

# Understanding Suicide in LGBTQ People

## Risks, Preventions and Practical Interventions

Nathaniel Sharon MD  
Assistant Professor  
Child/Adolescent Psychiatry Division  
Truman Health Services  
[nsharon@salud.unm.edu](mailto:nsharon@salud.unm.edu)

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# Learning Objectives

- Understand the risk factors leading to higher rates of suicide attempts in LGBTQ people
- Become familiar with protective factors that assist in lowering suicidal ideation and attempts in LGBTQ
- Increase competency in assessment and interventions for suicidal ideation in LGBTQ populations

# Case

- Fred a 59-year-old Pakistan-American man with depression, anxiety and PTSD. He was hospitalized for a suicide attempt a few months after moving from Los Angeles to Albuquerque New Mexico. He is assessed by a psychiatrist in the hospital after the attempt and Fred reveals the following

# Case

- Childhood: Fred grew up in Pakistan where his family consistently emotionally and physically abused him for his feminine gender expressions and behaviors. He was burned by his older sister and brother for “liking boys”. During this time, he also witnessed profound violence against his Mom by his Dad. He saw one older gay Uncle who was socially ostracized and who eventually committed suicide.
- All but Dad immigrated to California when he was 12. They lived in a community of other Pakistan immigrants. Fred struggled in school and was constantly bullied and beaten by peers because of his skin color, religious beliefs, difficulty with English and his female-typical gender expressions. He decided to keep his sexuality “hidden” because of fear of losing his family and of physical violence by other members in the community. He also feared the community would hurt his Mom and family if he came out. Because of the bullying in school, Fred began to hang out with peers who were using drugs and alcohol and began to use drugs and alcohol for peer acceptance. He also began to date other female peers “for appearances” while also engaging in high-risk sex behaviors with older male adults.

# Case

- Adolescence: Fred's alcohol use increased and he began to fail school. He also started missing school most days to avoid violence. Fred's older sister found an email about a sexual encounter with another male and he was subsequently kicked out of the home and rejected by his family. He "couch surfed" with friends for 3 years while continuing to engage in high-risk sexual behavior and would sometimes need to exchange sex for things such as housing and food. At age 20, he was diagnosed with HIV after using a dirty needle while injecting methamphetamine. He was also raped during a sexual encounter although the police did little to follow up because he had been using methamphetamine and alcohol at the time and they blamed him for the assault.

# Case

- Adulthood: Fred moves from Los Angeles CA to Albuquerque NM to “start new”. Albuquerque has no identifiable LGBT community center, businesses or healthcare and he remains socially isolated for years. He is hesitant to start HIV health care because he is afraid the doctor will blame him for having HIV. He attempts to start dating and finds the only few places to meet other men are at clubs with drugs or alcohol, particularly because there is no identifiable sober spaces to meet other gay men. He starts to date, but his boyfriend is abusing cocaine and meth and becomes violent. He is beaten and as a consequence, has a traumatic brain injury. He continues to have no family or religious involvement, although misses Friday prayers at the local mosque. He applies for SSDI due to his TBI, although his primary reason for not working is severe posttraumatic stress disorder symptoms and depression that have not been treated for years.

# Case

- Older adulthood: He begins to experience more health problems from lack of HIV treatment as well as obesity from his depression, poverty and poor health behaviors. He is reluctant to leave the home at all due to experiencing PTSD symptoms that are activated while riding the main bus line to the HIV clinic. He calls to initiate an appointment with a psychiatrist but is told there is a 2 month wait time. In the meantime, he starts to experience recurrent thoughts of suicide and believes with his isolation, declining health and lack of hope for things to get better, he is better off dead.

# Who Are LGBTQ?

- Sexual minorities
  - Sexual identity versus sexual behavior
- Gender minorities
  - Transgender\*, gender non-conforming
  - 30-45% also identify as a sexual minority
- 3.5% (8 million) adults in the US identify as lesbian, gay or bisexual
- 8.2% of adults reports they have engaged in same-sex behavior
- 0.3% adults identify as transgender
  - Transgender people also can identify as lesbian, gay or bisexual

# LGB and Suicide

- Suicide completions
  - Limited data in mostly adolescent and young gay males
  - So far, no evidence of increase in suicide completions
- Suicide attempts
  - Higher rates of attempts compared to heterosexual cohorts world-wide
  - LGB adolescents are 2-7 times more likely to attempt suicide
  - LGB adolescents have more lethal means of attempts
  - Prevalence of suicide attempts in gay or bisexual men is 4 times that of their heterosexual peers
  - Prevalence of suicide attempts in lesbian or bisexual women is 2 times that of their heterosexual peers
  - Departure from heterosexual data where women are more likely to attempt suicide
  - Most attempts tend to occur during adolescence or young adulthood
- Bisexual populations are the most at-risk sexual minority populations for poor health outcomes, high risk health behaviors and suicidal ideation/attempts

# Trans\* and Suicide

- Transgender populations continue to have the highest reported rates of suicide attempts
  - 41% of transgender adults reported attempting suicide
  - 50% of transgender youth report past suicidal ideation
  - 30% of transgender youth report at least one prior suicide attempt
  - Higher attempt rates with marginal employment status (60%)
  - Higher attempt rates if ethnic minority
    - Black: 45%
    - Latino(a): 44%
    - American Indian: 56%
  - Similar to LGB data, most attempts are reported in adolescence/young adulthood
  - Intersectional risk for trans people who are also sexual minorities

# Risk Factors

- Age
  - Majority of suicide attempts occur between age 15 and early 20's
  - Little data for older LGBTQ people (one study showed 4% suicide attempt rate in people over 60)
- Ethnicity
  - Latin populations have shown higher attempt rates, higher mental health problems
  - No differences observed between other ethnicities
- Higher rates of mental health problems
  - Even when adjusting for mental health problems, the suicide rates of LGB people are still higher
  - Increased rates have been attributed to experiences of minority stress
- Higher rates of substance use problems
- Minority stress
  - Individual experiences of discrimination and prejudice
  - Institutional discrimination and heteronormative culture
  - Intersectionality of minority stressors

# Risks Throughout the Lifespan

- Risk accumulates over the years
- Children/Adolescents
  - Family and peer rejection
  - Rejection by schools, camps, extracurricular activities
  - Trauma and neglect
  - Dropping out of school
  - Homelessness
  - Early use of drugs and alcohol
- Young adults
  - Difficulty with employment and lower socioeconomic status
  - Homelessness or marginally housed
  - Use of drugs and alcohol
  - High risk health and sexual behaviors
  - Physical, sexual and emotional trauma
- Adults
  - Decreased family and community connectedness
  - Unemployment or marginal employment
  - Increase in poor health outcomes
  - Physical, sexual and emotional trauma
- Elders
  - Socioeconomic hardships (continued struggle with employment, retirement, housing)
  - Isolation
  - Burden of chronic medical conditions
  - Sequelae of posttraumatic stress disorder, depression and chronic medical conditions

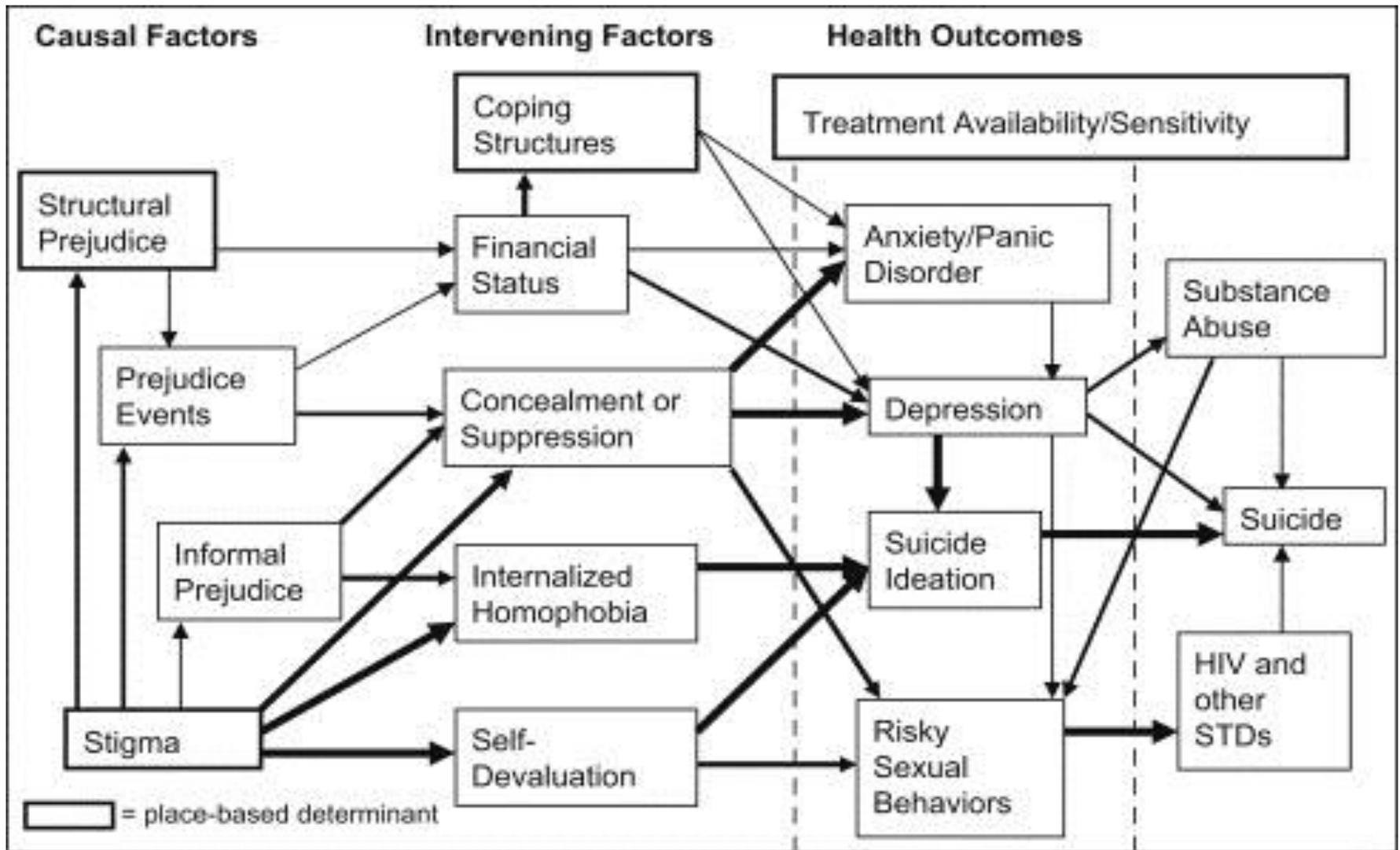


Fig. 1 Causal pathways between minority stress and mental health outcomes in gay men. Notes : Model: N. Lewis. Sources :Bagley and Tremblay (2000), Balsam et al. (2005)

Nathaniel M. Lewis. Mental health in sexual minorities: Recent indicators, trends, and their relationships to place in North America and Europe. *Health & Place*, Volume 15, Issue 4, 2009, 1029 - 1045

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# Protective Factors

- Childhood/Adolescence
  - Family and parental acceptance of sexual identity, behaviors and gender expression
  - Connectedness to family
  - Adults who are caring and accepting
  - School safety and accepting school environment
- Adulthood
  - Employment and access to insurance
  - Access to LGBTQ competent healthcare
  - Connectedness to community
  - Safe spaces to be “out”

# Practical Interventions For Mental Health Providers

- Do no harm
  - Reparative therapies to change sexual or gender identity and/or behaviors are unethical and have been shown to cause harm
  - Reparative therapies for LGBTQ people are illegal in many states
- Engage in services
  - History of pathologization in mental health settings
  - Make yourself known: advertise services as LGBTQ friendly
  - Receptive treatment environment from entry to exit
    - LGBTQ friendly posters, magazines, community information, health information
    - Staff and clinical managers receive LGBTQ cultural competency training
    - Intake forms reflective of LGBTQ demographics
    - Stay up-to-date on protective laws for LGBTQ people
- Educate yourself: Know the population you serve and culturally competent approaches!
  - Clinical guidelines
    - [Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling](#)
    - [American Psychological Association](#)
    - [National LGBT Health Education Center, Fenway Institute](#)

# Key Factors In Assessment of Suicide Risk

- At intake, assessment of sexual and gender identity
- Family supports (include family of origin and chose family)
- Community supports
- Religious or faith practices
- Substance use disorders
- Trauma
- Safety in relationships
- Intersectionality of risk factors
  - Socioeconomic status, geographical culture, ethnicity, gender + sexual minority
- Past suicide ideation, behaviors, attempts
- Past experience with mental health

# Assessing Acute Suicidal Ideation

- Past suicidal ideation, past suicide attempts
- Intent
- Means
- Co-occurring substance use
- Decompensation of mental health problems
  - Poor reality testing
  - Cognitive inflexibility
  - Hopelessness
- Social supports versus isolation
- Agitation or poor impulse control
- Safety plan versus psychiatric emergency
  - Safety plan to work to modify whatever risk factors can be modified and amplify protective factors
  - Safety trumps privacy: contact collateral

# Building Protective Factors

- Maslow's hierarchy of need
  - Safety
  - Food, clothing, shelter
  - Employment
- Mental health/substance use treatment
  - Tailored substance use treatment to specific LGBT population you are serving
  - Increase in problem solving, agency, behavioral activation
  - Increase in flexible cognitive thinking with CBT
  - Increase in distress tolerance with DBT
  - Trauma psychoeducation and trauma-specific therapies (trauma-informed care)
- Supporting to be “out” in environments that are safe to do so
- Increase social and family supports
  - Gay/Straight/Queer Alliances at schools
  - Psychoeducation and advocacy at schools
  - Connection with older peer or adult models
  - Support family of origin or chosen family (attachment based family therapy work)
  - LGBTQ churches, supports groups, organizations, community centers
- Harm-reduction practice approaches to reduce risky health behaviors and exposure to trauma

# Resources

- [Trevor Project](#)
- [Trans Lifeline](#)
- [GLAAD](#) (Gay and Lesbian Alliance Against Defamation)
- [GLSEN](#) (Gay, Lesbian, Straight Education Network)
- [PFLAG](#) (Parents, Family, Friends and Allies of LGBTQ People)

# References

- Belik S. L., Sareen J. Sexual orientation and its relationship to mental disorders and suicidal behavior. 2010, April 23. Paper presented at the annual conference of the American Association of Suicidology, Orlando, FL
- Cochran SD, Mays VM, Sullivan JG. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *J Consult Clin Psychol*. 2003 Feb; 71(1):53-61
- Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling, M. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
- Haas AP. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex*. 2011;58(1):10-51.
- Jacobs D, et. al. Practical Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. American Psychiatric Association, 2003.
- Kertzner RM, Meyer IH, Frost DM, Stirratt MJ. Social and psychological well-being in lesbians, gay men, and bisexuals: the effects of race, gender, age, and sexual identity. *Am J Orthopsychiatry*. 2009 Oct;79(4):500-10.
- Mathy R. M. Suicidality and sexual orientation in five continents: Asia, Australia, Europe, North America, and South America. *International Journal of Sexuality and Gender Studies*. 2002a;7(23):215–225
- Moody C, Smith NG. Suicide protective factors among trans adults. *Arch Sex Behav*. 2013 Jul;42(5):739-52
- Olson J, Schrager SM, Belzer M, Simons LK, Clark LF. Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria. *J Adolesc Health*. 2015 Jun. Ahead of print.