance abuse, and other psychiatric disorders. Some of these stressors are also experienced by heterosexual adolescents, but they have been shown to be more prevalent among gay adolescents (Gould et al., 2003; Goldfried, 2001; Russell & Joyner, 2001; Russell et al., 2002; Fergusson et al., 1999; Garofalo et al., 1998; DuRant et al., 1998). In Russell and Joyner's (2001) study using national data, adolescents who reported same-sexual orientation also reported significantly more substance abuse, depression, acquaintances' suicide attempts, and victimization. Thus, physicians can be more helpful in improving gay adolescents' quality of life by understanding their psychosocial stress load and its impact on suicide risk.
By noting the changes taking place in the media and the law, it is apparent that being gay is somewhat more accepted and tolerated by today's society. However, gays are still being discriminated against and victimized (Goldfried, 2001; Heimberg & Safren, 1999; Paul et al., 2002; Hart & Heimberg, 2001; DuRant et al., 1998; Russell et al., 2001; Bontempo & D'Augelli, 2002; McDaniel et al., 2001; Savin-Williams, 1994). Russell et al. (2001) reported a study involving 500 gay and lesbian adolescents in which it was found that 41% had experienced violence, and 46% of that violence was reported as being related to being gay. In a study by Bontempo and D'Augelli involving over 9,000 9th through 12th graders, 24% of gay/bisexual males reported at-school victimization ten or more times per year as compared with 2.7% of their heterosexual counterparts, and 10.1% of lesbian/bisexual females compared with 1.1% of their female counterparts (Bontempo & D'Augelli, 2002). These negative experiences can result in mood disorders, lower self-esteem, posttraumatic stress symptoms, substance abuse, and suicide (Gould et al., 2003; Paul et al., 2002; Nelson, 1997; Russell et al., 2001; Savin-Williams, 1994).

An adolescent does not need to be directly victimized to be affected by discrimination against gays. Matthew Shephard, a University of Wyoming student, was brutally murdered in 1998 because he was gay. What impact did this devastating event have on young individuals who were beginning to realize that they too were gay and living in the same society in which the murder was praised. What messages are protestors and politicians, including our President, who are against gay marriage sending to gay adolescents? How does living in a society where people can be rejected, disapproved of, or hated for their sexuality affect a gay adolescent's self-esteem or identity development? (Nelson, 1997).

Further, what may be even worse than being hated by society because of one's sexuality is being rejected, humiliated, and victimized by one's own family or peers. Gay adolescents have a much greater incidence of being thrown out of or opting to leave their homes (Nelson, 1997; Cochran et al., 2002). In a study involving 194 gay adolescents between the ages of 14 and 21, D'Augelli et al. (1998) reported that 26% of fathers, 10% of mothers, and 15% of siblings rejected their gay children when they came out. Goldfried (2001) reported that one out of every three were verbally abused by family members, one out of ten were physically assaulted by a family member, and one out of four had experienced physical abuse at school. The fear of experiencing such outcomes can be a tremendous stressor (Heimberg & Safren, 1999; Hart & Heimberg, 2001). How does a gay, closeted child feel when living with parents who adamantly reject gay marriage? Only 10 to 14% of gay adolescents who had not come out to their parents predicted
parental acceptance (D'Augelli et al., 1998). How do these negative outcomes or fear of such negative outcomes also affect an adolescent's self-esteem or identity development? Nelson (1974) points out that gay adolescents who report a history of a suicide attempt score significantly lower on scales of family support, self-perception and self-esteem, and extra-familial social support when compared to similar adolescents without a reported history of suicidal ideation or suicide attempts.

Physicians can help by strengthening the support structure needed by some gay adolescents. Physicians should have information about such resources as PFLAG (Parents, Family, and Friends of Lesbians and Gays) and community gay centers so that they can refer patients and their families for assistance. National associations such as the Gay and Lesbian Medical Association, Association of Gay and Lesbian Psychiatrists, and the Lesbian and Gay Child and Adolescent Psychiatric Association have openly gay physicians who welcome referrals.

Other Concerns

The following are other significant issues faced by gay adolescents:

1. Being a gay male has been recognized as a risk factor for eating disorders and body image disturbances (Hart & Heimberg, 2001; Russell, 2002; Carlat et al., 1997; French et al., 1996).

2. At a time when heterosexual adolescents are dating and talking about boyfriends and girlfriends, a gay adolescent may not know a single gay individual. He or she may not have gay community centers or access to the internet to communicate with other gay individuals. Unfortunately, some adults use the internet to take advantage of gay adolescents. Sometimes bars are the only places teenagers can interact with other gays and this can be just as dangerous. Negative sexual experiences can be devastating.


CONCLUSION

A gay adolescent may have to deal with many of the problems that have been discussed along with the typical stressors that come with being an adolescent. Thus, it should be no surprise that there is an increase in suicide risk for this population. Hopefully, a better understanding of the psychosocial issues associated with being gay will enable physicians to be more comfortable with their gay adolescent patients' problems, foster more open relationships, help them feel more accepted, and ultimately, help prevent adolescent suicide.
REFERENCES


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