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# Suicide Among Homosexual Youth

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**ABSTRACT.** The contemporary literature on homosexual youth and suicide risk are reviewed in order to delineate the incidence, development, causes/risk factors, and effects of suicidality among homosexual youth. In comparison to heterosexual youth, homosexual youths are more likely to attempt and complete suicide. They confront more challenges in identity development and face more risk factors for suicidality. In some cases, homosexual youths might use suicidal ideation as a means of rediscovering a will to live. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Homosexual, heterosexual, sexual orientation, youth, adolescent, teenage, suicide, suicidal, depression

I certainly know considerably more people in our [gay] community who have taken their own lives than I know who have died from AIDS. (Hellquist, 1993, in Bagley & Tremblay, 1997)

Suicide is the eighth overall leading cause of death in the United States, representing 1.3% of all deaths in 1998 (The Family Education Network, 1999a). It is the third leading cause of death among 15- to 24-year-olds

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(The Family Education Network, 1999b), representing an astonishing 13.3% of 37,000 annual deaths in that age range (Hershberger, Pilkington & D'Augelli, 1996), and has risen over 300% since the late 1960s (Kourany, 1987). Some correlates of suicide in the general population, which have also been found to be similar among teenagers specifically, are: externalization of problem behaviors such as ADHD and conduct disorders; perceived low levels of control, self-efficacy and familial support; internal attribution of negative life events; low self-esteem; and a history of attempted suicide (Hershberger et al., 1996). Other factors which have been identified as unique to youth suicide attempters include: an aggressive, chaotic and unstable family environment; paternal substance use/abuse; and physical abuse (Schneider, Farberow & Kruks, 1989). As many as 90% of those who complete suicide are mentally ill (Buhrich & Loke, 1988; Rich, Fowler, Young & Blenkush, 1986).

Strangely, relatively few studies investigating the relationship between alternative sexual orientations (henceforth, "homosexuality") and suicide risk have been conducted (Rich et al., 1986; Hershberger et al., 1996; Kourany, 1987). In a bibliography of over 2,000 studies about suicide, only two discussed homosexuality; conversely, in a bibliography of thousands of studies about homosexuality, only five discussed completed suicide (Buhrich & Loke, 1988). A variety of reasons for this apparent dearth of scientific curiosity have been proposed by the authors who have investigated such correlations, including the opinion that this is evidence of the heterosexism, homophobia and stigmatization of homosexuality ubiquitous in North America (Bagley & Tremblay, 1997). This paper will review the contemporary literature on homosexual youth and suicide risk in order to delineate the incidence, development, causes/risk factors, and effects of suicidality among homosexual youth, as well as to make recommendations for future avenues of clinical work and research.

## INCIDENCE

The statistics on suicide ideation and completed and attempted suicides among homosexuals are widely variable: the percentage of completed and attempted homosexual youth suicides comprise anywhere from 2.5% to 30% of those of youth in general (Remafedi, French, Story, Resnick & Blum, 1998), depending on who calculates the statistics; the risk among homosexuals is anywhere from slightly less than that of heterosexuals (Hershberger et al., 1996) to thirteen times greater

(Bagley & Tremblay, 1997); and as many as 60% of homosexuals have reported serious suicidal ideation (Schneider et al., 1989; Hershberger et al., 1996). Somewhere between 20-42% of homosexual adolescents attempt suicide (Hershberger et al., 1996; Remafedi et al., 1998), and suicidal gestures or attempts by homosexual teenagers are more serious and more often fatal than those of their heterosexual counterparts (Kourany, 1987; Remafedi et al., 1998).

The extremely wide range of statistics on the correlation between homosexuality and suicide stems from a number of factors. First, Remafedi, French, Story, Resnick and Blum (1998) note that it is exceedingly difficult to determine a suicide victim's sexual orientation: the primary source of such information, the victim, usually does not talk, and death certificates do not record sexual orientation. This is consonant with the findings of Hershberger, Pilkington and D'Augelli (1996) and Bagley and Tremblay (1997). They claim that determining the victim's sexual orientation is dependent on interviews with friends and relatives, who may be embarrassed to reveal the victim's homosexuality or simply may not know about it. Furthermore, it is very difficult to investigate the psychological differences between those who complete suicide and those who are unsuccessful: only those who are unsuccessful can be interviewed, yet they are usually presented as representative of all suicide attempters, including those who are successful. This may be a legitimate assumption, or it may not—as Buhrich and Loke (1988) write, “Many subjects who ‘attempt suicide’ are clearly not trying to kill themselves” (p. 116).

Another misleading commonly-overlooked fact is that the statistics thrown around in literature reviews are often based on different sub-populations: for example, one study might compare affluent upper-class young males in Calgary, Canada while another investigates lower-class minority women in New York City or young males recently diagnosed with HIV. Also, the stigmatization of homosexuality itself can yield different percentages: a population-based study will inevitably measure a different type of homosexual, including a presumably larger number of those who still experience torturous inner conflict, than a study which draws participants from an alternative-sexuality activist group.

A third reason for the seemingly contradictory studies are the subtle differences between what the studies are measuring: one might survey “suicidal gestures” while another examines “suicidal ideation.” Fourth, the reader must pay careful attention to authors' terminology: for example, does “gay” refer to men and women, or just men? Also, investiga-

tors' generalizations must be critically analyzed to discern if they are both legitimate and warranted (i.e., from homosexual university students to all homosexuals; from men to women; from Native Americans to Euro-Americans; etc.). Finally, there are confounding factors such as alcohol use (Rich et al., 1986; Gonsiorek & Rudolph, 1991; Buhrich & Loke, 1988; Schneider et al., 1989) and level of education—both higher among homosexual populations—which could independently decrease or increase the percentage of homosexual suicides.

Buhrich and Loke (1988) reveal some more obscure factors which could lead to overestimation of rates of suicide among homosexuals: first, homosexuals tend to congregate more in urban settings—where most studies are conducted—than rural; and second, a coroner who is aware of a victim's homosexual preference may be more apt to label the death a suicide, as it is easier to do so when the victim is not of one's own social group.

Buhrich and Loke also delineate some factors which could lead to underestimation of suicide: because a greater percentage of homosexuals than heterosexuals live alone, it may be more difficult to label a death as suicide since testimony of the victim's desire to die often comes from those that live with him/her. Also, suicide reporting is influenced by religious and cultural beliefs: Muslim and Catholic societies, they note, have lower reporting rates because of the religious prohibition against suicide; and O'Hara (1963, in Buhrich & Loke, 1988) found that suicide is more acceptable in Japanese than in Western culture. One final potential cause for varying statistics is political gain (Hershberger et al., 1996). Nonetheless, empirical evidence supports the assertion that homosexual youth are at greater risk for suicide and suicide ideation than their heterosexual counterparts.

## DEVELOPMENT

Troiden (1979, in Kourany, 1987, and Gonsiorek & Rudolph, 1991), proposed a multi-stage model for the development of homosexual identity: first, feelings of homosexuality start to emerge in the early adolescent years; then the budding homosexual, in a "dissociation" stage, experiences doubt, questioning and denial, subconsciously tweaking perceptions of self and the legitimacy of societal beliefs about homosexuality while struggling to integrate new feelings into a mental schema; and finally, the individual accepts and discloses the alternative sexual orientation, harmoniously merging emotions and sexuality.

These stages are fluctuating and undulating rather than uniform (Gonsiorek & Rudolph, 1991). The likelihood of depression and suicide increase, according to Troiden, when the effort to complete each stage becomes overwhelming. If an adolescent does not successfully pass from the second to the last stage, the homo-eroticism s/he experiences remains ego-dystonic indefinitely, causing feelings of disorganization, self-loathing and extended identity confusion. Internal coping for homosexual adolescents is limited to altering one's own levels of self-esteem, denial and depression; external coping resources, such as the availability of family and peers on whom to unburden oneself, are usually almost non-existent.

Allport (1954, in Gonsiorek & Rudolph, 1991) was the first theorist to specifically investigate identity development among groups targeted for prejudice. Although his subjects were blacks and Jews, other theorists have applied his theories to homosexuals, albeit usually to try to prove that homosexuality itself is a mental illness (Gonsiorek & Rudolph, 1991). Allport proposed that social environment influences and molds personality characteristics of minority individuals: those who belong to an oppressed group develop means of coping with prejudice and victimization. These means can include insecurity, withdrawal, self-loathing, neuroticism, and extremely positive or negative preoccupations with minority group membership. This is consonant with research on the feelings of homosexuals who attempt suicide.

There seem to be differences between women and men in the coming-out process. Gonsiorek and Rudolph (1991) claim that women may interpret burgeoning sexual and emotional feelings of intimacy and attraction towards other women as characteristic of a close friendship, whereas men, who are traditionally confined to a more narrow range of behavioral interaction and emotional expression, will quickly perceive themselves to be homosexual: "Consistent with traditional sex role socialization, males are more prone to sexualizing distress during the coming out process and women are more likely to respond with reflection and self-absorption" (Gonsiorek & Rudolph, 1991, p. 165). The authors go on to note that the emotional, romantic attachments found in the relationships of homosexual women may actually have more in common with heterosexual women than with homosexual men.

It should be noted that in the literature, all of the above developmental processes are consistently discussed as supplementary to, not in place of, the identity crises and developmental processes that heterosexuals pass through en route from childhood to adulthood. It is also impor-

tant to note that, like the risk factors and causes of suicide, the development of sexual identity is a highly individualized process.

### RISK FACTORS AND CAUSES

Like all human processes, the factors leading up to suicide among adolescents in general are exceedingly complex. Kourany (1987) found that therapists treating adolescents most often report family-related causes for suicide attempts, including poor parenting (e.g., working parents or bad parental role models) and a bad relationship between the parents (e.g., divorce or separation). "Adolescent intrapsychic distress" was the next most commonly cited cause, including perceptions and feelings of isolation, hopelessness, rejection, low self-esteem, uncertainties about identity, and lack of direction/goals in life. The third most frequently cited cause was socio-environmental factors such as external stress and difficulties in communication with peers and at school.

Schneider, Farberow and Kruks (1989) found comparable results. In their study of homosexual men who had attempted suicide, paternal alcoholism and physical abuse—especially violence directed towards the mother and the adolescent himself—were significantly correlated with suicidality among homosexuals, like in the general adolescent population. They also found that strong religious beliefs, which have been shown to be a deterrent against suicide, are less commonly found among suicide-attempting homosexual adolescents than among non-attempting homosexuals.

Similarly, Bagley and Tremblay (1997) summarize literature revealing that homosexual youth are at increased risk for suicide-related hardships such as physical, verbal and emotional abuse, downward-spiraling academic achievement, life on the street due to running away or being thrown out, prostitution as a means of survival and acting out, and abuse by professionals.

Homosexuals who attempted suicide differ from non-attempting homosexuals and heterosexuals in several respects: they became aware of homosexual feelings, label those feelings as homosexual and are involved in a homosexual relationship earlier than non-attempting homosexuals (Schneider et al., 1989; Hershberger et al., 1996; Bagley & Tremblay, 1997); they still experienced negative feelings about their own homosexuality at the time of the first suicide attempt, even though they were aware of their sexual orientation; intrapersonal angst, rather than interpersonal problems—such as breaking up with a romantic part-

ner, as in the case of many heterosexual adolescents—is often a major causative factor (this finding contradicts that of Buhrich & Loke, 1988); and most are still in the closet about their homosexuality as of the first suicide attempt, or experienced rejection when trying to come out (Schneider et al., 1989). Institutionalized and social homophobia could be another factor contributing to the incidence of suicide among homosexual youth (Bagley & Tremblay, 1997).

In addition to the risk factors commonly cited for heterosexual youth, factors unique to homosexuals are gender nonconformity, awareness of homosexual feelings at an earlier age, negative reactions from family and friends, and verbal and physical abuse related to sexual orientation. Counterintuitively, some studies have found that suicide-attempting homosexual youth are more open about their homosexuality, are more socially active, have more homosexual friends, and have better family relations, including parents who are more knowledgeable about their child's homosexuality. In line with other research, however, the latter studies have also found that attempters are more psychopathological, have lost more friends because of their sexual orientation, and have been victimized more than those who do not attempt suicide (Hershberger et al., 1996; Rich et al., 1986; Buhrich & Loke, 1988).

The concept of a “double” or even “triple” (in the case of lesbians) minority status has been proposed by several authors. This refers to the multiple minority groups to which a given homosexual can belong, each with its own set of frustrations, dangers and stressors. For example, an individual might be homosexual and Hispanic; or homosexual, black and female; or homosexual, elderly and Asian. People subject to multiple minority statuses are under increased pressure and stress, especially if they find that their minority statuses are mutually exclusive, such as the black man who is rejected by black culture because he is gay, and rejected by white gay culture because he is black (Gonsiorek & Rudolph, 1991).

The actual mode of suicide varies depending on the individual and availability, but Rich, Fowler, Young and Blenkush (1986) found that hanging is a very popular choice among homosexual victims: six out of the thirteen cases of confirmed homosexual suicide in their study were completed by hanging, as compared to only 12 out of 106 heterosexual cases, which is statistically significant. The only two comments the bewildered researchers could make on this finding were that none of the six hangings were found to be cases of sexual asphyxia, and that removing guns from suicidal homosexuals' environments will not prevent suicide.

## EFFECTS OF SUICIDAL IDEATION

The most comprehensive study of the outcomes of suicide ideation among a homosexual sample was completed by Siegel and Meyer (1999). They revealed the surprisingly positive psychological effects of suicide ideation and behavior in gay men who had been informed of their HIV-positive serostatus. These men were most likely to attempt suicide either immediately after learning of their HIV serostatus or in the late stages of AIDS: the former was typically an immediate reaction to the staggering implications the individual perceived, drawing from stereotypes about correlates of AIDS (ostracism, suffering, increased dependency, alienation from family and friends, disfigurement, etc.); the latter, a response to substantial pain and disability.

For the men who survived or did not actually attempt suicide, the suicidal ideation served as a sort of symbolic answer to the question of why to continue living: "This function was often not conscious, but nevertheless led the men to reassess their life goals and commitments. Along with contemplating suicide, many of the suicidal respondents in fact began to contemplate life" (Siegel & Meyer, 1999, p. 56). The men, according to the authors, were experiencing an existential crisis: in their minds, life had ended before a new, different sort of life had been conceived. The ones more likely to contemplate suicide were those less capable of accepting and incorporating their status as an HIV patient into their mental schema. For example, patients who distinguished between HIV as a chronic illness and AIDS as a fatal disease were able to protect their sense of self, as did those who made downward comparisons to sicker patients.

A five-stage process moved the men from suicidality to acceptance and adaptation, according to Siegel and Meyer (1999): first, they were forced to re-interpret HIV to be a condition in spite of which they could live a productive, fulfilling and healthy life; second, they used suicidal ideation to gain a sense of control—by taking their lives into their own hands, they re-established a feeling of control which notification of their HIV-positive serostatus had torn away; third, they sought resources, both internal and external, to assist in coping; fourth, they manipulated their perceptions of the meaning of life and their individual roles in it in order to compensate for their new status as an HIV patient; and finally, they established a new set of goals and a life plan to replace the one whose absence had sparked the initial existential crisis. As an interesting twist on the concept of HIV leading to suicidal ideation,

Frances, Wikstrom and Alcena (1985) warn of individuals who, as a means of passive suicide, seek out AIDS-infected sexual partners.

Although most homosexual youth suicide attempters are not HIV-seropositive, the above stages are both relevant and applicable. For those struggling with feelings of homosexuality, the first step is to redefine homosexuality as non-negative; some researchers have even shown certain aspects of homosexuality to have positive psychological effects (Gonsiorek & Rudolph, 1991). Next, and perhaps most important in the role of suicide ideation, is to regain a sense of control over one's life: "In the suicide fantasy, [life and] death, which is in reality a fateful occurrence over which one has little if any control, becomes controllable" (Siegel & Meyer, 1999, p. 59). Third, suicidal ideation acts as a "symbolic rock bottom," forcing the youth to choose between terminating life or recommitting to it, and stimulates seeking of internal and external resources to aid coping. The fourth stage is characterized by manipulation of the meaning of life and one's role in it as a homosexual. In the final stage a new life plan and set of goals are structured to accommodate one's homosexuality. It should be noted, however, that by this analogy the author is NOT implying that homosexuality is an illness, like HIV; rather, that suicidal ideation and coping mechanisms play similar roles in both cases.

Suicide attempters often do not really want to die, but rather desire to "relieve psychic pain in order to live" (Forstein, 1994, in Siegel & Meyer, 1999, p. 62). Like all individuals who attempt suicide, the HIV-seropositive men in Siegel and Meyer's (1999) study found that suicidal ideation often has an effect antithetical to what it suggests. Faced with the option of taking one's own life, people instead find the will and desire to live. The authors suggest that, if this is the case, it would be better not to instruct recently notified homosexual HIV-seropositive patients to suppress suicidal thoughts, but rather to let them run their constructive course. This could be good advice when dealing with that specific sub-population, but it seems dangerous to recommend when dealing with the population in general. However, it is an interesting proposal to utilize the extreme effects of suicidal ideation as a force to swing the patient back towards a desire to live: careful incorporation of that fantasy into counseling sessions with suicide ideators could be a powerful tool for therapists. However, that idea is suggested with extreme caution because of the obvious inherent risks.

## CONCLUSION

Regarding the incidence of completed and attempted suicide among homosexuals, it seems that a population-based longitudinal study on an unprecedented scale is needed, to provide evidence more concrete than that which currently exists. By surveying several thousands of adolescents at a young age and checking them every six to twelve months, researchers should have a large enough sample of homosexual, emerging homosexual, and heterosexual youths to be able to contrast them with sufficient statistical power. If suicide is the third leading cause of death among 15- to 24-year-olds (The Family Education Network, 1999b), then it would be expected that a substantial enough number of suicides would occur to allow for reasonable investigation of the patterns that appear.

Using the studies that have been conducted up to the present, however, some reasonable conclusions can already be drawn. First, it seems that homosexual youths who attempt suicide share most of their risk factors with heterosexual attempters, including a dysfunctional family background and alcohol use, suggesting that therapists should pay attention to the same sets of warning signals in homosexual as in heterosexual patients. Second, their sexual orientation provides an additional set of stressors and developmental goals to confront, including internalized and external homophobic responses as well as alienation from family and friends, which contribute significantly to their suicidal ideation.

These extra risk factors can be most effectively attenuated through long-term broad-based public education and de-stigmatization of homosexuality, although it is acknowledged that this process will be painfully slow because prevailing social attitudes are notoriously resistant to change (Kourany, 1987). Finally, in order to be able to best address suicidality among homosexual youth, therapists and counselors should be well trained in the issues facing adolescents struggling with their sexual orientation.

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