

# Sexual Orientation in adolescents who commit suicide

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> Abstract (summary)

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> It has been suggested that there is a strong relationship between suicidal behavior and homosexuality in adolescence. It has been further suggested that it is due to the stigmatization and feelings of isolation that are experienced by many gay adolescents. Much of the literature that has given support to these hypotheses has been conducted on uncontrolled nonrepresentative samples and its generalizability is open to question. An opportunity to examine the relationship in an unselected sample arose in a case control, psychological autopsy study of 120 of 170 consecutive suicides under age 20 and 147 community age, sex, and ethnic matched controls living in the Greater New York City area. Homosexuality was defined as having had homosexual experiences or having declared a homosexual orientation. Three teenagers and no controls met these criteria. The difference was not significant. The circumstances of death were examined and are described. In no instance did suicide directly follow an episode of stigmatization. All three suicides had evidence of significant psychiatric disorder before death. In spite of opportunities for biased reporting, it is concluded that this study finds no evidence that suicide is a common characteristic of gay youth, or that when suicide does occur among gay teenagers, that it is a direct consequence of stigmatization or lack of support.

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> Full Text

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> A paper in the 1989 report of the U.S. Department of Health and Human Services' Report of the Secretary's Task Force on Youth Suicide (Gibson, 1989) projected that "gay youth are 2 to 3 times more likely to attempt suicide than other young people. They may comprise up to 30% of completed youth suicides annually." The projection derived from reports of high rates of suicide-attempt behavior in gay adolescents and the likelihood that attempt rates are proportional to completion rates. Gibson went beyond predicting incidence and, based on his clinical experience, suggested that the high rate derived from gay teenagers' frequent experience of physical and verbal abuse and rejection. He reasoned that, because of this rejection, the gay teenager was relatively undersupported and had to fend for himself prematurely. "The root of the problem of gay youth suicide is a society that discriminates against and stigmatizes homosexuals while failing to recognize that a substantial number of its youth has a gay or lesbian orientation" (p. 110). Gibson's views and projections were influential. They have been widely presented as the basis for official resolutions of professional, political, and legislative groups (AACAP, 1992; New York Times, 1992). The purpose of this paper is to provide new data on this generally underresearched topic.

> Gibson's hypothesis included three components: a) that homosexuality is more common than is generally recognized; b) that the gay teenager is unsupported and is subject to stressful interpersonal experiences; and c) that these stresses contribute to a high rate of suicidal behavior.

> The first of these points may not seem directly relevant to the problem of gay suicide. Studies of completed suicide, however, tend to have small numbers so that case-control comparisons may be unstable. It is, therefore, useful to be able to refer to some general population norms. The prevalence of homosexuality in adolescents has been most carefully examined by Remafedi (1992), in a large probability sample of high school students, using a self-report form. Just under one percent of adolescents acknowledged being homosexual, but the rates of different forms of homosexual experience and

attraction varied, up to a maximum of 5%. Developmental patterns were complicated, with some forms of experience and attraction being more common in younger than older teenagers and, as a result, the prevalence of homosexuality could vary as a function of both definition and age, from less than one to approximately 6% of the adolescent population.

> The second component of the hypothesis is that stigmatization and lack of support contribute to suicide among gays. The basis for this view derives from reports of gays in special populations. Remafedi and colleagues (1991) found a high rate of past suicidal behavior in a sample of gay adolescents recruited from support groups, drop-in centers and bars, and acquaintance referrals. Martin and Hettrick (1988) made similar observations in a shelter for gay youth, many of whom had experienced family violence. Neither of these studies employed non-gay shelter or support-group controls. If only a minority of gay adolescents avail themselves of these services, then those subjects will be unrepresentative of homosexuals in general. In the only study that has looked at this question in an unbiased sample, Rich (1986) found no evidence that young gay suicides in the San Diego suicide study were less supported or more isolated than heterosexual suicides. Similar proportions of gays and straights were living in a stable relationship with others at the time of their death.

> The third part of Gibson's hypothesis was that a high proportion of suicides were gay. Two studies among adults have noted an association between homosexuality and suicide. Bell and Weinberg's (1972) large uncontrolled study of adult homosexuals found that many homosexual men had a past history of suicide attempts. However, a high proportion of the participants were recruited directly from gay bars or through acquaintances recruited in that way. Because of the well-established relationship between suicide and alcohol abuse, their pattern of recruitment could have led to biases for suicidal behavior. Woodruff and associates (1972), reviewing clinic records in a general psychiatric clinic, found that homosexuality was the diagnosis that was most likely to be associated with suicide-attempt behavior. The methods used to ascertain diagnostic information were not standardized or necessarily comprehensive and it is not possible to tell whether the association was indirect or confounded.

> Two other studies of predominantly adult suicides have failed to find an association with homosexuality. Both used the "psychological autopsy" technique, in which information about the deceased's symptoms and patterns of relationship are obtained from survivors who knew the victim during life. Robins (1981) reported on 134 consecutive suicides in St. Louis--all aged 20 or over--and stated there were no instances of a "diagnosis of homosexuality" (p. 7). However, an examination of the published interview protocol (pp. 25-46) shows no questions that specifically address sexual orientation and the conclusion seems to be based on a review of psychiatric diagnoses assigned to the suicide completers at the end of the inquiry. Rich (1986) reported on 283 consecutive suicides, of whom 133 were under 30 but only 14 were aged less than 20 (Rich et al., 1990). Homosexuality was defined as having a predominantly or exclusively homosexual relationship, and/or considering themselves to be homosexual. Suicides who were bisexual and who were known to have expressed a preference for heterosexual activity were classified as heterosexuals. Nine (7%) of the suicides under age 30 met the definition of being gay. There were no gays in the small number of suicides under age 21 and no lesbian suicides at any age. The pattern of psychiatric diagnosis and drug or alcohol problems were similar in gays and straights.

> Neither of these studies provide support for the hypothesis that gay adults may be overrepresented among suicide completers, but Gibson's hypothesis applied specifically to adolescents and there were too few in the San Diego study to draw any useful conclusions about the matter.

> The purpose of the present report is to examine whether Gibson's predictions receive support from a large-scale psychological autopsy study of adolescent suicides in the greater New York City area, in which a number of questions were asked about adolescent sexuality.

#### > METHODS

> The New York Suicide Study comprised a psychological autopsy study of consecutive suicides in the greater New York City area. The purpose of the study was to ascertain risk profiles of all suicides under age 20 who committed suicide during a pre-determined period. The project was approved by the New York State Psychiatric Institute Ethical Review Board. Informed consent was obtained from all informants.

> The area selected for study included the entire state of New Jersey, Litchfield, Fairfield, and New Haven

Counties in Connecticut, the five boroughs of New York City, and Nassau, Suffolk, Putnam, Rockland, and Westchester Counties in New York.

> Subjects

> Suicides were defined as deaths occurring in the above area between June 1, 1984 and May 31, 1986 that had been adjudicated by the medical examiner as a suicide (n = 170). The participation rate was 71%. Interview information was not obtained for 50 suicides of whom 9 (5% of the total sample) could not be located and 41 (24%) were traced but refused to be interviewed. A control group was identified from a stratified (by sex, age, and race) random sample drawn from telephone subscribers resident in the project study area. The number of calls made within a county was proportionate to the number of suicides in that county. Research staff re-telephoned initial refusers to ask them to reconsider participation. After this process 49 eligible controls out of 196 contacted refused interviews.

> Sample Characteristics. Of the 120 suicides who were fully investigated, 95 (79%) were male. Eighty-seven suicides (64%) were age 17 or over. Seventy percent of the suicides were white, 15% Hispanic, and 11% African-American. Gender and age distributions did not differ significantly between ethnic groups. 147 controls were evaluated. This included 116 males, 111 whites, 16 African Americans, and 15 Hispanics. Eighty-seven were age 17 or older. By design, controls did not differ significantly from the suicides in sex, mean age, proportion below age 17, sex, or ethnicity. Participant and nonparticipant suicides and controls did not differ significantly from each other in mean age, proportion over or below age 17, sex or ethnicity.

> Procedure

> The interval between suicide and assessment ranged from 28 to 976 days, with a median interval of 159 days. Fifty-four percent of the interviews took place within 6 months and 92% within 1 year of the suicide. Interviewers were masters- or doctoral-level psychologists and social workers who received systematic training on all instruments. Most interviews took place in informants' homes. Information about the suicide victims was usually obtained from: 1) a parent or another adult member of the household in which the victim was living at the time of death; 2) either a sibling or friend from the victim's peer group nominated by the parent or caretaker; and 3) at least one school teacher (and, more usually, three) nominated by the parent/caretaker or by the school principal as being well informed about the subject's classroom behavior. The procedure for controls was slightly different. Either a parent or caretaker was interviewed, and information was also obtained from the control adolescent themselves. Information from the control adolescent is not used in any case-control comparisons, but is referenced when there is a question about a third-party informant systematically underreporting. The interview procedure was such that the interviewer of the parent was blind to information from the control adolescent at the time of the evaluation. Suicides and controls were interviewed during the same time period.

> Measures

> Symptom presence during the 3 months before death (or in the case of controls before contact by the research team) was assessed by a broad interviewer-based diagnostic interview using the Diagnostic Interview Schedule for Children, version 2.1 (DISC--Shaffer et al., 1988; Shaffer et al., 1993) that employed the criterion structure of the Diagnostic and Statistical Manual-III (DSM-III--American Psychiatric Association, 1980). If a symptom was reported to have been present, a full description was elicited to ensure that it matched a symptom definition printed in the body of the interview as well as to ascertain onset, frequency and interference with function.

> Interviewers were instructed not to make inferences about subjective states; the presence of a pathological mood or thought was only endorsed if the informant could recall a definite statement made by the subject that indicated its presence (e.g., self-denigration required utterance of self-critical statements). Ratings of ambiguous responses were decided in conference. Algorithms were programmed to construct diagnoses from information about the criteria. The assessment took from 4 to 8 hours to administer.

> A proportion of interviews were re-rated from audio tapes and were then re-scored using the same computer algorithms. The kappa coefficient of agreement between raters for any diagnosis was 0.85; for any mood disorder 0.72; for any disruptive disorder 0.58; for any substance/alcohol abuse 0.76, and 0.81 for anxiety disorders.

> Six questions concerning sexual orientation were asked of all respondents. They were not constrained by the three-month time frame that applied to questions about psychiatric symptoms. The questions were as follows: Did he/she ever: 1) have a homosexual experience; 2) describe themselves as gay/bisexual; 3) express concern about being homosexual; 4) have homosexual friends; 5) say that they were teased because they were effeminate or gay; 6) behave in an effeminate way or, in the instance of girls, in an excessively masculine way. A further set of questions was asked about gender identity. These were: Did he/she ever: 1) state a wish that he/she was a girl/boy (opposite of assigned sex); 2) like to wear opposite sex clothing; 3) consistently prefer opposite sex activities. If any of these questions were answered positively, a further set of questions was asked about attitudes toward genitalia and desire for body change.

> For the purpose of the present study, homosexuality was defined broadly as "having been known to have had homosexual experiences" and/or "to have declared that they had a homosexual orientation." The reason for emphasizing experience and declared orientation is that norms are available for both (Remafedi, 1992) and that the other behaviors, specifically effeminacy or masculinity and having homosexual friends, are not necessarily indicative of sexual orientation.

#### > FINDINGS

##### > Homosexual Experience and Orientation

> Three suicides--all male (3.2% of the males; 2.5% of the entire group)--and no controls were reported to have had homosexual experiences. The difference was not significant (Fisher's exact test  $p = .088$ ). One of the three had openly declared his homosexual orientation. Two of the gay suicides were white and one was an African American. Case histories of the three male suicides are provided below.

##### > Case #1

> Case #1 was a 19-year-old male who was living in an adult homosexual household at the time of his death. He was the lover of an older member of the household. He committed suicide in an apparent pact with a 17-year-old male friend. The two teenagers were found holding hands and there was a brief note saying quite simply "sorry." Toxicology revealed high alcohol levels in both.

> During the two weeks before his death Case #1 had frequent arguments and fights with his friends and family over his frequent use of alcohol and other issues not directly relating to his sexual orientation. He became uncharacteristically withdrawn and made one serious suicide attempt. The night before his death he had become upset when only a few people attended a party he had given.

> Case #1 had shown an early interest in women's clothing, often wore make-up, and would behave in a feminine manner at parties. From the 7th grade onward he often cut classes, came to school under the influence of drugs, and abused teachers. He was suspended from school four times. His grades deteriorated and he finally dropped-out of school in the 10th grade. Although he had been teased at school for "not being manly" he hung out in the school even after he dropped out, often visiting his old class to see his former teachers and spend time with his friends. He was not exclusively homosexual and, at age 16, he had fathered a child.

> Twelve months before his death he took up residence in the gay household where he lived until his death. He would get drunk several times a week and this led to several police contacts. Four months before his death he tried to commit suicide, was admitted to the hospital, and was started on antidepressant medication. He gave up his job and remained withdrawn and depressed until his death.

> (Note: The other male who committed suicide in this pact had a long history of serious substance abuse and antisocial behavior. He had many girlfriends, and was known to have had heterosexual intercourse. His relatives and girlfriend knew of no homosexual experiences. The only evidence for his being gay was his close friendship with Case #1, which did not meet inclusion criteria for this report.)

##### > Case #2

> Case #2, a 16-year-old male, shot himself in his apartment. His suicide occurred in the context of a severe depression. There was no single identifiable precipitating event.

> He had been prone to explosive moods and tantrums for many years. A year before his death, he withdrew from his friends and family. He appeared depressed and often expressed anxiety about going to college. He complained of feeling academically "pressured" by his family. He would often lie on his bed in

a fetal position. He was referred for counseling. The male counselor he visited was reported to have engaged in sex with him.

> During the month before his death he was frequently tearful, made a wide range of self-derogatory remarks, spent much of the time on his bed in his room alone and seemed unusually agitated. He told his general practitioner that he was afraid he was going insane, that he felt hopeless about the future, and that he was thinking about committing suicide. His practitioner prescribed Haloperidol.

> He saw a priest and informed him that he had had a homosexual relationship with a relative starting at age 11 and continuing until a year before his death. He said he was worried about whether or not he was gay.

> He had had a steady female girlfriend for the past two years.

> Case #3

> Case #3 was a 19-year-old male who shot himself in his room after an argument with his girlfriend. He left her a note indicating that he loved her.

> He had a long history of conduct-disorder symptoms, including assaulting a teacher and frequent involvement in fights with both neighbors and family. He dropped-out of school at the age of 16, but was then unable to find work. He had been incarcerated for robbery and assault with a deadly weapon. He told friends that he was very much in love with his girlfriend. He also had told a family member that he regularly engaged in fellatio with an older man in exchange for money. He had been admitted to hospital twice for management of acute confusional states associated with the use of PCP. He had seemed depressed for about two months before his death.

> Homosexual Friends, Effeminacy, and Gender Dysphoria

> In addition to the three suicides who were known to have had homosexual experiences, a further six suicides, including the partner in the pact with Case #1, were known to be close friends with other gay teenagers. Three other suicides were reported to have been effeminate in their behavior.

> Three of the control adolescents reported that they had homosexual friends and two additional controls reported having been teased for being effeminate. None of these five or any other control adolescents admitted to having a homosexual orientation or to having had a homosexual experience. All of the above features in controls were reported by the adolescents themselves and in each instance the parent had stated that the behavior was not present.

> None of the informants of the suicides reported symptoms indicative of gender-identity disorder. The parents of one control girl reported that their daughter had said that she wished she was a boy.

> Associated Psychiatric Disorder

> All three suicides were assigned one or more psychiatric diagnoses. Two had long-standing substance- and alcohol-abuse disorder, one had an additional diagnosis of conduct disorder. In addition, all were assigned diagnoses of mood disorder.

> DISCUSSION

> Is There an Elevated Rate of Homosexuality among Teen Suicides?

> The 3 of 120 suicides who met the criterion for homosexuality give a rate of homosexuality of 2.5% in suicides of both genders or 3.5% among the males only. There were no control subjects whose parents knew of their child having homosexual experiences or a homosexual orientation. However, sample sizes are small and the difference between suicides and controls was not significant.

> These rates of homosexuality are similar to the prevalence rates reported in Remafedi's (1991) large scale (n = 13,000) study of adolescent sexual orientation and experience, in which 3% of 18-year-olds (the modal age for our study population) had had some form of homosexual experience. However, Remafedi determined past behavior with an anonymous self-completion form that may have been more sensitive than the face-to-face interview with a third-party informant, used in the present study.

> Our findings are broadly comparable with the 7% rate of homosexuality reported by Rich (1986) in an older group of 21-30-year-olds. There were no instances of homosexuality in his very small adolescent group. The present study used a broader definition than the San Diego study, accepting any reported homosexual behavior as indicative of homosexual status rather than the "established gay lifestyle" required by Rich. It seems that, in at least one of our three cases, homosexual behavior occurred only in

the context of prostitution and that case would probably not have been classified as gay in the San Diego study.

> Underreporting. It is reasonable to assume that parents will be less likely to report sexual orientation or sexual behavior compared with the teenagers themselves. The present study provides some direct evidence for this. None of the control parents reported that their child was abnormally effeminate or, in the instance of girls, "tomboyish," although five of the control adolescents reported being teased as gay or effeminate. Even so, there were no instances where the control teenager revealed a homosexual orientation or experience.

> A critical question is whether there were systematic differences in reporting between the suicides and the controls. There are several ways in which reporting differences might favor under- or overreporting of homosexuality.

> i) The range of informants is likely to have been a neutral influence. The cases of homosexuality reported in this paper were defined using a best-estimate procedure that pooled information from all known informants. In the case of the suicide victims this included peers and/or similar-aged siblings. In the case of controls this involved parents and controls themselves. In two of the three cases, information about sexual orientation and experience was derived from a peer or sibling informant and not from the parent. It seems that the differences in informant would balance themselves out with a neutral effect.

> ii) Recall Bias. Information can be lost in the psychological autopsy technique. Distant events may be telescoped, that is, remembered as being closer to the assessment procedure than they were. This should not have been a factor because information on sexual orientation and behavior was collected for a lifetime frame. On the other hand, the reporting period extended right up to the interview for the controls, facilitating recall. One would therefore expect a greater number of behaviors to be reported by the control group.

> iii) Search for Meaning. The tragedy of the death is likely to lead to overreporting of any "suspicious" behavior and could account for selective recall or judgments of homosexual friendships or apparent effeminacy. This would favor overreporting by the suicides.

> On balance, the factors favoring reports in the suicides and controls balance each other.

> Was Intolerance or Stigmatization a Precipitant to Suicide?

> The first case had been teased in the past for not being "manly", but this did not appear to be an acute precipitant of the suicide, which occurred in the context of a major depression, some years later. It is not clear how much the teasing was seen as a problem. It had not deterred to his returning to school to meet pupils and teachers after he had dropped out. None of the other case histories revealed recent teasing by others, family rejection, or discrimination because of sexual orientation.

> The informant for Case #2 indicated to the interviewer that the youth ruminated about his previous homosexual relationship and was "tortured" by the question of whether or not he was homosexual. However, this needs to be seen in the context of a severe depression with possible psychotic features. The boy's experiences may have done no more than provide content to his depressed self-recriminatory thoughts.

> CONCLUSION

> This study shows a slightly, but not significantly, higher rate of homosexual experience among teen suicides than controls.

> The rates of homosexuality appear similar to those reported in the general population but, because the ascertainment approach may have been less sensitive in this study, the real rate among suicides could be higher. However, it seems clear that only a small proportion of suicides were openly gay. We found no evidence that the risk factors for suicide among gays were any different from those among straight teenagers.

> The debate that links homosexuality to suicide may be a distracting side-issue to two real problems: a) some gay teenagers may experience significant adjustment difficulties that require precise study and appropriate intervention, and b) suicide is most common in individuals with a psychiatric illness, rather than in individuals with a "hard life." It should be reassuring that the data reported here suggest that the painful experience of establishing a gay orientation does not lead disproportionately to suicide.

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